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S. HRG. 115–276

THE FISCAL YEAR 2018 BUDGET FOR VETERANS' PROGRAMS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED FIFTEENTH CONGRESS

FIRST SESSION

JUNE 14, 2017

Printed for the use of the Committee on Veterans' Affairs

Available via the World Wide Web: http://www.fdsys.gov

U.S. GOVERNMENT PUBLISHING OFFICE
26–285 PDF WASHINGTON : 2018

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THE FISCAL YEAR 2018 BUDGET FOR VETERANS' PROGRAMS

WEDNESDAY, JUNE 14, 2017

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 2:41 p.m., in room 418, Russell Senate Office Building, Hon. Johnny Isakson, Chairman of the Committee, presiding.

Present: Senators Isakson, Moran, Boozman, Heller, Rounds, Tillis, Tester, Murray, Sanders, Brown, Blumenthal, and Manchin.

OPENING STATEMENT OF HON. JOHNNY ISAKSON, CHAIRMAN, U.S. SENATOR FROM GEORGIA

Chairman ISAKSON. I call this meeting of the Senate Veterans' Affairs Committee to order. I apologize again for being a little bit late, but I wanted to make sure we were on the right track and I did not mess anything up.

I want to welcome Secretary Shulkin, who has had a great start. I do not think anybody in this administration started out with a unanimous vote he received. You cannot do any better than unanimous when you get confirmed. I think the vote last week on accountability was extraordinary, and the way we got to the decision, working together hand in hand, was extraordinary. I commend the Ranking Member on his help in doing the same.

We have got some other things to do today to talk about, budgetwise, and we will have some other decisions to make. We can keep the same tempo, same discipline, and the same commitment to making sure we all know what each other knows before they happen rather than finding out after the fact, which we will all be an awful lot better off.

I welcome Dr. Shulkin and the other members of the VA staff that are here today. I appreciate all that they had done in our meeting the other day to explain where we are going with the Veterans Administration, which is upward and outward and further ahead all along.

I am not going to make a long statement at all, except to say a couple of things. I do not want to make this David Shulkin Day, but one other thing I have to brag about, the Cerner decision and getting our electronic medical records issue solved after years of unwillingness to address it is extraordinary. I think, from what I have heard, there are already signs that people are coming together who in the past had not been together to make sure this happens and works efficiently for our veterans and for the Depart-

ment of Defense and the Department of Veterans Affairs at the same time.

It was silly to have two different agencies in the same government serving the same soldiers, fighting for the same country and the same Constitution that had two medical systems that were not interoperable, one to the other, and where our veterans who fought for us would literally fall in a hole going from active duty from the Department of Defense to Veterans Affairs. I think this move to Cerner is going to prove to be a tremendous move economically for the VA and benefit-wise for our veterans. There is no possible way to do any better than that. So, I commend you on that decision as well.

With that, instead of getting into details, I am going to ask for an opening statement from the Ranking Member, Jon Tester.

OPENING STATEMENT OF HON. JON TESTER, RANKING MEMBER, U.S. SENATOR FROM MONTANA

Senator TESTER. Thank you, Mr. Chairman, and thanks for having this hearing. I think it is important to say that our thoughts are with the colleagues who were with the victims this morning. We wish a speedy recovery for Congressman Scalise and everybody else who was injured, and a big, big thank-you to the Capitol Police officers who work every day to make sure this place is a safe place. Our thoughts are with them.

Now, Secretary Shulkin, I want to thank you for being here, and I want to thank you for being here with your VA team. We spoke last week at some length about the future of the Choice Program, and I hope I made my perspective clear: the Choice Program was intended to supplement care, provided, directed by the VA, not replace it, not now and not into the future.

I worry that the budget proposed by this administration starts us down a path of unfettered choice that will hollow out the VA. In doing so, it proposes to increase funding for community care by a third, while proposing that the VA's own hospitals receive an increase that is less than half of the medical inflation rate—not much.

Further, the budget does absolutely nothing to address VA's aging infrastructure. If we are starving VA's hospitals for funding used to hire staff and actually provide care for veterans while also denying them money to address the environmental care concerns, we know what that outcome is going to be. Soon enough, there will not be any quality VA hospitals staffed by quality providers, and the VA care will become nothing more than a voucher plan to send veterans into the private sector to hunt for a doctor who has the time and the capacity and the knowledge to treat them. That is not what our veterans need, and it is not what the veterans want to happen. For a rural State like Montana, it would truly be a disaster.

We need to be honest. Each year, more and more rural hospitals are at the risk of closing, and if there are rollbacks to recent Medicaid expansions, it is likely that these closures would accelerate. We cannot assume that private care will work in rural communities where there are no providers in the first place or where the third-party administrators (TPAs) do not have sufficient networks.

We know that the vast majority of veterans using Choice over the last 2 years are eligible due to long wait lines, not because they live too far from a VA facility. Data shows that rural veterans are not just choosing Choice as much, but they actually do depend on VA care.

Now, based on your request yesterday, we may have to shift additional funds around and out of VA care accounts to get the Choice Program through the fiscal year. For months, we have been asking about the Choice Program spend rate and the amount of funds, the amount of remaining funds. We were never provided with those answers we needed to make informed decisions, and now we are in a difficult spot.

Mr. Secretary, no one wants to delay care for veterans—no one—and we will act appropriately and in a timely manner to solve this problem. But, for that to happen this late in the game is a bit frustrating to me, and my frustration is compounded by a budget that cuts services that veterans rely on, makes cuts to education oversight, makes cuts to information technology (IT), which impact every business line and how the department operates. I am most concerned that it appears that these cuts are being made in order to pay for certain veterans to get private care.

The new policies proposed in this budget to pay for private care are simply untenable. To put forward a proposal that would, without warning, stop earned benefits payments to severely disabled vets is unacceptable. In this case, we are not talking about folks milking the system for government-funded compensation that they do not need or do not deserve. To get the individual unemployment benefit payment, it must be determined that a veteran is unable to engage in substantive work as a direct result of service to their country.

President Trump's budget proposes that we just stop paying these veterans at a time when more Americans are having to work longer in their lives to make ends meet and all in the name of finding more money for Choice. That is a nonstarter, and I hope we can get your commitment today to keep this important benefit in place.

I look forward to working with my colleagues on both sides of the aisle to address these concerns and look forward to hearing from you and how you intend to prioritize funding for veterans who get care and benefits direction from the VA.

Finally, I would like to wish the U.S. Army a happy birthday.

I look forward to your testimony, Secretary Shulkin.

With that, thank you, Mr. Chairman.

Chairman ISAKSON. Secretary, welcome. Let me introduce those you brought with you to back you up and accompany you along the way, which we appreciate them being here too. Edward Murray, thank you for being here today as Acting Assistant Secretary for Management and Chief Financial Officer; Richard Chandler, Deputy Assistant Secretary, Resource Management; Mark Yow, Chief Financial Officer, Veterans Health Administration; James Manker, Acting Principal Deputy Under Secretary for Benefits; and Mr. Matthew Sullivan, Deputy Under Secretary for Finance and Planning and Chief Financial Officer, National Cemetery Administration.

Secretary Shulkin, the floor is yours.

STATEMENT OF HON. DAVID J. SHULKIN, M.D., SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY EDWARD MURRAY, ACTING ASSISTANT SECRETARY FOR MANAGEMENT AND CHIEF FINANCIAL OFFICER; RICHARD CHANDLER, DEPUTY ASSISTANT SECRETARY, IT RESOURCE MANAGEMENT; MARK YOW, CHIEF FINANCIAL OFFICER, VETERANS HEALTH ADMINISTRATION; JAMES MANKER, ACTING PRINCIPAL DEPUTY UNDER SECRETARY FOR BENEFITS, VETERANS BENEFITS ADMINISTRATION; AND MATTHEW SULLIVAN, DEPUTY UNDER SECRETARY FOR FINANCE AND PLANNING AND CHIEF FINANCIAL OFFICER, NATIONAL CEMETERY ADMINISTRATION

Secretary SHULKIN. Well, thank you, Chairman Isakson, Ranking Member Tester, and other Members of the Committee.

As you can see, I brought a big team with me because I know you are going to have lots of questions, in particular, with the opening statements, I really do look forward to having a meaningful discussion and getting to some solutions and some closure on some of these issues.

I also did want to echo the Ranking Member's concern that this is a sad day for the Nation where public servants who work as hard as I know all of you do have to worry about their personal safety, and our thoughts and prayers are with the Congressman and the staff and the Capitol Police as well.

Thank you again for allowing us to be here today. What we want to talk about today is the 2018 President's budget and the 2019 advanced appropriations, and all of this is in way of showing support for veterans. We appreciate the legislation that recently had been passed. As you know, you passed just within the past week, the accountability bill, and that went through the House yesterday. We are looking forward to actually next Tuesday bringing it for a signature for the President, which is good news.

We also appreciate your support for the Veterans Choice Improvement Act that you supported and for providing us, really for the first time in a long time, the full 2017 budget. This has really allowed us to make real progress for veterans, and we are, again, grateful for that support.

I have submitted the full written statement for the record, so let me just start by thanking you again for allowing us to participate in the hearing last week. It seems like we were just here with you, but I thought it was an excellent hearing, a good discussion on Choice. That type of discussion and dialog is going to allow us to help get it right for veterans.

When I testified before the House Veterans' Affairs Committee on March 7, we had $2.0 billion in the Choice account. Less than a month and a half later, when the President signed the Choice Extension Act into law, our Choice account was at $1.5 billion. Today, that account is at $821 million.

As we know, more veterans than ever are using Choice. We have authorized 8.2 million Community Care appointments since January of this year. That is 2.6 million more than last year or a 46 percent increase. In fact, March, April, and May were the largest months ever for Choice, and frankly, that happened because we fixed so many of the problems that we have all been working to fix

with Choice. We have been increasing our use of Choice. One of the reasons why is the 2017 budget, as you may remember, actually had $2 billion less in Community Care, so we have been putting more through Choice.

Two years ago—I am sure you are going to remember in July 2015, we had too little money in our Community Care accounts within the VA, which we solved with your help by accessing unused funds in the Choice account, so we transferred money from Choice into Community Care. We now have too little money in the Choice account, which we are working to solve, again, working with you, with legislative authority to replenish funds into the Choice account.

This is the situation that we have described before, where for a single purpose of providing care in the community, we have two checking accounts, and I will tell you, I wish it were easier than it is. We have to figure out how to balance these two checking accounts at all times. Obviously, it is not a science; it is an art. We are having difficulty with that once again. That is why we need to work with you to solve it.

The Veterans CARE Program that we outlined for you last week will solve this recurring problem permanently by modernizing and consolidating all of the Community Care accounts, including Choice. The President's budget in 2018 and 2019 provides additional funds for Choice and the resources necessary to continue the ongoing modernization of VA. It requests $186.5 billion for VA, $104.3 billion in mandatory funding, and $82.1 billion in discretionary funding, for a total increase of $6.4 billion or 3.6 percent over 2017.

It provides $2.9 billion in mandatory funding to continue the Choice Program in 2018 plus a 7.1 percent increase in discretionary funding for VHA to improve patient access and timeliness of care.

It supports the strengthening of foundational services as well as modernization in consolidating VA Community Care through the Veteran CARE Program announced last week, so veterans can make the right decisions about their care together with their physician or provider, giving them yet another reason to choose VA.

This budget reflects the President's strong personal commitment to the Nation's veterans. It is also a budget we need to achieve my five priorities as Secretary: providing greater choice for veterans; modernizing our systems; focusing our resources toward what is most important for veterans; improving the timeliness of our services; and suicide prevention.

We are already taking steps to meet the challenges that we face. At the President's direction, we have established a VA Accountability Office. The recent decisions made by the Senate and the House will help us with that.

We have recently removed two medical center directors and three other senior executive service leaders. We simply will not tolerate employees who act counter to our values or put veterans at risk.

I recently announced a new Fraud, Waste, and Abuse Prevention Advisory Committee, which will be set up and running later this summer.

I have also directed the VA Central Office remain under a hiring freeze—those are for administrative positions—as we consolidate

program offices, implement shared services, and realign overhead to get more money back to the field.

We now have same-day services for primary care and mental health at all of our medical centers. Veterans can now access wait-time data for their local VAs using an online easy-to-use tool to understand access and quality. No other health system in the country has this type of transparency.

We have made it easier for veterans to fill online health care applications, so much easier, in fact, that since last summer, we have received eight times as many online applications than the year before.

Last month, we were able to process a disability claim in just 3 days—I said that right: a disability claim processed in 3 days—using a new process called Decision Ready Claims. We will be introducing Decision Ready Claims nationally September 1.

At our regional offices, we will be completely paperless for claims by mid-2018.

A few months ago, the Veterans Crisis Line had a call rollover rate of more than 30 percent. Today, that rate is less than 1 percent.

We have launched a new predictive modeling tool called REACH VET allowing VA to provide proactive support for veterans who are at higher risk for suicide.

We are also launching a new initiative this summer, Getting to Zero, to help us end veteran suicide. This is my top clinical priority.

But, to keep moving forward, we are going to need your help. We have identified over a thousand facilities that are either vacant or underutilized, and we are working now to move forward with 142 of those facilities. With your help, we could do more of the same.

We need Congress to fund our IT modernization to keep our legacy systems from failing and to replace VistA with the system already in use by the Department of Defense. This will ultimately put all patient data in one shared system, enabling seamless care between the VA and DOD, without manual and electronic exchange and reconciliation of data between separate systems.

We also need Congress to authorize and overhaul our broken and failing claims appeals process. We have worked closely with VSOs and other stakeholders to draft a proposal to modernize the system, and we were pleased to see the House unite behind the bill last month. Now we just need the Senate to act.

Most of all, we need Congress to ensure the continued success of Choice for veterans. Veterans are responding to our modernization efforts by choosing VA more than before. To keep up with those choices, we need to fully fund Choice and help us modernize and consolidate VA Community Care through the Veterans CARE Program. The Veterans CARE Program will coordinate care so that veterans get the right care at the right time with the right provider, whether in a VA facility or from a high-performing VA Community Care provider. We just need your help to make it happen, including funding, to keep up with veterans as they choose VA.

Thank you, and we look forward to your questions today.

[The prepared statement of Secretary Shulkin follows:]

PREPARED STATEMENT OF HON. DAVID J. SHULKIN, M.D., SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

GOOD AFTERNOON, CHAIRMAN ISAKSON, RANKING MEMBER TESTER, AND DISTINGUISHED MEMBERS OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS. Thank you for the opportunity to testify today in support of the President's 2018 Budget and 2019 Advance Appropriation (AA) Request and to define my priorities to continue the dynamic transformation within the Department of Veterans Affairs (VA). I am accompanied today by Edward Murray, Acting Assistant Secretary for Management and Acting Chief Financial Officer; Richard Chandler, Deputy Assistant Secretary, IT Resource Management; Mark Yow, Chief Financial Officer for the Veterans Health Administration; James Manker, Acting Principal Deputy Under Secretary for Benefits in the Veterans Benefits Administration; and Matthew Sullivan, Deputy Under Secretary for Finance and Planning for the National Cemetery Administration. I also want to thank Congress for providing the Department its full 2017 budget prior to the start of the Fiscal Year—this is significant and has been extremely beneficial to our ability to provide services and care to Veterans. The 2018 budget request fulfills the President's strong commitment to all of our Nation's Veterans by providing the resources necessary for improving the care and support our Veterans have earned through sacrifice and service to our country.

FISCAL YEAR (FY) 2018 BUDGET REQUEST

The President's 2018 budget requests $186.5 billion for VA—$82.1 billion in discretionary funding (including medical care collections), of which $66.4 billion was previously provided as the 2018 AA for Medical Care. The discretionary request is an increase of $4.3 billion, or 5.5 percent, over 2017. It will improve patient access and timeliness of medical care services for over 9 million enrolled Veterans, while improving benefits delivery for our Veterans and their beneficiaries. The President's 2018 budget also requests $104.3 billion in mandatory funding, of which $103.9 billion was previously provided, such as disability compensation and pensions, and for continuation of the Veterans Choice Program (Choice Program).

For the 2019 AA, the budget requests $70.7 billion in discretionary funding for Medical Care and $107.7 billion in 2019 mandatory advance appropriations for Compensation and Pensions, Readjustment Benefits, and Veterans Insurance and Indemnities benefits programs in the Veterans Benefits Administration. The budget also requests $3.5 billion in mandatory budget authority in 2019 for the Choice Program.

This budget request will ensure the Nation's Veterans receive high-quality health care and timely access to benefits and services. I urge Congress to support and fully fund our 2018 and 2019 AA budget requests—these resources are critical to enabling the Department to meet the increasing needs of our Veterans.

MODERNIZING VA

As you all know, I was part of the VA team for the last year and a half prior to being confirmed as the Secretary of Veterans Affairs. I came to VA during a time of crisis, when it was clear Veterans were not getting the timely access to high-quality health care they deserved. I soon discovered that years of ineffective systems and deficiencies in workplace culture led to these problems. I know that the organization has made significant progress in improving care and services to Veterans. But I also know that VA needs more changes to the way we do business for Veterans and the country as a whole, in order for all to say, "That is a different organization now." VA needs to continue to fix numerous areas of the business, including access, claims and appeals processing, and many of our core functions, to ensure that the basics are done correctly. Beyond that, VA has to deliver to Veterans revolutionary leaps in care, benefits, and services. Congress, along with our VA employees, Veterans Service Organizations (VSO), and private industry, will play a critical role in making those revolutionary leaps a reality.

Focus on Execution

Above all else, VA needs to perform its core functions well. When Veterans arrive at a VA facility for care, they must be treated with respect, see a clean and modern facility, be seen by their provider on time, and understand what the next steps for their care will be. Veterans should be able to receive clear and accurate information about their claims and understand where they are in the process. We must ensure that this is every Veteran's experience every time they interact with VA. Where we fall short, we will hold employees accountable, ensure we are good stewards of the taxpayer dollar, and ask for Congress's support for legislative fixes where needed.

Make Bold Change

We know it is paramount that we increase our focus and intensify the efforts to improve how we execute our mission—Veterans should and do expect that from us. We also recognize that incremental change is not sufficient to achieve the additional improvements VA and Veterans need and demand for restoring the trust of Veterans and the American public.

As I have noted, VA is a unique national resource that is worth saving, and I am committed to doing just that. Veterans have unique needs, and the services VA provides to Veterans often cannot be found in the private sector. The Veterans Health Administration (VHA) provides support to Veterans through primary care, specialty care, peer support, crisis lines, transportation, the Caregivers program, homelessness services, vocational support, behavioral health integration, medication support, and a VA-wide electronic medical record system. These services and supports are unparalleled. We also know that VA hospitals perform well on quality compared to non-VA hospitals. In a study published in the Journal of American Medical Association (JAMA) Internal Medicine in April, researchers compared hospital-level quality data on 129 VA hospitals and 4,010 non-VA hospitals obtained through the Centers for Medicare and Medicaid's website. They found VA hospitals had better outcomes than non-VA hospitals on six of nine patient safety indicators, and there were no significant differences on the other three indicators. VA hospitals also had better mortality and readmission rates than non-VA hospitals. With the continued support of Congress, VA will supplement its services through private-sector health care, but we realize it is not a replacement for the services VA provides to Veterans.

We are already implementing bold changes in the agency. We are working hard to ensure employees are held accountable to the highest of standards and working with Congress to provide us with greater authority and flexibility to do that. We are also working with Congress on appeals reform and on a long-term solution for providing greater community care options. I will discuss these efforts in greater detail below.

FIVE PRIORITIES

As I prepared for my confirmation hearing earlier this year, I identified my top priorities to address as Secretary. These areas have shaped the first several months of my tenure and provide focus for our attention and resources, and the foundation for rebuilding trust with our Veterans. We will also use the budgeting process to support our strategy by shifting resources toward our "foundational services" that make VA unique while maintaining support to our strategic priorities.

Priority 1: Greater Choice for Veterans

The Choice Program is a critical program that has increased access to care for millions of Veterans. Coming into this new administration, extending the Choice Program was one of my top priorities for quick action, as VA anticipated that based on Veteran program participation, there would be an estimated $1.1 billion in unobligated funds left on the original expiration date of August 7, 2017. On April 19, 2017, the President signed into law the Veterans Choice Program Improvement Act (Public Law 115–26), allowing the Choice Program to continue until the Veterans Choice Fund is exhausted. Without this legislation, VA would have been unable to use funding specifically appropriated for the Choice Program by Congress, so we commend Congress for passing this legislation swiftly and in a bipartisan manner. This legislation also provides VA and Congress more time to develop a long-term solution for community care.

Since the start of the Choice Program, over 1.6 million Veterans have received care through the program. In FY 2015, VA issued more than 380,000 authorizations to Veterans through the Choice Program. In FY 2016, VA issued more than 2,000,000 authorizations to Veterans to receive care through the Choice Program, more than a fivefold increase in the number of authorizations from 2015 to 2016.

Looking at early data for 2017, it is expected that Veterans will benefit even more this year than last year from the Choice Program. In the first quarter of FY 2017, we have seen a more than 30 percent increase from the same period in FY 2016 in terms of the number of Choice authorizations. In addition to increasing the number of Veterans accessing care through the Choice Program, VA is working to increase the number of community providers available through the program. In April 2015, the Choice Program network included approximately 200,000 providers and facilities. As of March 2017, the Choice Program network has grown to over 430,000 providers and facilities, a more than 150 percent increase during this time period.

As these numbers demonstrate, demand for community care is high. In 2018, VA plans to spend a total of $13.2 billion to support community care for Veterans. Community care will be funded by a discretionary appropriation of $9.4 billion for the Medical Community Care account ($254 million above the enacted advance appropriation), plus $2.9 billion in new mandatory budget authority for the Choice Program. This, combined with an estimated $626 million in carryover balances in the Veterans Choice Fund, provides a total of $13.2 billion in 2018 for community care.

VA will continue to partner with Congress to develop a community care program that addresses the challenges we face in achieving our common goal of providing the best health care and benefits we can for our Veterans. We have also worked with and received crucial input from Veterans, community providers, VSOs, and other stakeholders in the past, and we will continue doing so going forward. However, we do need your help.

One such area is in modernizing and consolidating community care. Veterans deserve better, and now is the time to get this right. We are committed to moving care into the community where it makes sense for the Veteran. The ultimate judge of our success will be our Veterans, and our only measure of success will be our Veterans' satisfaction. With your help, we can continue to improve Veterans' care in both VA and the community.

Empower Veterans through Transparency of Information

We are also increasing transparency and empowering Veterans to make more informed decisions about their health care through our new Access and Quality Tool (available at www.accesstocare.va.gov). This Tool allows Veterans to access the most transparent and easy to understand wait-time and quality-care measures across the health care industry. That means Veterans can quickly and easily compare access and quality measures across VA facilities and make informed choices about where, when, and how they receive their health care. Further, they will now be able to compare the quality of VA medical centers to local private sector hospitals. This Tool will take complex data and make it transparent to Veterans. This new Tool will continue to improve as we receive feedback from Veterans, employees, VSOs, Congress, and the media.

Priority 2: Modernizing our System

Infrastructure Improvements and Streamlining

In 2018, VA will focus on fixing VA's infrastructure while we transform our health care system to an integrated network to serve Veterans. This budget requests $512.4 million in Major Construction funding as well as $342.6 million in Minor Construction for priority infrastructure projects. This funding supports projects including a new outpatient clinic in Livermore, CA, as well as gravesite expansions in Sacramento, CA; Bushnell, FL; Elwood, IL; Calverton, NY; Phoenix, AZ; and Bridgeville, PA. VA is also requesting $953.8 million to fund more than 2,000 medical leases in FY 2018, an increase of $141.9 million over the FY 2018 AA, and $862 million for activation of new medical facilities. In 2018, VA is seeking Congressional authorization of 27 major medical leases. The majority of these leases have been included in previous budget requests, some dating back to the FY 2015 budget submission. These major medical leases are vital to establish new points of care, expand sites of care, replace expiring leases, and expand VA's research capabilities.

The 2018 budget submission includes proposed legislative requests that if enacted, would increase the Department's flexibility to meet its capital needs. These proposals include: 1) increasing from $10 million to $20 million the dollar threshold for minor construction projects; 2) modifying title 38 to eliminate statutory impediments to acquiring joint facility projects with DOD and other Federal agencies; and 3) expanding VA's enhanced use lease (EUL) authority to give VA more opportunities to engage the private sector and local governments to repurpose underutilized VA property.

The Department is also a key participant in the White House Infrastructure Initiative to explore additional ways to modernize and obtain needed upgrades to VA's real property portfolio to support our continued delivery of quality care and services to our Nation's Veterans. We are excited about the opportunity to transform the way we approach our infrastructure.

Electronic Health Record Interoperability and IT Modernization

The 2018 Budget continues VA's investment in technology to improve the lives of Veterans. The planned IT investments prioritize the development of replacements for specific mission critical legacy systems, as well as operations and maintenance of all VA IT infrastructures essential to deliver medical care and benefits to Veterans. The request includes $358.5 million for new development to replace four spe-

cific mission critical legacy systems, including the Financial Management System, and establish an Integrated Project Team to develop the requirements and acquisition strategy for a new enterprise health information platform. It also invests $340 million for information security to protect Veterans' information and improve VA's information networks' resilience.

The 2018 budget submission includes a proposed legislative request that if enacted, would increase the Departments ability to apply agile program management to the dynamics of modern Information Technology development requirements. To do this, the Department recommends advancing the transfer threshold from $1 million to $3 million between development project lines, which equates to less than 1 percent of the Development account. Through the Certification process, Congress will maintain visibility of proposed changes.

VA recognizes 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, by making relevant clinical data available at the point of care and enabling clinicians to provide Veterans with prompt, effective care. Today, VHA, the Veterans Benefits Administration (VBA), and the Department of Defense (DOD) share more medical information than any public or private health care organization in the country. We have developed and deployed, in close collaboration with DOD, the Joint Legacy Viewer (JLV). JLV is available to all clinicians in every VA facility. It is a web-based user interface that provides clinicians with an intuitive display of DOD and VA health care data on a single screen. VA and DOD clinicians can use JLV to access the health records of Veterans, Active Duty, and Reserve Servicemembers from all VA, DOD, and any third party community providers who participate in Health Information Exchanges where a patient has received care. Multiple releases of Community Care applications, including JLV-Community Viewer, Community Provider Portal, and Virtru Pro Secure Email have enhanced care coordination with Community Providers through multiple methods of exchanging health records and multiple modes of communication improving the care the Veteran receives and allowing Community Providers not in Health Information Exchanges the ability to share medical documentation.

VA will complete the next iteration of the VistA Evolution Program, VistA 4, in 2018. VistA 4 will bring improvements in efficiency and interoperability, and will continue VistA's award-winning legacy of providing a safe, efficient health care platform for providers and Veterans. VistA Evolution funds have enabled investments in systems and infrastructure that support interoperability, networking and infrastructure sustainment, continuation of legacy systems, and efforts such as clinical terminology standardization. These investments are critical to the maintenance and deployment of the existing and future modernized VistA and essential to operational capability. That said our current VistA system is in need of major modernization to keep pace with the improvement in health information technology and cybersecurity, and software development.

I promised a decision on our EHR system by July 1st, and I have honored that commitment by announcing that, after much deliberation, VA will adopt the same EHR system as DOD, now known as MHS Genesis, which at its core consists of Cerner Millennium. VA's adoption of the same EHR system as DOD will ultimately result in all patient data residing in one common system and enable seamless care between the departments without the manual and electronic exchange and reconciliation of data between two separate systems. Still, VA has unique needs and many of those are different from the DOD. For this reason, VA will not simply be adopting the identical EHR that DOD uses, but we intend to be on a similar Cerner platform. VA clinicians will be very involved in how this process moves forward and in the implementation of the system.

Another critical system that will touch the delivery of all health and benefits is our new financial management system, which is under development. The 2018 budget continues modernizing our financial management system by transforming the Department from numerous stovepipe legacy systems to a proven, flexible, shared service business transaction environment. The budget requests $83 million in Information Technology funds and $61.6 million for business process re-engineering to support Financial Management Business Transformation (FMBT) across the Department.

Priority 3: Focus Resources More Efficiently

Strengthening of Foundational Services in VA

VA is committed to providing the best access to care for Veterans. To deliver the full care spectrum as defined in VA's medical benefits package, VA will focus on its foundational services—those areas in which it can excel—and build community partnerships for complementary services. VA developed the following guiding principles,

centered on improving the health, well-being, and experience of Veterans receiving care from VA and in the community. These principles include:

- Enabling VA to provide access to high-quality care for Veterans, by balancing services provided by VA and the community given changing demands for care and resource limitations;
- Promoting operational efficiency and simplicity, while supporting VA's clinical care, education, and research missions; and
- Allowing facilities to meet the changing needs of Veterans in a flexible way.

High-performing organizations cannot excel at every capability and thus must make decisions about how best to invest its resources. VA will therefore further define and grow its foundational services to excel in the provision of clinical care to Veterans.

Investing in foundational services within the Department is not limited to only health care. For over a decade, VA's National Cemetery Administration (NCA) has achieved the highest customer satisfaction rating of any organization—public or private—in the country. They achieved this designation through the American Customer Satisfaction Index six consecutive times. The President's 2018 Budget recognizes the need to nurture and advance this unprecedented success with a request for $306.2 million for NCA in 2018, an increase of $20 million (7 percent) over 2017. This request will support the 1,881 FTE needed to meet NCA's increasing workload and expansion of services. In 2018, NCA will inter approximately 133,600 Veterans and eligible family members, care for over 3.7 million gravesites, and maintain 9,400 acres. NCA will continue to memorialize Veterans by providing 366,000 headstones and markers, distributing 702,000 Presidential Memorial Certificates and expanding the Veterans Legacy program to communities across the country. VA is committed to investing in NCA infrastructure, particularly to keep existing national cemeteries open and to construct new cemeteries consistent with burial policies approved by Congress. In addition to NCA's funding, the 2018 request includes $255.9 million in major construction funds for six gravesite expansion projects. When all new cemeteries are opened, nearly 95 percent of the total Veteran population—about 20 million Veterans—will have access to a burial option in a Veterans' cemetery within 75 miles of their home.

VA/DOD/Federal Coordination

VA has proposed legislation to eliminate certain statutory impediments to VA more effectively pursuing joint projects with other Federal agencies, including DOD. Today, medical facilities that are not specifically under the jurisdiction of the Secretary require specific statutory authorization for optimal collaboration. I look forward to working with Congress to: (1) enhance our ability to coordinate with DOD and other Federal agencies; (2) improve the access, quality, and cost effectiveness of direct health care provided to Veterans, Servicemembers, and their beneficiaries; (3) permit joint capital asset planning and capital investments to design, construct, and utilize shared medical facilities; and (4) provide authority for VA to procure the use of joint medical facilities for itself and other Federal agencies like DOD, and to transfer funds between VA and other Federal agencies for such initiatives.

Deliver on Accountability and Effective Management Practices

Another critical area in which VA is serious about making significant changes relates to employee accountability. The vast majority of employees are dedicated to providing Veterans the care they have earned and deserve. It is unfortunate that certain employees have tarnished the reputation of VA and so many who have dedicated their lives to serving our Nation's Veterans. We will not tolerate employees who deviate from VA's I-CARE values and underlying responsibility to provide the best level of care and services to them. We support Congress' ongoing efforts to provide VA with the tools it needs to take timely action against employees who perform poorly or engage in misconduct. Where employees engage in inappropriate behavior, do not perform the duties of their job, are engaged in illegal activities, or otherwise do not meet the standards we expect of VA employees, we want the ability to ensure they can be promptly removed. Certain laws hamper our ability to optimally hold our employees accountable and remove those individuals that run afoul of my intent for the Department to function as a high-performing organization. We support legislation that is consistent with the following principles:

- Increase flexibility to remove, demote, or suspend VA employees for poor performance or misconduct;
- Provide authority to recoup bonuses of employees for poor performance or misconduct;
- Enable recovery of relocation expenses that occur through fraud or malfeasance; and

• Ensure that VA has the ability to retain high performers by paying them a salary that is competitive with the private sector and performance awards that are commensurate with other Federal agencies.

We thank the Senate for passing critical accountability legislation, S. 1094,—all signs point to new accountability rules for VA being the law of the land soon, but while that process continues, we are also focused on updating internal hiring practices. VHA is the largest health care system in the United States, and in an industry where there is a national shortage of health care providers, VHA faces competition with the commercial sector for scarce resources. Historically, VA has followed hiring practices that have proven unduly burdensome. Over the past year, VHA's business process improvement efforts have resulted in a more efficient hiring process. We were able to reduce the time it took to hire Medical Center Directors by 40 percent and obtained approval from the Office of Personnel Management (OPM) for critical position pay authority for many of our senior health care leaders. We recognize there is much work left to do. As we strive to find internal solutions, we look forward to working together on legislation to reform recruitment and compensation practices to stay competitive with the private sector and other employers.

To ensure that VA's management practices are effective, I have announced a major initiative to improve our ability to detect and prevent fraud, waste, and abuse within VA. The initiative includes:

• forming a fraud, waste, and abuse advisory committee comprised of experts from the private sector and other government organizations;

• identifying cutting edge tools and technologies available in the private sector; and

• coordinating all fraud, waste, and abuse detection and reporting activities through a single office.

With these improvements, VA has the potential to save millions of taxpayer dollars and more effectively serve America's Veterans. I look forward to updating you in the future regarding this initiative.

Priority 4: Improve Timeliness of Services

Access to Care and Wait Times

VA is committed to delivering timely and high quality health care to our Nation's Veterans. Veterans now have same-day services for primary care and mental health care at all VA medical centers across our system. I am also committed to ensuring that any Veteran who requires urgent care will receive timely care.

In March 2017, 96.82 percent of appointments, 5.15 million appointments, were completed within 30 days of the clinically-indicated or veteran's-preferred date, and as of April 15, 2017, VHA has reduced and the Electronic Wait List from 56,271 entries to 22,383 entries, a 60.2 percent reduction between June 2014 and April 2017. The Electronic Wait List reflects the total number of all patients for whom appointments cannot be scheduled in 90 days or less.

In 2018, VA will expand Veteran access to medical care by increasing medical and clinical staff, improving its facilities, and expanding care provided in the community. The 2018 Budget requests a total of $75.2 billion in funding for Veterans' medical care, which includes the following:

• $69.0 billion in discretionary budget authority ($2.65 billion above the 2018 AA enacted level of $66.4 billion and a $4.6 billion (7.1 percent) increase over the 2017 enacted level);

• $2.9 billion in mandatory budget authority to continue the Veterans Choice Program; and

• $3.3 billion in medical care collections.

The 2018 request will support nearly 315,000 medical care staff, an increase of over 7,000 above the 2017 level.

Through the Choice Program, VHA and its contractors created more than 3.6 million authorizations for Veterans to receive care in the private sector from February 1, 2016 through January 31, 2017. This represents a 23 percent increase in authorizations when compared to the period February 1, 2015 through January 31, 2016. When looking at overall appointment data not specific to the Choice Program, the March 15, 2017, pending appointment data set shows VA has increased the number of overall pending appointments "in house" by nearly 1.8 million over the same data the prior year. According to the same data, the number of appointments scheduled greater than 30 days from the Veterans clinically indicated data or preferred date has decreased by 3.9 percent (19,645) since the beginning of FY 2017.

Accelerating Performance on Disability Claims

Since 2013, VA has made remarkable progress toward reducing the backlog of disability compensation claims pending over 125 days and is working to use more effectively the resources provided by Congress. VBA's 2018 budget request of $2.8 billion allows VBA to maintain the improvements made in claims processing over the past several years. This budget supports the disability compensation benefits program for 4.6 million Veterans and 420,000 Survivors. VBA implemented new professional standards for Veterans Service Representatives (VSR) on March 1, 2017. In May 2016, VBA implemented the National Work Queue (NWQ) process. This allows VBA to prioritize and quickly distribute disability compensation claims according to processing capacity within VBA's regional footprint, regardless of the Veteran's place of residence. The NWQ process enables VA to more effectively balance the workloads nationally, relative to the productive capacity at each regional office. This means that Veterans who live in a location where claims decisions take longer, VBA can appropriately adjust capacity to match the changes in claims volume. In FY 2017, VBA added non-rating related claims to the NWQ. VBA has completed nearly 1.7 million non-rating claims from October 2016 through the end of April 2017. The effort to address non-rating claims has resulted in a 269,000 claim reduction in the dependency claims inventory since August 2015, from 359,000 to less than 90,000.

To continue improving disability compensation claim processing, VBA is currently piloting an initiative called Decision Ready Claims (DRC). The DRC initiative offers veterans and survivors faster claims decisions in which VSOs and other accredited representatives assist Veterans with ensuring all supporting medical evidence is included with the claim at the time of submission. The DRC initiative empowers Veterans by allowing them to receive medical examinations as early as possible in the claims process. This initiative also enhances partnerships with VSOs by improving access and capabilities to assist with gathering all required evidence and information to accelerate claims decisions. Submission of claims submitted through the DRC process will result in claim decisions within 30 days of submission to VA.

Decisions on Appeals

The current VA appeals process undoubtedly needs further improvements for our Nation's Veterans. As of April 30, 2017, VA had 470,546 pending appeals. The average processing time for all appeals resolved by VA in FY 2016 was approximately 3 years. For those appeals that were decided by the Board of Veterans' Appeals (the Board) in FY 2016, on average, Veterans waited at least 6 years from filing their Notice of Disagreement until the Board's decision was issued that year.

The 2018 request of $155.6 million for the Board continues the funding level enacted for 2017, which was a 42 percent increase over 2016. In combination with carryover resources from 2017, the requested funding will support a total of 1,050 FTE, an increase of 164 FTE above the 2017 estimate of 886 FTE. This request maintains the increased budgetary authority the Board received in 2017. In addition, VBA's request of $185 million for appeals processing maintains its current level of appeals FTE at 1,495. This funding level in tandem with sweeping legislative reform initiates a long-term strategy aimed at improving the timeliness of appeals for Veterans and is the best policy option for taxpayers.

Without significant legislative reform to modernize the appeals process, Veteran wait times and the cost to taxpayers will only increase. Comprehensive legislative reform is necessary to replace the current lengthy, complex, confusing VA appeals process with a new process that makes sense for Veterans, their advocates, VA, and other stakeholders. This reform is crucial to enable VA to provide the best service to Veterans and is one of my top priorities.

VA worked collaboratively with VSOs and other stakeholders to design this new process for Veterans who disagree with a VA decision. The result of that work was a legislative proposal that was introduced in the 114th Congress and has been reintroduced in the 115th Congress. The proposed process: (1) establishes multiple options for Veterans instead of the single option available today; (2) provides early resolution of disagreements and improved notice as to which option might be best; (3) eliminates the inefficient churning of appeals that is inherent in the current process; (4) features quality feedback loops to VBA; and (5) improves transparency by clearly defining VBA as the claims agency and the Board as the appeals agency in VA. This clear definition between VBA and the Board also provides workload transparency for better workload/resource projections, and efficient use of resources for long-term savings.

The new process, described in the legislation currently pending, will provide a modernized process going forward. However, VA is also committed to concurrently reducing the pending inventory of legacy appeals. VA has worked collaboratively with stakeholders to identify opt-ins that would make the new process available to

Veterans who would otherwise have an appeal in the legacy process. After assessing these various options, and collaborating with our partners, we have identified two opt-ins that we intend to implement to address the issue of the legacy appeals inventory.

The legislation must be enacted now to fix this process. It has wide stakeholder support and the longer we wait to enact this legislative reform, the more appeals enter the current, broken system. The status quo is not acceptable for our Nation's Veterans. The new process will provide much needed comprehensive reform to modernize the VA appeals process and provide Veterans a decision on their appeal that is timely, transparent, and fair.

Priority 5: Suicide Prevention—Eliminating Veteran Suicide

Every suicide is tragic, and regardless of the numbers or rates, one Veteran suicide is too many. Suicide prevention is VA's highest clinical priority, and we continue to spread the word throughout VA that "Suicide Prevention is Everyone's Business." The 2018 Budget requests $8.4 billion for Veterans' mental health services, an increase of 6 percent above the 2017 level. It also includes $186.1 million for suicide prevention outreach. VA recognizes that Veterans are at an increased risk for suicide and implemented a national suicide prevention strategy to address this crisis. VA is bringing the best minds in the public and private sectors together to determine the next steps in implementing the Eliminating Veteran Suicide Initiative. VA's suicide prevention program is based on a public health approach that is ongoing, utilizing universal, selective, indicated strategies while recognizing that suicide prevention requires ready access to high quality mental health services, supplemented by programs that address the risk for suicide directly. VA's strategy for suicide prevention requires ready access to high quality mental health (and other health care) services supplemented by programs designed to help individuals and families engage in care and to address suicide prevention in high-risk patients.

As part of VA's commitment to put forth resources, services, and technology to reduce Veteran suicide, VA initiated the Recovery Engagement and Coordination for Health Veterans Enhanced Treatment (REACH VET). This new program was launched by VA in November 2016 and was fully implemented in February 2017. REACH VET uses a new predictive model in order to analyze existing data from Veterans' health records to identify those who are at a statistically elevated risk for suicide, hospitalization, illnesses, and other adverse outcomes. Not all Veterans who are identified have experienced suicidal ideation or behavior. However, REACH VET allows VA to provide support and pre-emptive enhanced care in order to lessen the likelihood that the challenges these Veterans face will become a crisis.

Other than Honorable Expansion

We know that 14 of the 20 Veterans who on average commit suicide each day did not, for various reasons, receive care within VA. Our goal is to more effectively promote and provide care and assistance to such individuals to the maximum extent authorized by law. In that regard, VA intends to expand access to emergent mental health care for former Servicemembers, who separated from active duty with other than honorable (OTH) administrative discharges. This initiative specifically focuses on expanding access to former Servicemembers with OTH administrative discharges who are in mental health distress and may be at risk for suicide or other adverse behaviors. VA estimates there are more than 500,000 former Servicemembers with OTH administrative discharges. As part of this initiative, former Servicemembers with OTH administrative discharges who present to VA seeking mental health care in emergency circumstances for a condition the former Servicemember asserts is related to military service would be eligible for evaluation and treatment for their mental health condition. Such individuals may access the system for emergency mental health services by visiting a VA emergency room, outpatient clinic, Vet Center, or by calling the Veterans Crisis Line. Services may include: medication management/pharmacotherapy, lab work, case management, psycho-education, and psychotherapy. We intend to carry this initiative out within our existing resources because it is the right thing to do for Veterans.

CLOSING

Thank you for the opportunity to appear before you today to address our 2018 budget and 2019 Advance Appropriations budget requests and to provide you with the priorities that I am taking to ensure VA is viewed with pride from Veterans and beneficiaries for the services provided to them. I ask for your steadfast support in funding our full FY 2018 and FY 2019 AA budget requests and continued partnership in making bold changes to improve our ability to serve Veterans. I look forward to your questions.

RESPONSE TO PREHEARING QUESTIONS SUBMITTED BY HON. JOHNNY ISAKSON TO HON. DAVID SHULKIN, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

APPEALS REFORM

Question 1. In June 2016, then Deputy Secretary Sloan Gibson sent a letter regarding VA's proposed appeals reform legislation to the Senate Committee on Veterans' Affairs, including several attachments. One attachment contains this information:

Is the legislation enough to solve the current appeals problem without new money?

> .... The legislation is an effective fix for new appeals, but alone is insufficient to resolve the current pending inventory.
> In execution, if VA received no new funding for legacy appeals, VA must either keep the promise of the new legislation (125 day/365 day processing) and *allow legacy appeals to languish* OR prioritize legacy appeals, some of which will have been pending for years when the legislation takes effect, and delay action on the new framework appeals—which will impact the Board [of Veterans' Appeals] and also increase [the Veterans Benefits Administration's] pending rating claim inventory and claims backlog.
> The answer is NO. The legislation alone frees up some existing resources to work appeals, but these resources are insufficient to clear the legacy inventory alone.
> (Emphasis added.)

a. If the appeals reform legislation is enacted this calendar year, what level of funding would VA need to ensure that legacy appeals will not "languish" and by what date would VA need to have that funding made available?

Response. In fiscal years (FY) 2015 and 2016, Congress provided funding for additional staff that included a total of 300 full-time equivalent (FTE) employees for appeals processing at the Veterans Benefits Administration (VBA). In FY 2017, the Board of Veterans' Appeals (Board) received funding for an additional 242 FTE. As the result of hiring falling short of goals, the Board projects to have carryover of $15,609,600 from FY 2017, which the Board intends to utilize for personnel costs in FY 2018. By utilizing carryover, the Board's FY 2018 annualized FTE level is estimated to be 1,050, which is 164 FTE higher than the FY 2017 current estimate. VA continues to assess the current and future allocation of FTE to work appeals to ensure that the pending legacy appeals inventory is addressed in a timely and efficient manner. Whether VA will need additional resources for appeals after enactment of appeals reform legislation is contingent upon resource allocation decisions made by the Department of Veterans Affairs and the Administration during the annual budget process and cannot be predicted at this time.

b. What steps—other than potentially adding resources—is VA taking to speed up processing of legacy appeals, such as information technology improvements or making sure appeals staff work only on appeals, and what impact are those initiatives expected to have on the inventory of legacy appeals?

Response. VA is committed to reducing the pending inventory of legacy appeals. In January 2017, VBA realigned its appeals policy and oversight of its national appeals operations under a single office, the Appeals Management Office (AMO). The realignment promotes increased accountability of appeals performance and establishes a clear division of labor between claims and appeals work, with dedicated appeals FTE. Under this realignment, specific guidance has been disseminated instructing field offices that appeals staff must maintain authorized staffing levels and complete appeals production work exclusively. VBA's appeals productivity through May 31, 2017, has increased by 32% over FY 2016 production during the same period. This realignment allows VBA to focus on internal people, process and technology appeals initiatives, and implementation of appeals reform legislation if enacted. Unlike VBA, which adjudicates both claims and appeals, the Board only adjudicates appeals. The Board monitors its personnel resources to ensure they are focused on the Board's mission of holding hearings and deciding appeals.

Additionally, we have worked with our congressional committees and stakeholder partners to modify the design of the draft appeals reform legislation to provide opportunities for Veterans who would otherwise have an appeal in the legacy process to opt-in to the new process. The availability of these opt-ins ensure that as many Veterans as possible benefit from the streamlined features of the new process, while simultaneously assisting with the elimination of the inventory of legacy appeals.

The Board is also committed to modernizing appeals processing technology to optimize efficiency to best serve Veterans and their families and to ensure the seamless

transfer of appeals between jurisdictions by leveraging industry best practices and Human Centered Design principles. The Board is fortunate to have Digital Service at VA leading the technical approach to this effort. While modernized technology is part of increasing efficiency in appeals processing, comprehensive legislative reform is required to ensure Veterans receive a timely decision on their appeal, which is why the opt-ins that allow Veterans who would otherwise have a legacy appeal to enter the new process offer a good potential opportunity to speed processing of the pending legacy appeals inventory.

Question 2. In May 2017, the Congressional Budget Office provided a cost estimate regarding H.R. 2288, the Veterans Appeals Improvement and Modernization Act of 2017, which includes this information: "VA also expects that the efficiencies of the new system would allow the agency to continue processing legacy appeals under the current system, very gradually reducing the existing backlog, without the need for additional employees. (Reducing the backlog in a more expedited manner would require more employees and would have a substantial cost.)"

a. Please clarify whether VA intends, if the appeals reform legislation is enacted, to "very gradually" reduce the inventory of existing appeals or to address them in a "more expedited manner."

Response. If the appeals reform legislation is enacted, VA remains committed to reducing the pending inventory of legacy appeals as quickly and efficiently as possible. VA intends to resource the modernized system to maintain timely processing in the new process and then allocate all remaining appeals resources to address the inventory of legacy appeals. VA also worked collaboratively with stakeholders to identify opt-ins that will make the new process available to more Veterans. The opt-in features of the legislation will assist VA with more quickly and efficiently addressing the legacy appeals inventory.

b. In response to post-hearing questions in May 2016, VA indicated that, if the appeals reform proposal is enacted without added resources, "at least 214,837 appeals will take longer than 9 years to be resolved" and "some of these legacy appeals will take 28 years to be resolved." Is this in line with what would be expected if VA "very gradually" reduces the inventory of legacy appeals? If VA has more recent modeling data on this scenario, please provide copies.

Response. Depending upon legislative reform and available resources, VA intends to address the legacy appeals inventory as quickly and efficiently as possible. Without significant legislative reform to modernize the appeals process, VA projects that Veteran wait times and the cost to taxpayers will continue to increase over time. The goal is to eliminate the inventory of legacy appeals in a timely manner following enactment of the appeals modernization legislation, while also maintaining timely processing in the new process. Prioritization, assessment of resource requirements in the annual budget process, and the opt-in features of the new process will assist VA in accomplishing that goal. However, due to the nature of the complex, inefficient and outdated legacy process, VA projects that there will be an inventory of legacy appeals for a substantial amount of time, regardless of the amount of resources made available to legacy appeals processing. VA continues to refine its forecast modeling, to include based on annual budget levels.

MEDICAL CARE

Question 3. The Budget Justification shows an aggregate number of full-time equivalent employees (FTE) in the Medical Support and Compliance account for fiscal years 2016 through 2019. For each office within the Medical Support and Compliance account, please provide the total number of FTE for fiscal year 2016 and the estimate number of FTE for fiscal years 2017 through 2019.

Response. See "FTE by Program Office" table.

FTE by Program Office

Description	2016 Actual	2017 Cur. Est.	2018 Rev. Req.	2019 Adv. App.
VA Medical Centers, VISNs & Other Field Activities (0152)				
VAMCs and Other Field Activities	36,247	37,563	38,085	38,299
VISN Headquarters	961	999	1,018	1,024
Subtotal	37,208	38,562	39,103	39,323
VHACO & National Consolidated Activities (0152)				
Consolidated Mail Outpatient Pharmacies	1,203	1,251	1,275	1,282
Employee Education Service Center	40	42	42	43
National Center for Patient Safety	2,453	2,550	2,599	2,613
Office of Community Care	171	295	504	504
Office of Informatics and Information Governance	386	401	409	411
VHA Central Office	6,726	6,726	6,726	6,726
VHA Member Services	1,656	1,722	1,755	1,764
VHA Service Center	647	673	686	689
Subtotal	**13,282**	**13,660**	**13,996**	**14,032**
VACAA, Section 801 (0152XA)				
Activations	51	0	0	0
Staffing Shortage & Report (Sect. 301)	10	0	0	0
Hiring Medical Staff	3	0	0	0
Subtotal	**64**	**0**	**0**	**0**
FTE [Grand Total]	**50,554**	**52,222**	**53,099**	**53,355**

Question 4. In 2017 the Veterans Health Administration (VHA) consolidated three Veterans Integrated Service Networks (VISN). Please provide the number of FTE within each of those VISN's prior to consolidation and the total number of FTE in the new consolidated VISN.

Response. See attached file

Data Analytics Team
Human Capital Systems and Services (10A2A4)
Workforce Management and Consulting Office (10A2A)

New VISN Structure Onboard for merged VISNs
Data Source: VHA PAID data via VSSC HR Employee Cube excluding Veteran Canteen Service (VCS), intermittent, non-pay, medical residents, and trainees with assign codes T0-T9 current as of 05/31/2017.
Date Provided: 6/9/17

	30-Sep-15	31-May-17
V02	6,764	
V03	11,752	
Total	18,516	18,431

V10	11,616	
V11	13,260	
Total	24,876	25,686

V17	12,509	16,159
V18	11,713	
V21	13,903	17,264
V22	16,210	23,875
Total	54,335	57,298

VISN 17 gained Amarillo, Big Spring, and El Paso, TX
VISN 21 gained Las Vegas, NV
VISN 22 realigned Las Vegas, NV to VISN 21, and gained Mesa, Albuquerque, Phoenix, and Prescott, AZ

Question 5. The Budget Justification indicates that VHA created a new office, the Medical Center Solutions (MCS) office. Please describe in detail the duties of this office, the number of FTE associated with this office, and the estimated budget request for MCS.

Response. Member Services-Medical Center Solutions (MCS) office will provide for and support the development of comprehensive VA Medical Call Center capability solutions with applicability across the VHA enterprise. MCS, the first of its kind in VHA, will provide leadership and management for the purposes of improving access to clinical care and services by positively affecting the myriad of complexities associated with VA Medical Center and VISN-wide call centers. When activated effective 1QFY 2018, MCS will initially provide primary care appointment scheduling and call center-based nurse triage call center support for all (8) VISN 1 VA medical centers with the intent of expanding services to remaining VA Health Networks. This will result in system-wide, standardized improvements in access to clinical care and services, improved first contact resolution and an improved Veteran experience. The FY 2018 transition is being effected by a planned transfer of existing resources and FTEE from VISN 1 to MS-MCS that when combined with existing MS-MCS resources (1 FTEE and $2.691M) will establish the needed capability to provide comprehensive call centers services to VISN 1 while providing the basis for expanding services to remaining VISNs. The consolidation of VISN1 call center operations under MCS represents an organizational realignment and is FTEE and cost neutral.

Question 6. The Veterans Access, Choice, and Accountability Act of 2014 gave VHA the authority to enter into provider agreements to provide Veterans with care in the community. While the vast majority of that care is provided through the Patient Centered Community Care (PC3) contract, in 2016 VHA started using the provider agreement authority by entering into local agreements at the VA medical centers (VAMC).

a. Please provide the total number of provider agreements VHA has entered into broken out by VAMC.

Response. Please see spreadsheet that follows:

Count of Active Provider Agreements as of June 6, 2017

	Station	Count of Provider Agreements
(402)	Togus, ME	681
(405)	White River Junction, VT	361
(518)	Bedford, MA	60
(523)	VA Boston HCS, MA	183
(608)	Manchester, NH	158
(631)	VA Central Western Massachusetts HCS	168
(650)	Providence, RI	112
(689)	VA Connecticut HCS, CT	180
(528 A4)	Batavia, NY	1
(528 A8)	Albany, NY	21
(528)	Bath, NY	9
(528)	Canandaigua, NY	22
(528)	Syracuse, NY	107
(528)	Western New York, NY	60
(526)	Bronx, NY	6
(561)	New Jersey HCS, NJ	210
(620)	VA Hudson Valley HCS, NY	33
(630)	New York Harbor HCS, NY	10
(632)	Northport, NY	136
(460)	Wilmington, DE	192
(503)	Altoona, PA	258
(529)	Butler, PA	71
(542)	Coatesville, PA	139
(562)	Erie, PA	142
(595)	Lebanon, PA	104
(642)	Philadelphia, PA	67
(646)	Pittsburgh, PA	371
(693)	Wilkes-Barre, PA	145
(512)	Baltimore HCS, MD	139
(517)	Beckley, WV	79
(540)	Clarksburg, WV	70
(581)	Huntington, WV	73
(613)	Martinsburg, WV	83
(688)	Washington, DC	140
(558)	Durham, NC	177
(565)	Fayetteville, NC	60
(590)	Hampton, VA	65
(637)	Asheville, NC	108
(652)	Richmond, VA	222
(658)	Salem, VA	38
(659)	Salisbury, NC	95
(508)	Atlanta, GA	240
(509)	Augusta, GA	112
(521)	Birmingham, AL	129
(534)	Charleston, SC	235
(544)	Columbia, SC	188
(557)	Dublin, GA	174
(619)	Central Alabama Veterans HCS, AL	193
(679)	Tuscaloosa, AL	41
(516)	Bay Pines, FL	215
(546)	Miami, FL	71
(548)	West Palm Beach, FL	144
(573)	Gainesville, FL	401
(672)	San Juan, PR	160
(673)	Tampa, FL	201
(675)	Orlando, FL	72
(596)	Lexington, KY	45
(603)	Louisville, KY	40
(614)	Memphis, TN	104
(621)	Mountain Home, TN	160
(626)	Middle Tennessee HCS, TN	129
(506)	Ann Arbor, MI	145
(538)	Chillicothe, OH	74

Count of Active Provider Agreements as of June 6, 2017—Continued

	Station	Count of Provider Agreements
(539)	Cincinnati, OH	126
(541)	Cleveland, OH	179
(552)	Dayton, OH	142
(757)	Columbus, OH	105
(515)	Battle Creek, MI	441
(553)	Detroit, MI	28
(583)	Indianapolis, IN	330
(610 A4)	Ft. Wayne, IN	156
(610)	Northern Indiana HCS, IN	1
(655)	Saginaw, MI	279
(537)	Jesse Brown VAMC (Chicago), IL	69
(550)	Danville, IL	57
(556)	Captain James A Lovell FHCC	1
(578)	Hines, IL	310
(585)	Iron Mountain, MI	288
(607)	Madison, WI	55
(676)	Tomah, WI	39
(695)	Milwaukee, WI	76
(589 A4)	Columbia, MO	250
(589)	Eastern KS HCS, KS	192
(589)	Kansas City, MO	101
(589)	Wichita, KS	43
(657 A4)	Poplar Bluff, MO	140
(657 A5)	Marion, IL	58
(657)	St. Louis, MO	168
(667)	Topeka, KS	1
(502)	Alexandria, LA	39
(520)	Gulf Coast HCS, MS	85
(564)	Fayetteville, AR	123
(580)	Houston, TX	203
(586)	Jackson, MS	93
(598)	Little Rock, AR	54
(623)	Muskogee, OK	120
(629)	New Orleans, LA	113
(635)	Oklahoma City, OK	162
(667)	Shreveport, LA	202
(504)	Amarillo, TX	24
(549)	Dallas, TX	15
(671)	San Antonio, TX	45
(674)	Temple, TX	29
(740)	VA Texas Valley Coastal Bend HCS	4
(756)	El Paso, TX	21
(501)	New Mexico HCS	96
(644)	Phoenix, AZ	195
(649)	Northern Arizona HCS	144
(678)	Southern Arizona HCS	73
(436)	Montana HCS	316
(442)	Cheyenne, WY	53
(554)	Denver, CO	184
(575)	Grand Junction, CO	92
(660)	Salt Lake City, UT	576
(666)	Sheridan, WY	90
(463)	Anchorage, AK	21
(531)	Boise, ID	51
(648)	Portland, OR	257
(653)	Roseburg, OR	102
(663)	VA Puget Sound, WA	399
(668)	Spokane, WA	105
(687)	Walla Walla, WA	64
(692)	White City, OR	67
(459)	Honolulu, HI	175
(570)	Fresno, CA	65
(612)	N. California, CA	164

Count of Active Provider Agreements as of June 6, 2017—Continued

	Station	Count of Provider Agreements
(640)	Palo Alto, CA	376
(654)	Reno, NV	103
(662)	San Francisco, CA	110
(593)	Las Vegas, NV	129
(600)	Long Beach, CA	24
(605)	Loma Linda, CA	401
(664)	San Diego, CA	415
(691)	Greater Los Angeles HCS	144
(437)	Fargo, ND	334
(438)	Sioux Falls, SD	175
(568)	Black Hills HCS, SD	62
(618)	Minneapolis, MN	176
(636 A6)	Des Moines, IA	119
(636)	Iowa City, IA	314
(636)	Nebraska-W Iowa, NE	316
(656)	St. Cloud, MN	132
	Total	20,215

Source: VCP Provider Agreement Sharepoint
Only displaying agreements in an active status

b. What processes are in place to ensure the provider agreements do not duplicate care available in the PC3 contract?

Response. Currently Provider Agreements may only be used under the Veterans Choice Program (VCP) to provide medical care to our Nations Veterans. Provider Agreements are used to provide care and services that are not available through the contractor network. There are instances, when Provider Agreements are used to provide services that may be available through the PC3 Contract for Choice, those circumstance occur when the contractor has returned referrals they are unable to schedule. In addition, recently the Office of Community Care has allowed facilities to utilize Provider Agreements when a facility has identified a certain percentage of returns from the contractor for specific categories of care and the facility has identified they have active provider agreements for those categories of care and adequate staffing to schedule the Veterans identified, this new process ensures Veterans are receiving the medical care needed in a more timely manner.

Question 7. The Budget Justification identifies the creation of a VHA transitional care program office as one of its 2017–2019 goals. Please describe in detail the duties of this office, the number of FTE associated with this office, the estimated budget request for this office, and a projected timeline for its creation.

Response. VHA had the goal of realigning the Federal Recovery Coordination Program (FRCP) under Care Management and Social Work (CM/SW), and Transition and Care Management Services, to integrate care coordination services under one leadership. At this time, a new VHA transitional care program office is not under development. VA continues to provide assistance to transitioning Servicemembers and Veterans (SM/V) and their families through Transition and Care Management Services and the FRCP. These programs work in coordination to assist wounded SM/V to navigate the recovery care continuum.

Transition and Care Management (TCM) Services leads two national programs:

• The VA Liaison Program consists of 43 VA Liaisons for Health Care at 21 Military Treatment Facilities (MTF) to facilitate ongoing VA health care for ill and injured Servicemembers transitioning from Department of Defense (DOD) to VA. Since the inception of the program, VA Liaisons for Healthcare have coordinated over 84,000 transitions. In fiscal year (FY) 2016, VA Liaisons for Healthcare coordinated 11,130 transitions; provided 22,906 professional consultations and 2,412 briefings; and ensured Servicemembers transitioning from DOD to VA received timely access to care by ensuring 100 percent of Servicemembers who wanted VA healthcare had an initial VA appointment scheduled at the VA healthcare facility of their choice; 89 percent had appointments scheduled prior to leaving the MTF.

• The TCM Program consists of a TCM team at each VA Medical Center to provide comprehensive and specialized transition assistance and ongoing case management services to Post-9/11 Veterans as they reintegrate into their home communities and into VA health care. VA has approximately 400 TCM case managers na-

tionwide providing case management services to almost 30,000 Veterans. In FY 2016, 90 percent of these Veterans were contacted regarding their individualized care management plan, resulting in over 347,000 contacts.

The FRCP was developed as a joint program by VA and DOD, in January 2008, to provide care coordination services to SM/V who were severely wounded, ill, or injured after September 11, 2001. The program utilizes Federal Recovery Coordinators (FRCs), either social workers or nurses funded by VA Central Office, to monitor and coordinate clinical services, including facilitating and coordinating medical appointments; and non-clinical services, such as providing assistance in obtaining financial benefits or special accommodations needed by program enrollees and their families.

Question 8. The Comprehensive Addiction and Recovery Act of 2016 requires naloxone prescriptions and related education to be provided free of charge to Veterans.

a. The Budget Justification does not clearly state whether or not this reduction in co-pays is reflected in the estimated medical care collections. Please provide a detailed analysis of the expected reduction in estimated medical care collections for 2017 and 2018, including any impact caused by the reduction in copays for naloxone prescriptions.

Response. The Naloxone prescriptions and related education analysis was performed after the FY 2017 and FY 2018 medical care collections budgets were formulated. As such, there was no reduction explicitly incorporated into the FY 2017 & FY 2018 budgets as a result of the elimination of copayments for Naloxone prescriptions or outpatient visits pertaining solely to the education. Further, the number of Naloxone kits dispensed to Veterans has remained stable over the past three years with the percent of billable prescriptions assumed stable through FY 2026. The resulting impact of the copayment on the Pharmacy portion is only ~0.03% of the FY 2017 First Party Rx estimated collections. These impacts will be explicitly incorporated into the baseline collections forecasting when using FY 2017 data for future medical care collections budgets.

b. The Budget Justification states that over 50,000 naloxone kits have been dispensed as of January 2017 and that naloxone distribution will continue to expand. However, the 2017 current estimate for naloxone distribution is listed as $0. For 2018 and 2019, the Budget Justification includes $25 million a year for naloxone distribution. Please provide additional details on the expected naloxone kit distribution for 2017 and provide details for the $25 million requested, to include expected number of Veterans receiving overdose education and the estimated number of naloxone kits to be distributed.

Response. See table below.

Fiscal Year	Naloxone Kits Distributed	Drug Cost	Distribution/ Dispensing Cost	Total Cost
FY-16	48,462	$8,622,450	$169,925	$8,792,375
FY-17*	62,037	$7,310,048	$225,194	$7,535,242
FY-18**	68,241	$9,174,283	$259,316	$9,433,599
FY-19**	75,065	$10,091,710	$296,507	$10,388,217

*FY-17 estimated based on YTD distribution
**FY-18/19 assume 10% increase in usage and current contract price stabilization

Question 9. Please provide a sample of the preconception care counseling template found in the Computerized Patient Record System described in Volume II, VHA–191.

Response. Attached is the sample of the preconception care counseling template found in the Computerized Patient Record System described in Volume II, VHA–191 requested below.

VA-WH PRECONCEPTION CARE COUNSELING (PCC) TEMPLATE

The new Preconception Care Counseling Template was developed by the Veterans Affair's Office of Women's Health Services with input from the Preconception Care Workgroup. For women of reproductive age, preconception care is an essential part of comprehensive health care. Given that half of all pregnancies in the United States are unplanned, women's reproductive intentions should be considered at each clinical encounter and preconception and contraceptive care should be offered as appropriate to help women attain their reproductive goals.

Preconception care involves identifying and modifying medical, behavioral, and social risk factors to optimize a woman's health before, during, and after pregnancy. Some factors (e.g., folic acid supplementation) must be acted on before conception occurs or early in pregnancy for maximal impact on the health of the mother and fetus. The template is designed to improve the process and documentation of this care to enhance the provision of high quality care to reproductive age women Veterans who desire or are considering pregnancy. The template pre-populates with structured data from CPRS/VistA when available, allows ordering from the template itself, and provides guidance regarding next steps for women with particular risk factors who require additional work up and referrals.

It is anticipated that it will be used during primary care visits, preconception care visits, and gynecology visits. This will allow a clinician and woman Veteran to work together, using shared decision-making to work collaboratively to identify and implement strategies to address her risks and optimize her pregnancy health.

The template has the following sections:

I. Reproductive Life Plan
II. Obstetrical History
III. Gynecological History
IV. Medical History
V. Mental Health History
VI. Surgical History
VII. Medication
VIII. Vaccinations
IX. Family and Genetic History
X. Exposure History
XI. Social History and Home Environment
XII. Assessment and Plan

Screenshot of the template:

Reminder Dialog Template: VA-WH PCC

Preconception Care Counseling Template

☑ <======= Click here to view instructions on how to use this template.

This template is designed to improve the process and documentation of preconception care to enhance the provision of high quality care to reproductive age women Veterans who desire or are considering pregnancy. It is anticipated that it will be used during primary care visits, preconception care visits, and gynecology visits, allowing a clinician and woman Veteran to work together, using shared decision-making to work collaboratively to identify and implement strategies to address her risks and optimize her pregnancy health.

☐ I. REPRODUCTIVE LIFE PLAN
☐ II. OBSTETRICAL HISTORY
☐ III. GYNECOLOGICAL HISTORY
☐ IV. MEDICAL HISTORY
☐ V. MENTAL HEALTH HISTORY
☐ VI. SURGICAL HISTORY
☐ VII. MEDICATION
☐ VIII. VACCINATIONS
☐ IX. FAMILY AND GENETIC HISTORY
☐ X. EXPOSURE HISTORY
☐ XI. SOCIAL HISTORY AND HOME ENVIRONMENT

PRECONCEPTION CARE ASSESSMENT AND PLAN

This Preconception Care Assessment and Plan are based on information entered through the Preconception Care Template.

Assessment:
*

Preconception Plan:
*

Each section expands with content that is of relevance to preconception counseling. Appropriate note text is built as items are checked and ordered:

Reminder Dialog Template: VA-WH PCC

☐ History of gestational diabetes. Order 2 hour glucose tolerance test (GTT) if patient has not been screened for diabetes mellitus since delivery.
☐ History of a child or fetus with a neural tube defect and patient is planning a pregnancy.
☐ History of stillbirth (fetal death) or a child/fetus with a malformation.

☑ III. GYNECOLOGICAL HISTORY
☑ Screen for chlamydia (if high risk or < 25 years of age).
☑ History of amenorrhea/oligomenorrhea. Consider Gyn referral for menstrual abnormalities.
☐ History of PID (pelvic inflammatory disease). Counsel about increased risk for ectopic pregnancy, symptoms, and need for early evaluation of a positive pregnancy test.
☐ Recent high grade intraepithelial lesion (HGSIL) pap result. Counsel to delay pregnancy and use contraception until evaluation is complete.

Visit Info | Finish | Cancel

The patient was advised to take a daily folic acid supplement or prenatal multivitamin/multimineral supplement.

OBSTETRICAL HISTORY
Gravida:
0
Para:
0
PREGNANCY HISTORY

GYNECOLOGICAL HISTORY
Patient was screened for Chlamydia.
Patient has a history of amenorrhea/oligomenorrhea. Counseled regarding the need for a Gynecology consult.

Health Factors: VA-WH PCC ASSESSMENT COMMENT, VA-WH PCC ASSESSMENT PLAN, VA-WH PCC EXPOSURE TOB CESS NO, VA-WH PCC EXPOSURE TOBACCO, VA-WH PCC FAMILY HX KNOWN CARRIER, VA-WH PCC GYNE FOLIC ACID SUPP, VA-WH PCC GYNE HX PLAN AMENORRHEA, VA-WH PCC GYNE HX PLAN CHLAMYDIA, VA-WH PCC GYNE SPACING

Sample Completed Note:

```
Preconception Care Counseling Template

REPRODUCTIVE LIFE PLAN
Pregnancy desires:
  Patient indicates she would like to become pregnant in the future, but
  not in the next year.
  The patient was counseled regarding a recommended interval of at least
  18 months from birth to the next pregnancy.
  The patient was advised to take a daily folic acid supplement or
  prenatal multivitamin/multimineral supplement.

OBSTETRICAL HISTORY
Gravida:
  2
Para:
  1
PREGNANCY HISTORY
  Patient has a history of a stillbirth or a child/fetus with a
  malformation.  Counseled regarding the need for genetic consultation and
  an Obstetrics consult.

GYNECOLOGICAL HISTORY
  Patient was screened for Chlamydia.
  Patient has a history of amenorrhea/oligomenorrhea. Counseled regarding
  the need for a Gynecology consult.

MEDICAL HISTORY
  Patient was counseled regarding the need for HIV screening prior to
  pregnancy. HIV Screen ordered.

  Patient has history of asthma and was counseled about pregnancy risks
  related to asthma and the importance of good control.

MENTAL HEALTH HISTORY
  Patient has a mental health disorder and is planning a pregnancy.
  Counseled regarding pregnancy risks and the need for a treament plan for
  before and during pregnancy from her mental health provider.

SURGICAL HISTORY
  Patient has a history of having a LEEP or cone procedure. Counseled
  patient about possible increased risk for second trimester pregnancy
  loss and importance of early prenatal care.

MEDICATION HISTORY
```

```
  No Medications Found


VACCINATION HISTORY


    No data available
  Patient advised to receive the following vaccine(s):
    Measles, mumps, rubella (live, attenuated vaccine) vaccine ordered.

FAMILY AND GENETIC HISTORY
  Patient has a family history of an anatomical malformation and was
  referred for genetic counseling.

EXPOSURE HISTORY
  Patient uses tobacco.  Counseled regarding personal and pregnancy risks
  of tobacco use. Counseled to establish a smoke free home during
  pregnancy and after pregnancy to reduce respiratory illness in the
  child.
    Encouraged to continue smoking cessation couseling.

SOCIAL HISTORY AND HOME ENVIRONMENT
  Mental Health consult ordered.
  Discussed importance of pregnancy planning in setting of social upheaval
  or stresses.

PRECONCEPTION CARE ASSESSMENT AND PLAN
  This Preconception Care Assessment and Plan are based on information
  entered through the Preconception Care Template.
  Assessment:
    35 year old planning pregnancy
  Preconception Plan:
    Plan as documented above.
```

Question 10. What percentage of women veteran gender-specific care is provided at VA facilities and what percentage is provided through non-VA care? Please break out each category included under gender-specific health care for fiscal year 2017 as well as projections for fiscal year 2018.

Response. See table below.

	FY 2016		FY 2017 Estimate		FY 2018 Estimate	
Description	VA Facilities	Community Care	VA Facilities	Community Care	VA Facilities	Community Care
Female Cancer and Screening	90%	10%	89%	11%	89%	11%
Genitourinary Care	67%	33%	66%	34%	65%	35%
Osteoporosis	83%	17%	81%	19%	80%	20%
Pregnancy and Childbirth	27%	73%	27%	73%	25%	75%
VA Women's Clinics	100%	N/A	100%	N/A	100%	N/A

Question 11. Please provide an updated list of VA medical facilities that have a gynecologist on staff and whether they are full-time, part-time, or contracted.

Response. See attached.

Data Analytics Team
Human Capital Systems and Services (10A2A4)
Workforce Management and Consulting Office (10A2A)

VHA Gynecologist (0602-03) by Station and Duty Basis/Fee Basis
Data Source: VHA PAID data excluding Veteran Canteen Service (VCS), non-pay, medical residents, and trainees with assign codes T0-T9 current as of 06/03/2017.
Date Provided: 6/8/2017

VISN	Station #	Organization	Duty Basis/FEE Basis			
			Full Time	Part Time	Intermittent	FEE Basis/Intermittent
VHACO	101	Safety and Risk Awareness (10A4E)				1
1	402	HCS Maine - Togus (Augusta, ME)		1		
1	405	VAMC White River Jct, VT		1		
1	523	HCS Boston, MA (Jamaica Plain)	2	1		
1	608	VAMC Manchester, NH				1
1	650	VAMC Providence, RI		2		
1	689	HCS Connecticut (West Haven)		1	2	
2	526	VAMC Bronx, NY		1		
2	528	HCS Western NY (Buffalo)		1		
2	561	HCS New Jersey (East Orange)		1		
2	630	HCS NY Harbor, NY	1	1		
2	632	VAMC Northport, NY		1		
2	528 D	VAMC Albany, NY	1		1	
2	528 E	VAMC Syracuse, NY		1		
4	503	VAMC Altoona, PA				2
4	595	VAMC Lebanon, PA	1			
4	642	VAMC Philadelphia, PA		2		
4	693	VAMC Wilkes-Barre, PA	1			
5	517	VAMC Beckley, WV		1		
5	540	VAMC Clarksburg, WV	1			
5	581	VAMC Huntington, WV		1		
5	688	VAMC Washington, DC		1		
6	558	VAMC Durham, NC		5		
6	565	VAMC Fayetteville, NC	1			
6	590	VAMC Hampton, VA	1			
6	637	VAMC Asheville, NC		1		
6	652	VAMC Richmond, VA		1		
6	658	VAMC Salem, VA	1			
6	659	VAMC Salisbury, NC	1			
7	508	VAMC Atlanta, GA (Decatur)	1	3	1	
7	509	VAMC Augusta, GA	1			
7	521	VAMC Birmingham, AL		2		
7	534	VAMC Charleston, SC		2		
7	544	VAMC Columbia, SC	1			
7	557	VAMC Dublin, GA	1			
7	619	HCS Central AL (Montgomery)	1			
8	516	VAMC Bay Pines, FL		2		1
8	546	HCS Miami, FL	2			
8	573	HCS North Florida-South Georgia (Gainsville, F	5			
8	672	HCS San Juan, PR	1			
8	673	VAMC Tampa, FL	3			
8	675	VAMC Orlando, FL	2			
9	603	VAMC Louisville, KY		1		
9	614	VAMC Memphis, TN		1		
9	621	VAMC Mountain Home, TN	1			
9	626	HCS TN Valley (Nashville)		3		
10	539	VAMC Cincinnati, OH		2		
10	541	VAMC Cleveland, OH	1	1		1
10	583	VAMC Indianapolis, IN	1	1		
10	655	VAMC Saginaw, MI		1		
10	757	ACC Columbus, OH		1		
12	537	VAMC Chicago, IL		2		
12	556	FHCC Captain James A. Lovell (N Chicago, IL)	2			
12	578	VAMC Hines, IL		1		
12	607	VAMC Madison, WI		1		
12	695	VAMC Milwaukee, WI		3		

Human Capital Systems and Services

VISN	Station #	Organization	Duty Basis/FEE Basis			
			Full Time	Part Time	Intermittent	FEE Basis/Intermittent
15	589	VAMC Kansas City, MO		1		
15	657	HCS St. Louis, MO		1		
15	589 EA	HCS Eastern Kansas				2
15	589 WA	VAMC Wichita, KS				1
15	657 MA	VAMC Marion, IL	1			
16	520	HCS Gulf Coast Veterans (Biloxi, MS)	2			
16	564	HCS of the Ozarks, Fayetteville, AR	1			
16	580	VAMC Houston, TX	1	1		
16	586	VAMC Jackson, MS		1		
16	598	HCS Central Arkansas (Little Rock)	1			
16	629	HCS Southeast LA (New Orleans)		1		1
17	671	HCS South Texas (San Antonio)	2			
17	674	HCS Central Texas (Temple)	1	2		
17	756	HCS El Paso, TX	1			
19	436	Montana VA Health Care System, Ft Harrison, MT		1		
19	442	VAMC Cheyenne, WY		1		
19	554	HCS Eastern CO (Denver)	1			
19	660	HCS Salt Lake City, UT		2	1	
20	531	VAMC Boise,ID	1			
20	663	HCS Puget Sound, WA	3			
20	668	VAMC Spokane, WA		1		
21	459	HCS Pacific Islands (Honolulu, HI)				2
21	570	HCS Central California (Fresno)		1		
21	593	HCS Southern Nevada (N Vegas)	1	1		
21	612	HCS Northern California (Mather)	2	1		
21	640	HCS Palo Alto, CA		1		
21	654	HCS Sierra Nevada (Reno)			1	
21	662	HCS San Francisco, CA		2		
22	600	HCS Long Beach, CA		4		
22	605	HCS Loma Linda, CA		2		
22	644	HCS Phoenix, AZ	1	3		
22	664	HCS San Diego, CA		1	1	
22	678	HCS Southern AZ (Tucson)	1	1		
22	691	HCS Greater Los Angeles, CA		3		
23	437	HCS Fargo, ND	1			
23	438	HCS Sioux Falls, SD		1		
23	568	HCS Black Hills, SD	1	1		
23	618	HCS Minneapolis, MN		1		
23	636	HCS Nebraska-Western Iowa (Omaha, NE)		1		
23	636 I	HCS Iowa City, IA		1		
Totals			56	88	7	12

Human Capital Systems and Services

Question 12. Current law allows VA to cover care for newborns of eligible women Veterans for the first seven days after birth. Please provide a breakout of the average number of days VA has covered care for newborns and the total cost of this care in fiscal year 2017 and projections for fiscal year 2018.

Response. To reiterate this data only relates to the newborn care, it does not include any expenditure for services provided to the mother. On average, VA authorizations in FY 2017 covered 3 days for inpatient newborn care. Please refer to the table below.

	Neonates	Average Length of Stay	Obligations $m
Actual FY 2016	2,705	3.44	$19.82
Annualized FY 2017	2,264	3.10	$16.67
Estimated FY 2018	2,176	3.02	$16.04

CONSTRUCTION

Question 13. The Budget Justification requests authorization for 27 leases in 2018. Twenty-one of these leases were submitted in prior years but were not authorized. Six are new lease requests. Three leases in Pontiac, Michigan; Birmingham, Alabama; and Mission Bay, California were requested in previous budgets but are not included in the 2018 request. Please provide additional details for removing these three leases from the Budget Justification.

Response. In preparing the FY 2018 Budget Request, lease requirements previously authorized but not yet in the solicitation process were reviewed and validated to assure optimum use of alternatives. The following three leases pending authorization were removed from the request after this review.

1. Outpatient Clinic Lease Birmingham, AL—Expanding community care and additional efficiencies realized at the local medical center mitigate the need for this 89,900 Net Useable Square Feet (NUSF) lease.
2. Research Lease Mission Bay, CA—Use of available space on the medical center campus and private partnering solutions are being pursued to meet this research space need.

3. Outpatient Clinic Lease Pontiac, MI—This replacement/expansion lease is being re-scoped which will reduce the size of the lease under the Major Lease threshold.

Question 14. Please provide a detailed breakout of the judgment fund payments for 2017 and the estimated judgment fund payments for 2018.

Response. On January 25, 2017, VA reimbursed the Department of the Treasury for Contract Disputes Act Claims in the total amount of $9 million as follows:

(1) $4,019,844.67—For a claim against the Menlo Park, CA, Seismic Corrections project.

(2) $4,050,306.54—For two claims against the Denver, CO, New Medical Facility project.

In FY 2018, VA will use the Judgment Fund to reimburse the Department of the Treasury for Contract Disputes Act Claims in the amount of $10 million for claims related to the Menlo Park, CA, project and the Orlando, FL, New Medical Facility project.

Question 15. For the major construction staff request, please provide the total number of FTE for fiscal year 2016 and the estimated number of FTE for fiscal years 2017 and 2018.

Response. For the major construction staff request, the total number of FTE in FY 2016 was 115. The estimated number for FY 2017 is 139 FTE, and for FY 2018 the estimate is 197 FTE. Note the appropriation language was changed in FY 2017 to allow major construction staff funding to include support for contracting officers working directly on major construction projects to ensure alignment with the program they are supporting.

Question 16. Please provide a list of the non-recurring maintenance projects included in the $1.9 billion request for 2018. Specifically break out the projects included in the "second bite" $1.3 billion portion of the request for 2018 advance appropriations.

Response. Attached is the list of "first bite" and "second bite" NRM projects for FY 2018. NRM projects that have had design funded in years prior to SCIP 2018, and only needing construction funding to complete, are mostly funded in the "first bite." Design of newly scored SCIP projects is funded in the "second bite," as well as some projects prior to FY 2018.

Planned 2018 Non-Recurring Maintenance Projects

VISN	Location	ST	Project Type	Project Name - Short Description	Total Estimated Cost ($000)	Planned FY 2018 Obs ($000)	"First Bite" ($000)	"Second Bite" ($000)
1	Newington	CT	BT	Emergency Generator #7	678	600		600
1	Newington	CT	SCIP 2018	Replace the Boilers and Systems for Newington VAMC, Phase 1	9,700	970		970
1	Newington	CT	SCIP 2018	Demolish Buildings 6,7, & 8	2,561	256		256
1	West Haven	CT	BT	Yard Drain Tunnel Refurbishment	685	500	500	
1	West Haven	CT	BT	West Haven SPS Chiller	825	750		750
1	West Haven	CT	CSI	Fisher House Infrastructure and Prep	3,500	3,200	3,200	
1	West Haven	CT	SCIP 2016	Renovate Mental Health Inpatient Unit	6,571	5,863		5,863
1	West Haven	CT	SCIP 2015	Replace and Upgrade Electrical Supervisory Control and Data Acquisition System	2,300	2,070		2,070
1	West Haven	CT	SCIP 2018	Refurbish Building Exterior For Building 1	6,300	630		630
1	Bedford	MA	SCIP 2018	Replace Water Mains	3,300	330		330
1	Boston (JP)	MA	SCIP 2016	IT infrastructure upgrades JP	2,200	2,000		2,000
1	Boston (JP)	MA	SCIP 2018	Install Site Security Systems Campus Wide Jamaica Plain	7,150	715		715
1	Boston (WR)	MA	SCIP 2013	Building 5 Fire and Safety Improvements	2,400	2,200	2,200	
1	Boston (WR)	MA	SCIP 2012	EM Infrastructure Backup Water supply	1,650	1,500	1,500	
1	Boston (WR)	MA	BT	FCA Window Replacement	766	701		701
1	Boston (WR)	MA	SCIP 2013	Site Security Installation WR	7,600	7,000	7,000	
1	Boston (WR)	MA	SCIP 2015	FCA HVAC Upgrade PH3	5,060	5,400		5,400
1	Boston (WR)	MA	SCIP 2015	FCA Electrical Upgrade WR, PH 3	4,840	4,356		4,356
1	Boston (WR)	MA	SCIP 2018	IT infrastructure upgrades WR	3,300	330		330
1	Boston (WR)	MA	SCIP 2018	Construct Central Chiller Plant West Roxbury	9,850	985		985
1	Brockton	MA	SCIP 2013	Install Sprinkler System	2,000	1,800	1,800	
1	Brockton	MA	SCIP 2013	FCA Replace Damaged Doors and Upgrade Card Access System Phase 2	2,200	2,050	2,050	
1	Brockton	MA	SCIP 2016	Improve Site Parking Roadway and Drainage Systems	3,410	3,100		3,100
1	Brockton	MA	SCIP 2018	Central Chiller Plant Phase 1	9,900	990		990
1	Northampton	MA	Pending OOC	Water System Improvement & Legionella Prevention Phase 1	4,981	4,000		4,000
1	Northampton	MA	Pending OOC	Replace HVAC System Building 4 Upper	3,800	3,500		3,500
1	Northampton	MA	Pending OOC	Upgrade Building 5 Electrical and HVAC Systems	1,600	1,500		1,500
1	Northampton	MA	Pending OOC	Exterior Site Improvements	4,396	4,000		4,000
1	Northampton	MA	BT	Exterior Wayfinding	720	650	650	
1	Northampton	MA	BT	Occupational Therapy wing Asbestos Abatement	40	28	28	
1	Northampton	MA	BT	Ward 4 Lower Upgrades	778	670	670	
1	Northampton	MA	Pending OOC	Electrical Distribution System Upgrade Phase I	5,050	4,600		4,600
1	Togus	ME	CSI	Provide Infrastructure to Fisher House	1,351	1,351		1,351
1	Togus	ME	SCIP 2016	Install Legionella Mitigation Infrastructure	4,235	3,876		3,876

1	Togus	ME	SCIP 2018	Relocate Primary Care Clinic to B205	5,500	550		550
1	Togus	ME	SCIP 2018	Correct Stormwater System Deficiencies throughout Campus	3,710	371		371
1	Togus	ME	SCIP 2018	Replace Damaged Roofs and Masonry	4,845	485		485
1	Togus	ME	SCIP 2018	Repair Damaged Windows and Entranceway Doors	4,405	441		441
1	Manchester	NH	BT	Replace OR Suite Doors	360	300	300	
1	Manchester	NH	SCIP 2016	Replace Aboveground Storage Tanks	1,164	1,063		1,063
1	Manchester	NH	BT	Building #2 demolishing	495	425	425	
1	Manchester	NH	SCIP 2018	Renovate Building 1, 3rd Floor for Dental	2,914	291		291
1	Providence	RI	SCIP 2015	Renovate Wing 2C & 3C for Dentistry	9,210	8,560		8,560
1	Providence	RI	SCIP 2013	Renovate Space for Relocation of Inpatient Pharmacy	2,237	2,013	2,013	
1	Providence	RI	SCIP 2014	FCA Pavement Repairs	2,600	2,507		2,507
1	Providence	RI	BT	Repair and Upgrade 5B and 6B Isolation Suite HVAC System	670	600	600	
1	Providence	RI	SCIP 2016	Install Legionella Remediation System	3,500	3,250		3,250
1	White River Junction	VT	Pending OOC	Renovate Clinical Lab	6,200	6,026		6,026
1	White River Junction	VT	SCIP 2017	Underground Utility Replacement	7,700	7,000		7,000
1	White River Junction	VT	BT	Acute Mental Health PH2	990	900	900	
1	White River Junction	VT	SCIP 2015	Repair and Upgrade Building 1 Heating, Ventilation, and Air Conditioning (Phase II)	5,227	4,758		4,758
2	East Orange	N	BT	Upgrade men's bathrooms& Drinking Fountains	889	800	800	
2	East Orange	NJ	Pending OOC	Improve outpatient Environment (4D)	2,854	2,594		2,594
2	East Orange	NJ	BT	Storage Building	440	400	400	
2	East Orange	NJ	BT	Legionella Plumbing Field Study	140	140		140
2	Lyons	NJ	BT	Tuckpoint & Waterproofing B 1, 2, 53	350	315	315	
2	Lyons	NJ	BT	Repair & Repave Roadways	540	500	500	
2	Lyons	NJ	BT	Demolish Bldg 18	440	400	400	
2	Lyons	NJ	BT	Replace Porch Roofs & Woodwork Bldg 10, 11	577	525	525	
2	Lyons	NJ	BT	Repair Brick Facade—B-135	550	500	500	
2	Lyons	NJ	BT	Repair Sidewalks Phase II	450	450		450
2	Lyons	NJ	BT	Replace Steps & Railings	550	500	500	
2	Lyons	NJ	CSI	Digital Radiography Room (K113 LY)	500	500		500
2	Lyons	NJ	BT	Upgrade Generator & Transfer Switches	605	550	550	
2	Albany	NY	BT	Structural Repairs at Chapel Windows	116	101	101	
2	Albany	NY	BT	Roof Improvements & Misc Work	669	669		669
2	Albany	NY	SCIP 2017	Radiology Master Plan	3,740	3,400		3,400
2	Albany	NY	SCIP 2015	Renovate 6B for Dialysis	7,262	6,631		6,631
2	Albany	NY	Pending OOC	Renovate for CLC phase 4	5,741	473		473
2	Batavia	NY	SCIP 2016	Replace Fire Alarm System	3,150	2,700		2,700
2	Batavia	NY	SCIP 2016	Replace Roofs Batavia	2,950	2,700		2,700
2	Batavia	NY	SCIP 2018	Improve Potable Water Distribution Systems Batavia, Bldgs #1 & 5	2,300	2,070		2,070
2	Bath	NY	BT	Upgrade 104 Sprinklers and Hot Water	935	850	850	
2	Bath	NY	SCIP 2017	Replace Roof/Renovate Wood Molding, B76	1,225	1,125		1,125

Planned 2018 Non-Recurring Maintenance Projects—Continued

VISN	Location	ST	Project Type	Project Name - Short Description	Total Estimated Cost ($000)	Planned FY 2018 Obs ($000)	"First Bite" ($000)	"Second Bite" ($000)
2	Bath	NY	SCIP 2017	FCA Renovate Main Kitchen, B24	1,375	1,250		1,250
2	Bath	NY	OOC	Renovate CLC 3	5,200	4,750	4,750	
2	Bath	NY	BT	Improve Accessibility & Install 2nd Floor Handicap Accessible Bathroom, B-32	20	20		20
2	Bath	NY	SCIP 2018	B76 Renovations	3,000	300		300
2	Bronx	NY	Pending OOC	Combined Heat & Power Plant Construction	18,000	18,000		18,000
2	Bronx	NY	Pending OOC	Renovate CLC for Polytrauma Ph 3	4,380	3,900		3,900
2	Bronx	NY	SCIP 2016	Modernize ER	4,194	3,724		3,724
2	Bronx	NY	OOC	Renovate CLC Recreation & Dining Area	3,850	3,500	3,500	
2	Bronx	NY	SCIP 2017	Renovate ICU	4,900	4,500		4,500
2	Bronx	NY	OOC	Correct Safety Deficiencies at Loading Dock	2,750	2,500	2,500	
2	Bronx	NY	OOC	Replace Air Handling Units, Phase 4	5,400	5,100	5,100	
2	Bronx	NY	SCIP 2013	Replace Air Handler Units, Phase 3 (for GG, 2B, 2C, 2G)	3,150	2,500	2,500	
2	Bronx	NY	SCIP 2014	Renovate for New Learning Center	5,335	4,850		4,850
2	Bronx	NY	OOC	Replace Existing Boilers #1 & 2	4,300	4,000	4,000	
2	Bronx	NY	SCIP 2016	Replace/Install Parking Lot/Street Lights Ph 2	2,950	2,600		2,600
2	Bronx	NY	BT	Install 20 KW Roof-Mounted Wind Turbine System	594	500	500	
2	Brooklyn	NY	SCIP 2015	Install Secondary Main Water Supply Line	1,540	1,400		1,400
2	Brooklyn	NY	SCIP 2017	Renovate Outpatient Pharmacy(SA)	1,040	950	950	
2	Brooklyn	NY	SCIP 2017	Upgrade Elevators	3,000	3,000		3,000
2	Brooklyn	NY	SCIP 2017	Bldg 2 Replace Pressure Relief Valve and Condensate Pumps	1,200	1,080		1,080
2	Brooklyn	NY	SCIP 2015	Upgrade Life Safety/Critical Branch Electrical Distribution	7,260	7,260		7,260
2	Brooklyn	NY	BT	Replace Air & Vacuum Compressor	935	850	850	
2	Brooklyn	NY	BT	Laundry Plant Storm Disposal	805	750	750	
2	Brooklyn	NY	Pending OOC	Renovate C3 and D3 Ward(SA)	6,545	5,950		5,950
2	Brooklyn	NY	OOC	Laundry Mechanical Room Upgrade (SA)	2,100	1,910	1,910	
2	Buffalo	NY	SCIP 2016	Replace High Pressure Water Risers, Bldg #1	1,600	2		2
2	Buffalo	NY	SCIP 2017	Fuel Oil Tanks Replacement	1,095	975	975	
2	Buffalo	NY	Pending OOC	Improve Potable Water Systems	2,420	2,200		2,200
2	Buffalo	NY	Pending OOC	Upgrade HVAC SPS	1,320	1,200		1,200
2	Buffalo	NY	BT	Sub-Basement Safety Improvements	275	250	250	
2	Buffalo	NY	SCIP 2018	Renovate 9th Floor B Wing	4,650	465		465
2	Canandaigua	NY	BT	Upgrade HVAC B3	250	200		200
2	Canandaigua	NY	BT	Heating Upgrades for B7 and B8	475	400		400
2	Canandaigua	NY	BT	Design and Install Backflow prevention on campus	950	800		800

2	Canandaigua	NY	BT	Provide Electrical Upgrades	800	800		800
2	Canandaigua	NY	SCIP 2017	Replace Roofs Stationwide	1,350	1,350		1,350
2	Canandaigua	NY	BT	Fire Department Upgrades	860	750	750	
2	Canandaigua	NY	BT	Renovations to Support Swing Space Development	50	50		50
2	Canandaigua	NY	BT	Relocate Grounds and Transportation	595	500	500	
2	Canandaigua	NY	OOC	Renovate 6A for Member Services	6,500	6,000	6,000	
2	Canandaigua	NY	SCIP 2018	Replace Primary Electrical Distribution System	2,500	250		250
2	Castle Point	NY	SCIP 2016	Renovate STP Replace Trinkling Filter	1,480	1,200		1,200
2	Castle Point	NY	SCIP 2018	Upgrade Central Air Conditioning Plant Chilled Water Units and Distribution Main	4,400	440		440
2	Montrose	NY	SCIP 2014	Install Elevator Building 29	1,800	1,500		1,500
2	Montrose	NY	SCIP 2013	Replace aging steam distribution equipment for Buildings 3. 4 & 12	3,795	3,450	3,450	
2	Montrose	NY	SCIP 2016	Correct Deficiencies with SPS Area in Building 7 FDR	1,285	1,090		1,090
2	Montrose	NY	SCIP 2018	Install new Temperature, pH, and Flow measuring devices on Domestic Water Systems at FDR	2,465	247		247
2	New York	NY	Pre-SCIP	Admitting Area/ ER Expansion Phase 2	3,850	3,500	3,500	
2	New York	NY	SCIP 2017	Replace Chiller Phase II	3,800	3,430		3,430
2	New York	NY	SCIP 2015	Renovate Research Area/ Animal Lab	5,500	4,090		4,090
2	New York	NY	SCIP 2017	Correct Accessibilities Ph I	5,375	3,400		3,400
2	New York	NY	SCIP 2018	Correct Accessibility Deficiencies PH1	5,375	538		538
2	Northport	NY	SCIP 2015	Replace Primary Electrical Distribution Phase 1	9,971	9,063		9,063
2	Northport	NY	OOC	Upgrade Sewage Treatment Plant, Phase 1	2,860	1,230	1,230	
2	Northport	NY	SCIP 2015	Renovate Roads Project 4	4,695	4,268		4,268
2	St. Albans	NY	SCIP 2013	Laundry Heat Recovery SA	1,975	1,800	1,800	
2	Syracuse	NY	BT	Demolish Abandoned Piping in Sub Basement	295	265		265
2	Syracuse	NY	OOC	Upgrade Chiller Plant Switchgear	2,525	2,300	2,300	
2	Syracuse	NY	SCIP 2015	Laboratory Renovations	3,510	3,150		3,150
4	Wilmington	DE	SCIP 2017	Replace AHU's Serving Nuclear Medicine and the Lab	1,100	1,000		1,000
4	Wilmington	DE	SCIP 2017	Correct ICU Heat and Facility-Wide Humidification	2,200	2,000		2,000
4	Wilmington	DE	SCIP 2017	Renovate Building 13	3,850	3,500		3,500
4	Wilmington	DE	Pending OOC	Renovate the Auditorium	1,100	1,000		1,000
4	Wilmington	DE	Pending OOC	Renovate 2 East	2,200	2,000		2,000
4	Wilmington	DE	SCIP 2017	Provide Chiller Plant Redundancy	2,200	2,000		2,000
4	Wilmington	DE	SCIP 2016	Convert the Special Procedures Room to an Operatory	4,400	4,000		4,000
4	Wilmington	DE	Pending OOC	Evaluate and Replace Roofs Throughout the Facility	2,200	2,000		2,000
4	Wilmington	DE	SCIP 2014	Study and Correct Domestic Water Storage	5,540	4,200		4,200
4	Wilmington	DE	SCIP 2014	Renovate the First Floor of Building 1 for Primary Care	6,600	6,000		6,000
4	Wilmington	DE	SCIP 2017	Assess and Replace Steam and Condensate Distribution Piping	3,300	3,000		3,000
4	Altoona	PA	BT	Make Fire Safety Improvements	356	324	324	
4	Altoona	PA	BT	Correct Air Conditioning Deficiencies in Biomedical Shop & Mailroom	160	146	146	
4	Altoona	PA	SCIP 2017	Replace Keying System For Outbuildings	1,745	1,587		1,587
4	Altoona	PA	BT	Provide For Green Environmental Management (GEM), Phase 1	500	455	455	

Planned 2018 Non-Recurring Maintenance Projects—Continued

VISN	Location	ST	Project Type	Project Name - Short Description	Total Estimated Cost ($000)	Planned FY 2018 Obs ($000)	"First Bite" ($000)	"Second Bite" ($000)
4	Altoona	PA	BT	Facility Chlorination System	300	270	270	
4	Altoona	PA	BT	Provide Security Upgrades, Phase 2	605	550	550	
4	Altoona	PA	BT	Replace Space Signage	622	566	566	
4	Altoona	PA	BT	Provide Electronic Signage	398	362	362	
4	Altoona	PA	BT	Paint Walls	242	220	220	
4	Altoona	PA	SCIP 2017	Correct Retro-commissioning Discrepancies Phase 2	3,722	3,384		3,384
4	Butler	PA	SCIP 2015	Renovate Building 6	3,045	1,750		1,750
4	Coatesville	PA	Pending OOC	Renovate Building 58	8,800	8,000		8,000
4	Coatesville	PA	BT	Update Campus Water Lines	490	190	190	
4	Coatesville	PA	SCIP 2018	Correct Electrical Deficiencies (PH2)	2,225	2,000		2,000
4	Coatesville	PA	BT	Remove Fuel storage tanks	470	400	400	
4	Coatesville	PA	Pending OOC	Hospice Oxygen System	1,100	900		900
4	Coatesville	PA	BT	FCA Repairs Bldg 14	485	425	425	
4	Coatesville	PA	BT	Tree Management & Sidewalks Oval 1	495	450	450	
4	Coatesville	PA	Pending OOC	SPS Satellite Storage Rooms	1,100	900		900
4	Coatesville	PA	SCIP 2015	Replace Steam & Condensate Mains—Oval 2 & Outlying Branches	3,000	2,700		2,700
4	Coatesville	PA	SCIP 2017	Upgrade HVAC System B/57	2,200	1,690		1,690
4	Coatesville	PA	BT	Correct FCA Deficiencies Building 10	350	300	300	
4	Coatesville	PA	BT	Roof Fall Protection Systems Evaluation & Upgrades	600	500	500	
4	Coatesville	PA	SCIP 2017	Exterior Signage & Wayfinding Campus Wide	1,870	1,750		1,750
4	Coatesville	PA	SCIP 2018	Renovate Building 58—A Floor	4,950	495		495
4	Coatesville	PA	SCIP 2018	Correct Electrical Deficiencies—Phase 2	2,225	2,002		2,002
4	Erie	PA	SCIP 2016	Renovate Exterior Building—Masonry, Windows, Sunshades	2,200	2,000		2,000
4	Erie	PA	Pending OOC	Replace Roofs	1,815	1,650		1,650
4	Erie	PA	SCIP 2015	New Central Chiller Plant	9,680	8,800		8,800
4	Erie	PA	SCIP 2013	Renovate Fourth Floor (Design)	4,950	4,500	4,500	
4	Erie	PA	SCIP 2015	Correct Retro-Commissioning Project Findings	1,100	100	100	
4	Lebanon	PA	SCIP 2015	Renovate 1-4C for Multi-purpose Area	2,200	2,200		2,200
4	Lebanon	PA	OOC	Replace Electrical Substation	4,500	4,000	4,000	
4	Lebanon	PA	Pending OOC	Correct Physical Security Issues	3,300	3,000		3,000
4	Lebanon	PA	OOC	Renovate Food Service Kitchen	3,830	3,500	3,500	
4	Lebanon	PA	SCIP 2015	Renovate Primary Care/Specialty Clinic Building 17	1,950	1,750		1,750
4	Lebanon	PA	SCIP 2017	Replace Chillers	3,850	3,500		3,500
4	Lebanon	PA	SCIP 2017	Renovate Bldg. 22	5,000	4,500		4,500

4	Lebanon	PA	SCIP 2015	Renovate 1-4C for Patient Activity Area	2,200	1,900		1,900
4	Lebanon	PA	SCIP 2015	Renovate for MOVE! program	3,300	3,000		3,000
4	Lebanon	PA	SCIP 2018	Correct Physical Security Issues Phase 1	3,300	2,970		2,970
4	Lebanon	PA	SCIP 2018	Correct Facade Issues Phase 3	3,300	330		330
4	Lebanon	PA	SCIP 2018	Retro-Commissioning Corrections	3,300	330		330
4	Philadelphia	PA	SCIP 2017	Modernize Dental Exam Rooms	1,884	1,713		1,713
4	Philadelphia	PA	BT	Relocate On-Call Rooms	550	500	500	
4	Philadelphia	PA	Pre-SCIP	Correct Building Facade Deficiencies	8,000	7,800	7,800	
4	Philadelphia	PA	SCIP 2017	Architectural Improvements for Wards 5 and 6	2,973	2,543		2,543
4	Philadelphia	PA	BT	Upgrade Toilets 1st Floor	225	200	200	
4	Philadelphia	PA	CSI	Upgrade CLC Unit C Ph 2	4,400	4,000	4,000	
4	Philadelphia	PA	SCIP 2017	Correct FCA for Lightning Protection	1,100	737	737	
4	Philadelphia	PA	SCIP 2017	Renovate Building 1 7th Floor for Mental Health	3,190	2,900		2,900
4	Philadelphia	PA	SCIP 2017	Address EmergencyPower0 Deficiencies in Building 1	4,600	4,200		4,200
4	Philadelphia	PA	CSI	Women's Imaging Center	2,200	2,000	2,000	
4	Philadelphia	PA	BT	Install Security Fencing at Parking Garage Bldg 28	278	216	216	
4	Philadelphia	PA	SCIP 2016	Renovate Specialty Clinics	3,500	3,300		3,300
4	Philadelphia	PA	OOC	Upgrade Patient Environment NHCU	1,700	1,200	1,200	
4	Philadelphia	PA	CSI	Replace Catheterization Lab	1,100	1,000	1,000	
4	Philadelphia	PA	SCIP 2017	Upgrade Halls and Wall Phase 1	2,200	2,000		2,000
4	Philadelphia	PA	BT	Radiology Rooms	563	500	500	
4	Pittsburgh	PA	SCIP 2018	Renovate Building One-10 East for Architectural, Mechanical and Electrical Deficiencies	5,250	525		525
4	Pittsburgh	PA	SCIP 2018	Replace Elevators in Building 51 and Building 50 at Heinz Division	3,420	342		342
4	Pittsburgh	PA	SCIP 2018	Replace Air Handling Units serving Operating Rooms (AC12 & AC13)	9,600	960		960
4	Pittsburgh (UD)	PA	SCIP 2015	Install Wayfinding Signage at UD and HZ Campuses	5,500	5,000		5,000
4	Pittsburgh (UD)	PA	SCIP 2017	Replace Domestic Water Branch Piping at UD and HZ	22,000	20,000		20,000
4	Wilkes-Barre	PA	OOC	Replace Exterior Windows	4,800	4,400	4,400	
4	Wilkes-Barre	PA	SCIP 2015	Improve Wayfinding and Signage	1,650	1,500		1,500
4	Wilkes-Barre	PA	SCIP 2015	Renovate 2 West Rehab	5,600	5,000		5,000
4	Wilkes-Barre	PA	SCIP 2017	Correct FCA Electrical Deficiencies	4,400	4,000		4,000
4	Wilkes-Barre	PA	SCIP 2015	Construct New Chiller Plant	6,000	5,000		5,000
4	Wilkes-Barre	PA	SCIP 2013	Renovate 8 East for Nursing Administration	3,800	3,455	3,455	
4	Wilkes-Barre	PA	Pending OOC	Building 1 HVAC, Phase 2	4,950	4,500		4,500
4	Wilkes-Barre	PA	OOC	Improve Landscaping	1,000	900	900	
4	Wilkes-Barre	PA	SCIP 2017	Install Fence and Gates	2,200	180	180	
4	Wilkes-Barre	PA	SCIP 2017	Renovate 2 North- Radiology	3,300	300	300	
5	Washington	DC	SCIP 2018	Correct FCA Infrastructure Deficiencies and Functional Deficiencies in Research B4 , Phase IV	4,295	430		430
5	Washington	DC	SCIP 2018	Replace Walk-In Refrigerators and Freezers in Patient Kitchen, Morgue, Pharmacy, Lab and Research.	2,765	277		277

Planned 2018 Non-Recurring Maintenance Projects—Continued

VISN	Location	ST	Project Type	Project Name - Short Description	Total Estimated Cost ($000)	Planned FY 2018 Obs ($000)	"First Bite" ($000)	"Second Bite" ($000)
5	Washington	DC	SCIP 2018	Replace and Upgrade Room Air Distribution Terminal Devices and Controls to Correct FCA deficiency.	1,962	196		196
5	Washington	DC	SCIP 2018	Renovate MICU 4B for Patient Privacy and Correction of FCA Deficiencies	9,617	962		962
5	Washington	DC	SCIP 2018	Correct Seismic, Structural, and Facility Condition Deficiencies in Building 1	2,745	275		275
5	Washington	DC	SCIP 2016	Correct NFPA 70 (NEC) Code Deficiencies in all Secondary Distribution Panels and Separate Branch Circuits for Critical, Life Safety and Equipment Branches.	3,028	2,750		2,750
5	Washington	DC	SCIP 2014	Renovate Research Labs, Phase 3	2,691	2,427		2,427
5	Washington	DC	SCIP 2016	Replace and Upgrade Outside Distribution for Site Storm and Sanitary Sewer System	3,700	3,400		3,400
5	Washington	DC	SCIP 2016	Upgrade Sprinkler System for Building #6	2,462	2,262		2,262
5	Washington	DC	SCIP 2016	Upgrade Chiller Plant and Cooling Tower	8,800	8,000		8,000
5	Baltimore	MD	BT	Upgrade and Repair CLC Heating Boilers	450	450		450
5	Baltimore	MD	OOC	Upgrade Emergency Switchgear and Distribution	200	1,800	1,800	
5	Baltimore	MD	BT	Replacement of Exterior Breezeway Precast Concrete Paver Sidewalk System	715	650	650	
5	Baltimore	MD	SCIP 2013	Convert Semi-Private Beds to Private 3A	8,800	8,000	8,000	
5	Baltimore	MD	BT	Upgrade SPD Closet HVAC	770	700	700	
5	Baltimore	MD	BT	Loch Raven Drainage Corrections	770	700	700	
5	Baltimore	MD	SCIP 2017	Upgrade and Renovate OR Suite	6,710	6,100		6,100
5	Baltimore	MD	SCIP 2016	Convert 6A Semi-Private Mental Health Beds to Private	8,290	7,461		7,461
5	Baltimore	MD	SCIP 2018	Upgrade Building Air Handler Units and Improve Heating, Ventilating, and Air Conditioning Systems.	5,170	517		517
5	Baltimore	MD	SCIP 2018	Convert 3B Semi Private Beds to Private	7,040	704		704
5	Perry Point	MD	BT	Expand Fire House for EMS	330	300	300	
5	Perry Point	MD	SCIP 2016	Upgrade Fire Alarm System Campus Wide—Phase 1—Patient Buildings	7,416	6,674		6,674
5	Perry Point	MD	BT	Emergency Steam Condensate System Repairs	550	500	500	
5	Perry Point	MD	Pending OOC	Improvements to Bldg 361 Urgent Care Clinic (UCC)	5,060	4,600		4,600
5	Perry Point	MD	BT	PP Enhanced Dining	660	600	600	
5	Perry Point	MD	SCIP 2014	Convert Bldg 364B for Residential Rehabilitation Treatment Program	2,640	2,400		2,400
5	Perry Point	MD	BT	Waterproof Tunnel to Bldg 364	880	800	800	
5	Perry Point	MD	SCIP 2016	Replace Boiler No. 2 at Perry Point	1,484	1,336		1,336
5	Perry Point	MD	SCIP 2016	Upgrade Medical Gas Systems	1,912	1,721		1,721
5	Perry Point	MD	SCIP 2018	Replace Main Transformers and Switchgear at Perry Point Substation	1,276	128		128
5	Perry Point	MD	SCIP 2018	Renovate Building 15H for Mental Health Homeless Staff and Voluntary Service	4,040	404		404
5	Perry Point	MD	SCIP 2018	Replace Chilled Water along Avenue D to Correct FCA Deficiency	4,796	480		480
5	Perry Point	MD	SCIP 2018	Upgrade HVAC at Bldg 4H to Correct FCA Deficiency	2,751	275		275

5	Beckley	WV	SCIP 2018	Upgrade Boiler Plant System	3,850	385		385
5	Beckley	WV	SCIP 2018	Correct High Voltage Deficiencies	4,840	484		484
5	Beckley	WV	SCIP 2018	Corrections to Medical Gas System	1,600	160		160
5	Beckley	WV	SCIP 2018	Correct Domestic Water Supply System	3,025	303		303
5	Clarksburg	WV	OOC	Modernize Specialty Clinics	6,380	5,844	5,844	
5	Clarksburg	WV	OOC	Construct Replacement Chiller Plant	7,976	7,251	7,251	
5	Clarksburg	WV	SCIP 2018	Replace Deficient Domestic Water Riser Building 1	2,200	220		220
5	Huntington	WV	SCIP 2018	Upgrade and Correct FCA Deficiencies for Campus Building Management System	6,278	628		628
5	Huntington	WV	SCIP 2018	Repair and Upgrade Buildings 23 and 23R to Correct FCA Deficiencies	7,069	707		707
5	Huntington	WV	SCIP 2018	Improve Facility Safety and Security	2,700	270		270
5	Huntington	WV	SCIP 2015	Construct Secondary Access Road	2,905	2,600		2,600
5	Huntington	WV	SCIP 2016	Correct Boiler Plant Steam Deficiencies	3,005	2,705		2,705
5	Huntington	WV	SCIP 2016	Replace Mechanical Systems Bldg 4	4,235	3,850		3,850
5	Huntington	WV	SCIP 2015	Replace Air Handling Units Bldgs 1&1S	2,109	1,900	1,900	
5	Huntington	WV	BT	Improve Signage and Wayfinding	999	850	850	
5	Huntington	WV	CSI	Construct RRTP Building	4,840	4,400	4,400	
5	Huntington	WV	SCIP 2015	Replace Windows Bldg 1S	1,500	1,500		1,500
5	Martinsburg	WV	SCIP 2018	Relocate Electrical Feeder for Physical Security Compliance	2,785	279		279
5	Martinsburg	WV	SCIP 2018	Repair Steam Piping from Buildings 217, 318 & 328 to Boiler Plant	1,534	153		153
5	Martinsburg	WV	OOC	Renovate Building 305 for Fiscal	1,540	1,400	1,400	
5	Martinsburg	WV	BT	Construct Internet Cafe Healing Garden	710	600	600	
5	Martinsburg	WV	BT	Renovate 217 for Veterans' Music Room	890	800	800	
5	Martinsburg	WV	OOC	Renovate Building 317, Post Theater	2,075	1,900	1,900	
6	Durham	NC	Pending OOC	Correct High Priority FCA Deficiencies	3,850	3,500		3,500
6	Durham	NC	Pending OOC	Install Security Fence	1,100	1,050		1,050
6	Durham	NC	BT	Renovate Utility Space in Basement	545	500	500	
6	Durham	NC	BT	Renovate Access Improvement Spaces	570	570		570
6	Durham	NC	Pending OOC	Expand PACU	2,870	2,600		2,600
6	Durham	NC	BT	Correct Life Safety Deficiencies	395	350	350	
6	Durham	NC	Pending OOC	Pharmacy Processing Renovation	1,925	1,925		1,925
6	Durham	NC	BT	Install Lightning and Fall Protection	700	700		700
6	Durham	NC	BT	Renovate OR Locker Rooms	715	650	650	
6	Durham	NC	Pending OOC	Replace Roofs Phase II	2,300	2,150		2,150
6	Fayetteville	NC	SCIP 2018	Renovate Intensive Care Unit	5,028	4,528		4,528
6	Fayetteville	NC	SCIP 2017	Renovation of 1A corridor and offices	790	700	700	
6	Fayetteville	NC	SCIP 2017	Renovate Nursing Area 1A	1,114	1,000		1,000
6	Fayetteville	NC	SCIP 2014	Replace AHUs in A-wing Basement	2,500	2,250		2,250
6	Fayetteville	NC	SCIP 2014	Replace Windows Bldg 1	2,400	2,160		2,160
6	Fayetteville	NC	SCIP 2013	Renovate Lab, Radiology and Pharmacy High Traffic Areas	3,520	3,200	3,200	
6	Salisbury	NC	SCIP 2018	Renovate Building 2 for Medical Surgical Modernization	6,002	5,402		5,402

Planned 2018 Non-Recurring Maintenance Projects—Continued

VISN	Location	ST	Project Type	Project Name - Short Description	Total Estimated Cost ($000)	Planned FY 2018 Obs ($000)	"First Bite" ($000)	"Second Bite" ($000)
6	Salisbury	NC	SCIP 2014	Install New Steam Control Valves at Existing Convectors Buildings 2, 3, and 4	1,665	1,498		1,498
6	Salisbury	NC	SCIP 2014	Replace Chilled Water Lines Building 3	2,080	1,872		1,872
6	Salisbury	NC	SCIP 2016	Replace Campus Fire Alarm System	4,285	3,900		3,900
6	Salisbury	NC	SCIP 2013	Construct Water Tower	3,250	2,925	2,925	
6	Salisbury	NC	SCIP 2018	Renovate Building 2 for Medical Surgical Modernization	6,002	5,452		5,452
6	Salisbury	NC	BT	Resurface Station Roadways and Repair Sidewalks	992	992		992
6	Salisbury	NC	BT	Road Access Modifications at Building 3	300	300		300
6	Salisbury	NC	SCIP 2016	Correct Information Technology FCA Deficiencies	3,500	3,100		3,100
6	Hampton	VA	BT	Access Control Prime Clinics	165	150	150	
6	Hampton	VA	SCIP 2013	Implement Master Plan Design and Building Systems Upgrade, Building 110	8,900	8,091	8,091	
6	Hampton	VA	SCIP 2016	Improve Data Distribution/Security/Infrastructure	1,650	1,500		1,500
6	Hampton	VA	OOC	Replace Natural Gas Line and Initial ESPC Pay Down	1,730	1,655	1,655	
6	Hampton	VA	CSI	Construct New MRI Facility	900	819	819	
6	Hampton	VA	BT	Renovate Prime Clinics for PACT Alignment	153	140	140	
6	Richmond	VA	SCIP 2018	Upgrade Pharmacy to USP 800	1,045	105		105
6	Richmond	VA	BT	Pharmacy Giant Omni-Cell	15	15		15
6	Richmond	VA	BT	Parking Access Improvement	550	500	500	
6	Richmond	VA	SCIP 2016	Renovate for Operating Rooms	8,725	7,900		7,900
6	Richmond	VA	BT	Secure 3D with PACS	75	75		75
6	Richmond	VA	BT	Radiology Mobile MRI Awning	150	150		150
6	Richmond	VA	BT	Roof Replacement	750	750		750
6	Richmond	VA	OOC	Replace Air Handlers SCI	2,725	2,450	2,450	
6	Richmond	VA	BT	Canteen Renovations	550	500	500	
6	Richmond	VA	BT	Remodel Admin Space	996	905	905	
6	Richmond	VA	BT	Remodel Support Spaces	945	900	900	
6	Richmond	VA	BT	Fisher House Exterior Painting	15	15		15
6	Richmond	VA	SCIP 2014	Improve Patient Privacy 4B	3,700	3,370		3,370
6	Richmond	VA	OOC	Renovate Spinal Cord Injury Unit for Privacy	5,720	5,200	5,200	
6	Richmond	VA	Pending OOC	Replace HVAC Systems 2 and 5	1,980	180		180
6	Richmond	VA	Pending OOC	SPS/OR Vertical Transportation	1,650	150		150
6	Salem	VA	SCIP 2016	Replace Roofs and Tuckpoint	6,000	5,480		5,480
6	Salem	VA	BT	Renovate Basement Building 8	750	675	675	
6	Salem	VA	BT	Construct Simulation Center Building 4	938	900	900	
6	Salem	VA	BT	Replace Finishes Various Buildings	550	550		550

7	Birmingham	AL	SCIP 2018	Correct Critical Mechanical and Plumbing Deficiencies by Replacing Aging and Deteriorating Steam Distribution Systems.	5,500	550		550
7	Birmingham	AL	SCIP 2014	Install New Interior Finishes—Blind Rehabilitation Center	3,850	3,500		3,500
7	Birmingham	AL	SCIP 2016	Replace Information Technology Cabling Infrastructure	2,200	1,980		1,980
7	Birmingham	AL	SCIP 2016	Replace/Upgrade Pressure Piping and Hot Water Distribution System	6,600	5,940		5,940
7	Birmingham	AL	SCIP 2016	Replace Air Handling Units—Phase IV	4,400	3,960		3,960
7	Birmingham	AL	BT	Upgrade Negative Pressure Rooms	830	750	750	
7	Montgomery	AL	BT	Renovate Building 90 Therapeutic Pool for Fitness Center	330	300	300	
7	Montgomery	AL	BT	Replace Air Handling Equipment and add Generator, Bldg. 1	825	750	750	
7	Montgomery	AL	BT	Upgrade Restrooms with Water Conservation Measures, Phase 2	820	734	734	
7	Montgomery	AL	SCIP 2018	Renovate Inpatient Medicine Unit for privacy—Building 1, floor 4.	9,290	929		929
7	Tuscaloosa	AL	SCIP 2018	Masonry Restoration	5,960	596		596
7	Tuscaloosa	AL	BT	Improve Building 12 (Warehouse)	239	206		206
7	Tuscaloosa	AL	SCIP 2016	Replace HVAC Systems	2,807	2,359		2,359
7	Tuscaloosa	AL	SCIP 2017	Improve in Building 3	2,580	862	862	
7	Tuscaloosa	AL	BT	Improve Courtyard Building 1	283	265	265	
7	Tuscaloosa	AL	BT	Install Legionella Precautions	858	780	780	
7	Tuscaloosa	AL	SCIP 2016	Electrical Upgrades	1,664	1,498		1,498
7	Tuscaloosa	AL	OOC	A/E Legionella Survey/Assessment Design Phase II Tuscaloosa	6,700	6,200	6,200	
7	Tuskegee	AL	BT	Improve Facility Condition Assessment Findings-Plumbing Upgrades	985	895	895	
7	Tuskegee	AL	SCIP 2018	Repair the Roof on Buildings #3,#3A,#4A,#65,#83,#88,#97,#120 and #129	2,204	220		220
7	Tuskegee	AL	SCIP 2018	Repair FCA Electrical Deficiencies in Buildings #5,#12,#14	1,795	180		180
7	Tuskegee	AL	SCIP 2018	Repair Electrical FCA Deficiencies in Buildings #65 and #68	2,260	226		226
7	Tuskegee	AL	SCIP 2018	Replace Refrigeration Equipment for Building #120 and #97	1,426	143		143
7	Atlanta	GA	SCIP 2018	Correct Infrastructure, Patient Safety, and FCA Deficiencies in Mechanical, Electrical, and Architectural in Research and the Medical Center.	9,930	993		993
7	Atlanta	GA	SCIP 2018	Replace Campus Fire Alarm System	2,370	237		237
7	Atlanta	GA	BT	Bariatric Bedroom	350	290	290	
7	Atlanta	GA	OOC	Correct Emergency Care Deficiencies	7,145	6,255	6,255	
7	Atlanta	GA	BT	Correct Piping Deficiencies, Phase II	810	736	736	
7	Atlanta	GA	SCIP 2016	Renovate and Expand Oncology Medical Specialty Services	3,350	3,015		3,015
7	Atlanta	GA	SCIP 2016	Renovate and Expand Medical/Surgical Inpatient Services on 6th Floor Building 1C Nursing Tower	6,576	5,918		5,918
7	Atlanta	GA	OOC	Upgrade Elevators Building 1A & 1B	3,700	3,350	3,350	
7	Augusta	GA	OOC	Renovate and Upgrade Operating Rooms, Phase 1	9,995	9,086	9,086	
7	Augusta	GA	SCIP 2016	Replace Emergency Generator Systems Uptown	2,814	2,558		2,558
7	Dublin	GA	SCIP 2014	Implement Retro Commissioning Recommendations	1,815	1,650		1,650
7	Dublin	GA	SCIP 2016	Correct Information Technology Infrastructure Deficiencies	1,814	1,656		1,656
7	Dublin	GA	SCIP 2016	Install Emergency Power Generator	3,780	3,500		3,500
7	Dublin	GA	SCIP 2016	Renovate 26A for Swing Space Functions	2,354	2,150		2,150
7	Charleston	SC	SCIP 2018	Replace E&F Buildings and Building Frame Seismic	9,887	989		989

Planned 2018 Non-Recurring Maintenance Projects—Continued

VISN	Location	ST	Project Type	Project Name - Short Description	Total Estimated Cost ($000)	Planned FY 2018 Obs ($000)	"First Bite" ($000)	"Second Bite" ($000)
7	Charleston	SC	SCIP 2018	Fire alarm Ph 2 /life safety improvements removal fire dampers, quick response head replacement, dry system replacement.	9,977	998		998
7	Charleston	SC	SCIP 2018	Expand/Replace Direct Digital Control	5,486	549		549
7	Charleston	SC	SCIP 2018	Address Potential Legionella Issues (Phase II)	9,991	999		999
7	Charleston	SC	SCIP 2018	Correct Structural Seismic Deficiencies to the Medical Center (Building 1)	9,901	990		990
7	Charleston	SC	SCIP 2018	Renovate electrical/telephone closet upgrades (separation of ENG and IT)	9,890	989		989
7	Charleston	SC	SCIP 2018	Update Mechanical Systems	9,842	984		984
7	Charleston	SC	SCIP 2016	Renovate Canteen Kitchen	1,000	900	900	
7	Charleston	SC	SCIP 2016	Construct Patient Surgical Elevator	2,500	2,250		2,250
7	Charleston	SC	SCIP 2017	Correct/Repair External Architectural Barriers and Structures	6,380	5,800		5,800
7	Charleston	SC	SCIP 2016	Renovation of Common and Support Areas in Building 1	5,000	4,500		4,500
7	Charleston	SC	SCIP 2016	Overhaul/Replace Elevators	2,500	2,250		2,250
7	Charleston	SC	SCIP 2017	Remove ACM throughout VAMC	1,128	1,000		1,000
7	Charleston	SC	SCIP 2015	Correct Security Deficiencies	3,195	2,700		2,700
7	Columbia	SC	SCIP 2018	Replace Hot Water Piping	2,182	218		218
7	Columbia	SC	SCIP 2016	Upgrade Elevator Systems	1,685	1,450		1,450
7	Columbia	SC	BT	Implement Lab Energy Conservation Measures	660	600	600	
8	Bay Pines	FL	SCIP 2014	Replace Air Conditioning System B-102 PH I (Multi-Phase)	1,764	1,210		1,210
8	Bay Pines	FL	SCIP 2014	Replace Roof Building 102	1,221	1,221		1,221
8	Bay Pines	FL	SCIP 2012	Renovate Patient Wards B100, 3C & 4A	8,262	7,511	7,511	
8	Bay Pines	FL	SCIP 2017	Resolve SPS Temp, Humidity, Air Change and Air Flow Deficiencies	3,513	3,193		3,193
8	Bay Pines	FL	SCIP 2018	Replace Domestic Water Mains	3,839	384		384
8	Gainesville	FL	OOC	Install Parking Garage Fall Protection	2,210	714	714	
8	Gainesville	FL	OOC	Renovate Ambulatory Care Area	6,300	5,670	5,670	
8	Gainesville	FL	SCIP 2018	Replace Air Handler Unit No. 3	9,950	995		995
8	Gainesville	FL	SCIP 2018	Replace Air Handler Unit No. 2	9,900	990		990
8	Lake City	FL	SCIP 2018	Renovate Common Area Restrooms	2,750	275		275
8	Lake City	FL	SCIP 2018	Replace Windows and Weather Protection	9,900	990		990
8	Lake City	FL	SCIP 2018	Expand Electrical Distribution	9,900	990		990
8	Lake City	FL	SCIP 2018	Replace Site Water Distribution	7,000	700		700
8	Miami	FL	SCIP 2018	Replace pneumatics with direct digital control	9,079	5,530		5,530
8	Miami	FL	BT	Renovate locker and rest rooms for staff	901	901		901
8	Miami	FL	SCIP 2017	Replace coolers and refrigerators	2,020	1,087		1,087
8	Miami	FL	SCIP 2018	Replace Duct work and piping and conduct duct cleaning building 1	8,346	7,199		7,199

8	Miami	FL	SCIP 2017	Renovate Ambulatory surgery	1,418	882	882	
8	Miami	FL	SCIP 2017	Renovate inpatient Mental Health 4th Floor A & B	6,104	5,535		5,535
8	Miami	FL	BT	Renovate Room B1023	32	32		32
8	Miami	FL	BT	Update spinal cord injury outdoor rehabilitation area	352	317	317	
8	Orlando	FL	BT	Add Variable Air Volume and Environmental Controls at Viera OPC	864	786	786	
8	Orlando	FL	BT	Correct Access and Stormwater Deficiencies—Viera	925	836	836	
8	Orlando	FL	SCIP 2017	Renovate Building 500 for Administration Space	4,400	4,000		4,000
8	Orlando	FL	SCIP 2014	Renovate Building 500 for Veterans Benefit Administration Space	3,962	3,660		3,660
8	Tampa	FL	SCIP 2017	Upgrade Facility Security	4,600	4,000		4,000
8	Tampa	FL	SCIP 2017	Replace and Consolidate Domestic Water Distribution, Bldg 1	6,112	5,557		5,557
8	Tampa	FL	BT	Contractor Area Renovation	45	31	31	
8	Tampa	FL	SCIP 2018	Replace Air Handler Units 12, 20, 65 and 66, Building 1	8,600	860		860
8	Tampa	FL	SCIP 2018	Replace Chilled Water System for Building #1	9,100	910		910
8	West Palm Beach	FL	BT	Replace Air Cooled Chillers in Operating Rooms	669	669		669
8	West Palm Beach	FL	SCIP 2017	Provide Return Ducts and Controllers on Air Handler Units (AHU)	1,090	990	990	
8	San Juan	PR	SCIP 2012	Provide New Environmental Integrated Waste Center	3,610	3,310	3,310	
8	San Juan	PR	BT	Replace Air Handling Units at Various Sites	946	880	880	
8	San Juan	PR	SCIP 2017	Upgrade Perimeter Fence Upgrade	2,300	1,414		1,414
8	San Juan	PR	BT	Repair Paver System and Add Canopy at Administrative Building	507	461	461	
8	San Juan	PR	BT	Replace Reheat System	890	800	800	
8	San Juan	PR	BT	Replace Exhaust Fans	739	688	688	
8	San Juan	PR	CSI	Site Prep for New Linear Accelerator	2,209	2,008	2,008	
8	San Juan	PR	BT	Install Non Structural Components and Equipment Seismic Correction and Remove Asbestos at Basement Area.	955	875	875	
8	San Juan	PR	SCIP 2018	Correct Nonstructural Components at OPA	3,800	380		380
9	Lexington—Leestown	KY	SCIP 2018	Renovate B29, 2nd Flr, for Women's Health, C&P and Primary Cary	7,400	6,730		6,730
9	Lexington—Leestown	KY	BT	Chiller Plant Improvements	310	310		310
9	Lexington—Leestown	KY	SCIP 2016	Renovate Building 28 for Specialty Care	9,474	8,641		8,641
9	Lexington—Leestown	KY	BT	Construct Additional Parking B28	561	510	510	
9	Lexington (CD)	KY	BT	Replace Boiler Controls and Burners	437	378	378	
9	Lexington (CD)	KY	BT	Repair Pkg Garage Deck	880	800	800	
9	Lexington (CD)	KY	SCIP 2013	Upgrade Physical Access Control System (PACS) and Site Security	7,124	4,577	4,577	
9	Lexington (CD)	KY	BT	Activate OR for CT Surgery	550	500	500	
9	Lexington (CD)	KY	BT	Renovate Chemo Infusion Ante-Room	446	401	401	
9	Louisville	KY	BT	Install Closed Circuit Security at Louisville Community Based Outpatient Clinics	500	500		500
9	Louisville	KY	BT	Upgrade Motors Project	78	78		78
9	Louisville	KY	BT	Renovate Area for Emergency Department Fast Track	374	340	340	
9	Louisville	KY	BT	Renovate Building 3 for PRRC	494	450	450	
9	Louisville	KY	SCIP 2016	Replace AHUs, Ph 5	2,500	2,250		2,250
9	Louisville	KY	SCIP 2016	Replace Fire Alarm System	5,500	5,000		5,000

Planned 2018 Non-Recurring Maintenance Projects—Continued

VISN	Location	ST	Project Type	Project Name - Short Description	Total Estimated Cost ($000)	Planned FY 2018 Obs ($000)	"First Bite" ($000)	"Second Bite" ($000)
9	Louisville	KY	BT	Replace TIP Units in 23 IT Closets	354	354		354
9	Louisville	KY	OOC	OR Anesthesia Supply Head Replacement Rooms 1—6	1,328	1,195	1,195	
9	Louisville	KY	BT	Replace Steam Traps	90	90		90
9	Louisville	KY	BT	Upgrade 6 South Reheats	440	400	400	
9	Memphis	TN	SCIP 2018	Correct Plumbing Piping and Replace Fixtures	9,185	919		919
9	Memphis	TN	SCIP 2018	Renovate Clinical Lab	7,409	741		741
9	Memphis	TN	BT	Renovate Surgical Service	619	619		619
9	Memphis	TN	BT	Install Equipment Pad for Voluntary Service Carts	30	30		30
9	Memphis	TN	Pending OOC	Renovate Building 1 for Primary Care	9,879	8,989		8,989
9	Memphis	TN	Pending OOC	Renovate Building 1 Clinical Lab	9,945	9,050		9,050
9	Memphis	TN	BT	Replace Building 10 Rooftop AC Units	55	55		55
9	Memphis	TN	BT	Upgrade Elevators for Oil Coolers and UV	189	189		189
9	Memphis	TN	BT	Replace Automatic Doors	978	978		978
9	Memphis	TN	BT	Renovate Physical Medicine & Rehabilitation Pool Area	871	785	785	
9	Memphis	TN	OOC	Upgrade Spinal Cord Injury Patient Bathrooms	1,678	1,526	1,526	
9	Memphis	TN	BT	Replace Building 1 and 1A Medical Vacuum Pump	250	225	225	
9	Memphis	TN	BT	Replace Finishes for Halls and Walls	950	950		950
9	Memphis	TN	BT	Replace Flooring and Ceilings for Safety and Infection Control	964	877	877	
9	Mountain Home	TN	BT	Replace Building 200 Roof	950	893	893	
9	Mountain Home	TN	OOC	Replace AHU 3 For SPD Building 77	1,672	1,520	1,520	
9	Mountain Home	TN	BT	Renovate Building 160 Main Lobby	901	825	825	
9	Mountain Home	TN	BT	Replacement of Signs Bldg 200/204/205/77/160	900	895	895	
9	Mountain Home	TN	SCIP 2015	Correct Bldg 20 Condition & Environment Deficiencies for Clinical/Support Staff Recruitment & Training.	1,439	1,316		1,316
9	Mountain Home	TN	BT	Modify Pharmacy HVAC System for USP 800 & USP 797 Compliance	825	750	750	
9	Mountain Home	TN	BT	Replace Facility Condition Assessment Deficient Elevators, Building 160	935	935		935
9	Mountain Home	TN	BT	Renovate CLC Dining Room	968	880	880	
9	Mountain Home	TN	BT	Renovate Halls & Walls, Building 200 Phase I	929	851	851	
9	Mountain Home	TN	BT	Correct Facility Condition Assessment Exterior and Structural Deficiencies for Historic Chapel, Bldg 13.	988	899	899	
9	Mountain Home	TN	BT	Implementation of Electrical Infrastructure Upgrades—Phase 2	948	862	862	
9	Mountain Home	TN	BT	Replace AHU and Upgrade Duct System in Primary Care, Bldg. 160	957	870	870	
9	Murfreesboro	TN	BT	Renovate Bathrooms	896	800	800	
9	Murfreesboro	TN	BT	Replace Air Handling Unit 12	840	750	750	

9	Murfreesboro	TN	BT	Replace Nuclear Medicine Air Handling Unit 4	728	650	650	
9	Murfreesboro	TN	BT	Upgrade Elevator Building 5	840	750	750	
9	Murfreesboro	TN	SCIP 2016	Upgrade Security Measures	1,760	1,600		1,600
9	Murfreesboro	TN	SCIP 2016	Upgrade Corridors and Waiting	1,980	1,800		1,800
9	Murfreesboro	TN	BT	Replace Flooring and Abatement	658	658		658
9	Murfreesboro	TN	SCIP 2016	Abate Asbestos	1,000	900	900	
9	Murfreesboro	TN	SCIP 2018	Renovate Ward 1A	8,330	833		833
9	Nashville	TN	BT	Cardiology Improvements	762	680	680	
9	Nashville	TN	BT	Replace AHU-3A for Sterile Processing Supply	840	750	750	
9	Nashville	TN	BT	Reconfigure Sterile Processing Supply Scope Processing	358	300	300	
9	Nashville	TN	BT	Improvements for Surgical Clinic	909	810	810	
9	Nashville	TN	BT	Expand Clinical Support	498	464	464	
9	Nashville	TN	SCIP 2016	Upgrade Public Corridors and Waiting Rooms	1,980	1,710		1,710
9	Nashville	TN	SCIP 2016	Install Boiler System Condensing Economizer	1,205	1,105		1,105
9	Nashville	TN	SCIP 2016	Upgrade Energy Management System Infrastructure	1,100	990	990	
9	Nashville	TN	SCIP 2016	Upgrade Electrical Distribution	3,300	3,000		3,000
10	Fort Wayne	IN	BT	Increase Fort Wayne Site Accessibility	775	705	705	
10	Fort Wayne	IN	SCIP 2018	Remodel West Wing, 3rd Floor	4,035	404		404
10	Indianapolis	IN	SCIP 2018	Modify Water Systems for Legionella Prevention	2,750	275		275
10	Indianapolis	IN	SCIP 2015	Replace Air Handling Units and Correct Deficiencies	9,240	8,400		8,400
10	Indianapolis	IN	BT	Install Entrance Gate System	200	175	175	
10	Indianapolis	IN	BT	Install A-Wing Reheat Victaulic Fittings	687	625	625	
10	Indianapolis	IN	BT	Upgrade Fire Suppression System	990	900	900	
10	Indianapolis	IN	BT	Reconfigure Waiting Rooms	990	900	900	
10	Indianapolis	IN	SCIP 2015	Upgrade Building 1 for Accessibility	9,900	9,000	9,000	
10	Indianapolis	IN	Pending OOC	Renovate Space for Veteran Centered Care	1,045	950		950
10	Marion	IN	SCIP 2017	Renovate 4th Floor, Building 138	9,600	8,640		8,640
10	Marion	IN	BT	Improve Infrastructure Building 65	990	990		990
10	Marion	IN	SCIP 2015	Demolish Buildings 7, 10, 11, 18, 24, 60, 75, CC-2	8,800	8,000		8,000
10	Marion	IN	BT	Renovate Atrium, Building 172	620	564	564	
10	Marion	IN	BT	Remodel Medication Rooms, Building 185	307	279	279	
10	Marion	IN	BT	Replace Roof, Building 138	770	700	700	
10	Marion	IN	SCIP 2018	Demolish Buildings 25, 42 and 122, Marion	4,537	454		454
10	Ann Arbor	MI	SCIP 2018	Upgrade Electrical Switchgear and Distribution	2,200	220		220
10	Ann Arbor	MI	SCIP 2016	Renovate Intensive Care Units	8,672	7,805		7,805
10	Ann Arbor	MI	BT	Renovate Outpatient Pharmacy for Ambulatory Care Clinics	885	770		770
10	Ann Arbor	MI	BT	Upgrade HVAC for SPS	945	850	850	
10	Ann Arbor	MI	BT	Chiller Plant Optimization	885	800	800	
10	Ann Arbor	MI	BT	Renovate Lab Service	900	750	750	
10	Ann Arbor	MI	BT	Install Gypboard Ceiling in SPS	475	402	402	

Planned 2018 Non-Recurring Maintenance Projects—Continued

VISN	Location	ST	Project Type	Project Name - Short Description	Total Estimated Cost ($000)	Planned FY 2018 Obs ($000)	"First Bite" ($000)	"Second Bite" ($000)
10	Battle Creek	MI	BT	Repair Gutters and Downspouts	705	624	624	
10	Battle Creek	MI	SCIP 2015	Install ADA Access, Various Buildings	1,971	1,760		1,760
10	Battle Creek	MI	BT	Replace Water Heaters Various Buildings	666	555	555	
10	Battle Creek	MI	BT	Install Energy Efficient HVAC, B84	621	550	550	
10	Battle Creek	MI	BT	Install Water Monitoring System	572	500	500	
10	Battle Creek	MI	SCIP 2016	Replace Windows, Various Buildings	2,528	2,257		2,257
10	Battle Creek	MI	SCIP 2015	Renovate B83—2 for Patient Privacy	5,577	4,979		4,979
10	Battle Creek	MI	SCIP 2018	Replace Roofs, Various Buildings	2,750	275		275
10	Battle Creek	MI	SCIP 2018	Correct Water Distribution Deficiencies for Legionella	4,950	495		495
10	Detroit	MI	SCIP 2018	Upgrade Fire Alarm Notification System	2,750	275		275
10	Detroit	MI	SCIP 2018	Replace Poz Loc Fire Sprinkler Piping, Phase II	2,240	224		224
10	Detroit	MI	SCIP 2016	Install Electrical Switchgear Enclosures	6,700	6,000		6,000
10	Detroit	MI	BT	Installation of Simulation Lab for Education	500	450	450	
10	Detroit	MI	BT	Renovate Hallway A4 and B4	390	350	350	
10	Saginaw	MI	SCIP 2016	Renovate 3rd Floor Building 1	6,225	5,600		5,600
10	Saginaw	MI	SCIP 2015	Pharmacy Renovation	1,500	1,390		1,390
10	Saginaw	MI	Pending OOC	Medical Center Security and Controls Upgrades	3,292	3,000		3,000
10	Saginaw	MI	Pending OOC	Building 22 Sprinkler Replacement	1,600	1,500		1,500
10	Saginaw	MI	SCIP 2015	Electrical Deficiencies and Improvements	1,000	875	875	
10	Chillicothe	OH	SCIP 2018	Improve Water System to Reduce Risk of Legionella Contamination and Patient Injury	9,999	1,000		1,000
10	Chillicothe	OH	BT	Renovate Student Housing Buildings 15 and 16	988	889	889	
10	Chillicothe	OH	BT	Sanitary Sewer inspection and Repair	500	425	425	
10	Chillicothe	OH	BT	Upgrade IT Infrastructure to Support VoIP Phone System	550	484	484	
10	Chillicothe	OH	OOC	Demolish Buildings 2, 6, 10 & 11	1,300	1,170	1,170	
10	Chillicothe	OH	SCIP 2016	Renovate Building 25 to Improve Efficiency	3,720	3,348		3,348
10	Chillicothe	OH	SCIP 2016	Address and Resolve Hazmat Deficiencies	2,860	2,540		2,540
10	Cincinnati	OH	SCIP 2018	Improve Exhaust System	4,875	488		488
10	Cincinnati	OH	SCIP 2018	Replace Hospital Steam Heating Systems, Phase II	3,355	336		336
10	Cincinnati	OH	SCIP 2017	Relocate PM&R to Basement of Building #2	1,200	1,072		1,072
10	Cincinnati	OH	SCIP 2017	Upgrade Water Systems for Legionella and Improve Water Efficiency	1,200	1,056		1,056
10	Cincinnati	OH	BT	Upgrade UPS and AC in Computer Room	605	550	550	
10	Cincinnati	OH	BT	Replace Operating Room Chillers	880	795	795	
10	Cincinnati	OH	BT	Install PA Systems in Trailers	242	220	220	
10	Cleveland	OH	SCIP 2018	Replace Air Handling Unit AC-17&18	6,900	690		690

10	Cleveland	OH	SCIP 2018	Upgrade Fire Alarm System	4,000	400		400
10	Cleveland	OH	SCIP 2018	Replace CARES Tower Roof and Repair Overhangs	5,950	595		595
10	Cleveland	OH	BT	Renovate Boiler Plant Heat Recovery System	385	325	325	
10	Cleveland	OH	BT	Replace Automatic Transfer Switch 15 in Energy Center	250	225	225	
10	Cleveland	OH	BT	Provide Chiller Plant Automatic Transfer Switch	275	250	250	
10	Cleveland	OH	BT	Consolidate Chaplain Services	440	400	400	
10	Cleveland	OH	BT	Expand Emergency Department Parking Area	440	400	400	
10	Columbus	OH	BT	Remodel Pharmacy IV Prep Room- FCA	915	800	800	
10	Columbus	OH	BT	Add Domestic Water Pressure Booster	208	190	190	
10	Columbus	OH	BT	Construct temporary chiller connection	510	464	464	
10	Columbus	OH	SCIP 2015	Construct Chiller Plant	9,100	8,190		8,190
10	Columbus	OH	BT	Increase Size of Smoking Shelter	100	90	90	
10	Columbus	OH	BT	Expand Existing Emergency Distribution Panel Board and Add Cooling to Substation Room	783	712	712	
10	Dayton	OH	SCIP 2018	Renovate Laboratory, Building 310	8,602	860		860
10	Dayton	OH	SCIP 2018	Renovate Infrastructure for National Historical Archives, Building 116	4,400	440		440
10	Dayton	OH	SCIP 2018	Renovate TCU/ICU Space	4,950	495		495
10	Dayton	OH	SCIP 2016	Improve Campus Access and Security	4,500	4,100		4,100
10	Dayton	OH	BT	Correct Arc Flash Deficiencies	438	393	393	
10	Dayton	OH	SCIP 2017	Renovate B410 East Wing	4,400	3,660		3,660
12	Chicago	IL	BT	Renovate Sterile Processing	970	900	900	
12	Chicago	IL	SCIP 2016	Remodel Patient Admitting	3,750	3,500		3,500
12	Chicago	IL	BT	Replace Fire Pump Controller in Building #1-Damen	210	185	185	
12	Chicago	IL	BT	Replace ATS for Elevators in Building #1-Damen	185	135	135	
12	Danville	IL	SCIP 2017	Remediate Legionella Station Wide Phase 1	4,087	3,700		3,700
12	Danville	IL	BT	Building 98 Exterior Ductwork Insulation	178	178		178
12	Danville	IL	SCIP 2014	Renovate 58-5 Endoscopy Suite	1,871	1,750		1,750
12	Danville	IL	BT	Legionella Continuous Temperature Monitoring System	160	160		160
12	Danville	IL	BT	Demolish Quarters 31, 32, 33	600	450	450	
12	Hines	IL	BT	Remodel Resident Kitchen, Bldg. 221	56	50	50	
12	Hines	IL	SCIP 2017	Legionella Suppression—Task Order #1	3,450	3,000		3,000
12	Hines	IL	BT	Install Patient Lifts, Multiple Locations	522	381	381	
12	Hines	IL	BT	Correct HVAC Central Supply and Storage Rooms	598	500	500	
12	Hines	IL	Pending OOC	Upgrade Chilled Water System, Bldg. 200	9,914	9,013		9,013
12	North Chicago	IL	SCIP 2018	Upgrade Water Distribution System	6,500	650		650
12	North Chicago	IL	SCIP 2018	Improve Facility Accessibility	4,815	482		482
12	North Chicago	IL	BT	Construct Hemodialysis Area Building 133	275	250		250
12	North Chicago	IL	BT	Renovate Occupational Health Bldg 133	330	300	300	
12	North Chicago	IL	BT	Oncology Renovation USP 800 Requirement	330	300	300	
12	North Chicago	IL	BT	Building 135 HR Renovation	165	150	150	
12	North Chicago	IL	SCIP 2017	Facility Roofs	3,300	3,300		3,300

Planned 2018 Non-Recurring Maintenance Projects—Continued

VISN	Location	ST	Project Type	Project Name - Short Description	Total Estimated Cost ($000)	Planned FY 2018 Obs ($000)	"First Bite" ($000)	"Second Bite" ($000)
12	North Chicago	IL	BT	Chilled Water Efficiency Part 2	900	900		900
12	North Chicago	IL	BT	Prosthetics Renovation	550	500	500	
12	North Chicago	IL	SCIP 2017	Renovate Building 131-4 ''A'' Wing	1,100	1,100		1,100
12	North Chicago	IL	OOC	Renovate Audiology	1,320	1,200	1,200	
12	North Chicago	IL	OOC	Replace Chiller #5	1,650	1,500	1,500	
12	North Chicago	IL	CSI	Construct Space for 1.5T MRI	3,969	3,500	3,500	
12	North Chicago	IL	BT	Modify Chilled Water System Valves	500	500		500
12	North Chicago	IL	BT	Construct Misc Catwalks	120	120		120
12	North Chicago	IL	BT	Repair Misc. Fire Suppression Systems in Various Bldgs	50	50		50
12	North Chicago	IL	OOC	ATFP Measures—Gates and Fencing	3,000	300	300	
12	North Chicago	IL	BT	Expand Police Area Bldg. 133	220	20	20	
12	Iron Mountain	MI	BT	Install Server Room AHU	170	150	150	
12	Iron Mountain	MI	BT	Upgrade OPC Heat Exchangers	255	225	225	
12	Iron Mountain	MI	BT	HVAC Pressurization Study	638	600	600	
12	Iron Mountain	MI	SCIP 2017	Install Potable Water Mixing Valves and Control Upgrades	1,330	1,250		1,250
12	Iron Mountain	MI	Pending OOC	Renovate 5 West	2,000	1,850		1,850
12	Madison	WI	OOC	Renovate 3B for Inpatient Ward	4,918	4,500	4,500	
12	Madison	WI	SCIP 2015	Renovate 3A/3C	6,146	5,246		5,246
12	Madison	WI	SCIP 2018	Renovate 4B	6,550	655		655
12	Milwaukee	WI	Pending OOC	112 Replace (3) Boilers	9,900	9,000		9,000
12	Milwaukee	WI	SCIP 2016	Upgrade HVAC V9, S1, S4 in Bldg 111	7,260	6,600		6,600
12	Milwaukee	WI	BT	Replace Refrigerant Units Various Locations	285	285		285
12	Milwaukee	WI	SCIP 2015	Correct FCA Sanitary Deficiencies Grounds Phase 1	3,300	3,000		3,000
12	Milwaukee	WI	BT	Upgrade Elevators Buildings 5 and 6 A Wing	748	680	680	
12	Milwaukee	WI	SCIP 2016	Replace Security Card Readers and Upgrade Security	1,552	1,384		1,384
12	Milwaukee	WI	BT	Repair Campus Steam Tunnel and Structural Supports	500	450	450	
12	Milwaukee	WI	BT	Replacement of Structural Floor Slab for Building 43 Dining Room Mental Health	485	425	425	
12	Tomah	WI	SCIP 2016	Renovate South End of Building 406, 2nd Floor	2,783	2,530		2,530
12	Tomah	WI	CSI	Construct Warehouse	4,600	4,250	4,250	
15	Marion	IL	BT	Install Ventilation Corrections for Sterile Processing	150	130	130	
15	Leavenworth	KS	SCIP 2018	Renovate Infrastructure of Laundry Building 153	5,000	500		500
15	Leavenworth	KS	SCIP 2018	Replace Steam/Condensate Lines throughout the facility	2,650	265		265
15	Topeka	KS	SCIP 2017	Renovate Bldg 6, Wing B of Existing CLC	4,990	4,456		4,456
15	Topeka	KS	OOC	Renovate Space For VA Call Center At Fort Riley For VHA Member Services	9,000	8,100	8,100	

15	Topeka	KS	BT	Upgrade Oncology For Pharmacy—Topeka	390	350	350	
15	Topeka	KS	BT	Relocate Gastrointestinal Laboratory	899	800	800	
15	Topeka	KS	BT	Repair Boiler Plant Chimney	360	320	320	
15	Topeka	KS	BT	Repair Surgery Ventilation System and Connect to Emergency Power	625	550	550	
15	Wichita	KS	CSI	Construct Substance Abuse Residential Rehabilitation Treatment Building 59	4,730	4,300	4,300	
15	Wichita	KS	BT	Correct Mechanical Deficiencies, Building 26	500	450	450	
15	Columbia	MO	BT	Replace Air Handler (AC -S2)	880	800	800	
15	Columbia	MO	BT	Renovate Vacated Surgery, Ward 6	890	800	800	
15	Kansas City	MO	BT	Replace Central Boiler Plant Control System	900	800	800	
15	Kansas City	MO	BT	Replace Building 26 Roof	500	475	475	
15	Kansas City	MO	BT	Extend Chilled Water Loop Building 15 and 26	900	800	800	
15	Kansas City	MO	CSI	Expand Outpatient Mental Health Clinic	2,200	2,000	2,000	
15	Poplar Bluff	MO	OOC	Replace Boilers, Building 7	3,000	2,700	2,700	
15	Poplar Bluff	MO	SCIP 2017	Replace Station 518,000 Volt Amps Electrical Life Safety Generator	1,315	1,206		1,206
15	Poplar Bluff	MO	BT	Create Exterior Secure Storage Area	250	200	200	
15	Poplar Bluff	MO	BT	Correct Legionella Deficiencies Phase 1	900	810	810	
15	St. Louis	MO	OOC	Renovate Operating Rooms and Support Spaces	6,120	5,943	5,943	
15	St. Louis	MO	CSI	Demolish Sextro Warehouse, John Cochran Division	4,100	4,000	4,000	
15	St. Louis	MO	BT	Prepare Site for X-Ray Units	640	640		640
16	Fayetteville	AR	SCIP 2018	Renovate B9 Laundry	1,925	193		193
16	Fayetteville	AR	SCIP 2018	Replace Eaves, Soffit, Integral Gutters and Fascia, Multiple Buildings	1,855	186		186
16	Fayetteville	AR	BT	Replace Primary Care Elevator Controls	80	80		80
16	Little Rock	AR	SCIP 2016	Provide 100% Emergency Power	9,900	9,000		9,000
16	Little Rock	AR	SCIP 2018	Develop Private/Semi-Private Bed Spaces	8,360	836		836
16	Alexandria	LA	SCIP 2016	Emergency Generator Replacement	4,950	600	600	
16	Shreveport	LA	SCIP 2018	Correct Electrical Deficiencies, Building 1	7,300	730		730
16	Shreveport	LA	SCIP 2018	Abate Central Chase/Replace Fire Main Risers	1,320	132		132
16	Shreveport	LA	BT	Renovate Morgue, Building 1	407	370	370	
16	Shreveport	LA	SCIP 2017	Replace Primary Switch Gear	1,557	1,410		1,410
16	Jackson	MS	OOC	Renovate Ground Floor Community Living Center—Bldg. 7	8,505	7,667	7,667	
16	Jackson	MS	BT	Continuous Monitoring of Potable Water Engineering Controls	200	200		200
16	Jackson	MS	BT	Replace Cable TV System	150	150		150
16	Jackson	MS	BT	Repair Employee Parking Lot Area I	550	550		550
16	Jackson	MS	OOC	Upgrade HVAC System 9B	5,335	4,850	4,850	
16	Jackson	MS	BT	Upgrade Auto Transfer Switches/Emergency Generator Control Units	935	850	850	
16	Oklahoma City	OK	SCIP 2018	Renovate Pharmacy for Chapter 797/800 Compliance	1,760	176		176
16	Oklahoma City	OK	SCIP 2018	Correct Domestic Hot Water Distribution System Deficiencies	1,980	198		198
16	Oklahoma City	OK	SCIP 2018	Renovate to Separate OIT and Engineering Closets	1,878	188		188
16	Oklahoma City	OK	SCIP 2018	Renovate 6 North for Patient Privacy	2,715	272		272
16	Houston	TX	SCIP 2018	Renovation of Pathology and Laboratory- Phase 1	6,000	600		600

Planned 2018 Non-Recurring Maintenance Projects—Continued

VISN	Location	ST	Project Type	Project Name - Short Description	Total Estimated Cost ($000)	Planned FY 2018 Obs ($000)	"First Bite" ($000)	"Second Bite" ($000)
16	Houston	TX	Pending OOC	Replace Elevators B-100	6,000	5,250		5,250
16	Houston	TX	SCIP 2017	Renovate/Expand ER Building 100	6,500	1,800		1,800
17	Amarillo	TX	SCIP 2016	Replace HVAC Components for Energy Savings Building 28	3,800	3,500		3,500
17	Amarillo	TX	SCIP 2016	Replace HVAC Components for Energy Savings Building 1	2,750	2,000		2,000
17	Amarillo	TX	BT	Repair Medical Air & Vacuum Systems	150	150		150
17	Amarillo	TX	OOC	Renovate Building 28 Medical Ward for Privacy	3,372	3,322	3,322	
17	Big Spring	TX	BT	Renovate fifth floor Nursing Station and Corridor	825	700		700
17	Big Spring	TX	BT	Relocate & Expand Audiology	599	544		544
17	Big Spring	TX	BT	Replace Deficient HVAC Fan Coil Units	975	850	850	
17	Big Spring	TX	BT	Renovate Street Entrance	455	400	400	
17	Big Spring	TX	OOC	Replace Roofs on Building 1	3,350	3,200	3,200	
17	Big Spring	TX	BT	Construct Restrooms for Education Training Center	375	300	300	
17	Big Spring	TX	BT	Replace Flag Pole	410	350	350	
17	Big Spring	TX	OOC	Renovate Administration for Physical Therapy and Prosthetics	2,530	2,300	2,300	
17	Big Spring	TX	BT	Correct Facade Deficiencies	95	50	50	
17	Big Spring	TX	OOC	Install Perimeter Fencing Around Campus	2,700	2,500	2,500	
17	Big Spring	TX	OOC	Upgrade Electrical Panels	2,250	2,000	2,000	
17	Big Spring	TX	BT	Replace HVAC in Bldg 4 & 7	800	725	725	
17	Big Spring	TX	SCIP 2015	Remove Dead Leg Water Lines in the Facility	1,150	1,035	1,035	
17	Bonham	TX	SCIP 2016	Replace HVAC Bldg 1 & 2	2,170	2,000		2,000
17	Bonham	TX	OOC	Replace Pipe Support Stands	2,303	2,100	2,100	
17	Bonham	TX	SCIP 2015	Replace Bonham Fire Alarm System	3,200	3,000		3,000
17	Dallas	TX	BT	Roof Top Chiller Pressurized System	874	800		800
17	Dallas	TX	OOC	Renovate Building #60 Bed & Bath Rooms B Wing	3,600	3,500	3,500	
17	Dallas	TX	BT	Correct B.70 Deficiencies	990	900	900	
17	Dallas	TX	BT	Replacing Bldg. 6 & 8 AHU System	550	500	500	
17	Dallas	TX	BT	Replace/Repair Roof Bldg.60	550	500	500	
17	Dallas	TX	OOC	Replace Patient Exterior and Interior Signage	3,000	3,000	3,000	
17	El Paso	TX	OOC	Repair FCA Deficiencies	1,650	1,500	1,500	
17	Harlingen	TX	OOC	Upgrade HVAC	2,750	2,500	2,500	
17	Harlingen	TX	OOC	Repair Parking Lot Corpus Christi Outpatient Clinic	550	500	500	
17	San Antonio	TX	BT	Activate Emergency Well Water @ ALMD	666	600	600	
17	San Antonio	TX	BT	Conduct Legionella Study	440	400	400	
17	San Antonio	TX	SCIP 2016	Replace 1000kw Generator and Fuel Storage Tank	2,200	2,000		2,000

17	San Antonio	TX	SCIP 2018	Replace main switch gear	2,200	220		220
17	Temple	TX	Pending OOC	Reconfigure Specialty Clinics 4th Floor Teague Tower	2,838	2,580		2,580
17	Temple	TX	SCIP 2018	Relocate Mental Health to Dom C-Wing	9,686	4,860		4,860
17	Temple	TX	SCIP 2018	Relocate Mental Health to Dom D-Wing	7,578	4,440		4,440
17	Temple	TX	BT	Construct 2nd Cardiac Cath	491	450	450	
17	Temple	TX	OOC	Replace Air Handler Units Bldg 163 Tower	4,075	3,705	3,705	
17	Temple	TX	SCIP 2017	Convert Bldg 44W to Admin	1,650	1,500		1,500
17	Temple	TX	OOC	Prevention of Legionella—Temple	3,377	3,070	3,070	
17	Temple	TX	OOC	Replace Medium Voltage Switchgear	3,232	3,000	3,000	
17	Waco	TX	SCIP 2017	Relocate Canteen Bldg 202	2,299	2,090		2,090
17	Waco	TX	OOC	Upgrade Electrical Secondary Distribution System	2,200	2,000	2,000	
17	Waco	TX	BT	Replace Building 1 HVAC	817	777	777	
17	Waco	TX	OOC	Prevention of Legionella—Waco	2,742	2,493	2,493	
19	Denver	CO	OOC	Replace CBS West AHU	2,321	2,121	2,121	
19	Grand Junction	CO	Pending OOC	Energy Audit Finding Corrections	1,118	1,026		1,026
19	Grand Junction	CO	BT	Correct Building 33 FCA Deficiencies	229	208	208	
19	Grand Junction	CO	SCIP 2016	Replace AHU 9 AND 10	1,680	1,500		1,500
19	Grand Junction	CO	Pending OOC	Ventilate and Expand IT Closets	1,090	1,000		1,000
19	Grand Junction	CO	SCIP 2017	Replace Boilers and Controls, Phase 2	7,616	7,201		7,201
19	Grand Junction	CO	Pending OOC	Renovate 4E/4W and Upgrade Mechanical AHU	2,150	1,980		1,980
19	Grand Junction	CO	SCIP 2013	Elimination of Substandard Beds on 3rd Floor	3,740	3,400	3,400	
19	Grand Junction	CO	BT	DR Site Prep	175	160	160	
19	Ft Harrison	MT	SCIP 2017	Replace Penthouse HVAC Systems	2,420	2,150		2,150
19	Ft Harrison	MT	BT	Digital Security Enhancements	935	850	850	
19	Ft Harrison	MT	OOC	LED Lighting Phase I	1,100	990	990	
19	Ft Harrison	MT	SCIP 2017	Building 141 Heating	1,452	1,280		1,280
19	Muskogee	OK	BT	Replace & Upgrade DW1 Cart Elevator	375	375		375
19	Muskogee	OK	Pending OOC	Replace Surveillance System	2,050	1,900		1,900
19	Muskogee	OK	SCIP 2015	Install Energy Retrofits for Air Handling Units, Controls, and Lighting	5,445	4,901		4,901
19	Muskogee	OK	BT	Upgrade Roofing Systems Phase 2	800	800		800
19	Oklahoma City	OK	CSI	Remodel Cath Labs	1,450	1,300	1,300	
19	Oklahoma City	OK	SCIP 2016	Renovate 7 East for Patient Privacy	3,215	2,700		2,700
19	Oklahoma City	OK	SCIP 2016	Renovate Canteen Food Court and Office Suite	1,628	1,480		1,480
19	Oklahoma City	OK	SCIP 2016	Increase Electrical Capacity to 9th Floor Server Room	1,540	1,400		1,400
19	Oklahoma City	OK	OOC	Upgrade Interior Fixed Equipment	2,075	1,850	1,850	
19	Oklahoma City	OK	CSI	Site Prep for New 80 Slice CT	660	500	500	
19	Salt Lake City	UT	SCIP 2017	Upgrade Public Address Mass Notification System (PAMNS)	4,750	4,300		4,300
19	Salt Lake City	UT	BT	B.7, B.35, B.37 Research Renovation	880	800	800	
19	Salt Lake City	UT	OOC	Legionella—Mixing Valves, Schematics, Controls	1,870	1,700	1,700	
19	Salt Lake City	UT	SCIP 2017	Chilled Water Distribution Line Ph. 6	1,980	1,800		1,800

Planned 2018 Non-Recurring Maintenance Projects—Continued

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19	Salt Lake City	UT	SCIP 2017	Upgrade Fire Alarms	1,527	153	153	
19	Salt Lake City	UT	SCIP 2016	Site Electrical Replacement	1,000	100	100	
19	Salt Lake City	UT	SCIP 2016	Solar PV Parking Garage	4,180	380	380	
19	Cheyenne	WY	SCIP 2016	Improve Facility Security Phase 1	1,000	988	988	
19	Cheyenne	WY	BT	FCA Improve Wayfinding	135	135		135
19	Cheyenne	WY	BT	Potable Water Improvements	990	900	900	
19	Cheyenne	WY	Pending OOC	Renovate Pharmacy & SPS, Phase 2	1,090	90		90
19	Sheridan	WY	BT	Demo 30,34,39 & 83	700	700		700
19	Sheridan	WY	BT	Replace O2 Tanks	580	580		580
19	Sheridan	WY	Pending OOC	Site Prep Sheridan MRI	1,700	1,700		1,700
19	Sheridan	WY	BT	Porch and Roof Corrections	682	592		592
19	Sheridan	WY	BT	Boiler Upgrade Ph3	960	850	850	
19	Sheridan	WY	Pending OOC	IT Comm Closet Upgrades Ph 1	2,080	1,900		1,900
19	Sheridan	WY	BT	Replace B64 Parking Lots	958	860	860	
19	Sheridan	WY	SCIP 2018	IT Communication Closets Upgrade Phase I	2,180	218		218
20	Anchorage	AK	BT	Surgical Suite Steam Humidification System	600	520	520	
20	Anchorage	AK	BT	Building 100 Site Improvements	440	400	400	
20	Boise	ID	BT	Replace Officer's Row Road	335	300	300	
20	Portland	OR	SCIP 2017	Upgrade and Replace condensate and steam infrastructure (V)	2,750	2,500		2,500
20	Portland	OR	BT	Upgrade Building 18 TLU HVAC	880	800	800	
20	Portland	OR	BT	Simulation Lab Relocation	335	300	300	
20	Roseburg	OR	SCIP 2016	Upgrade Campus Security	3,300	3,000		3,000
20	Roseburg	OR	SCIP 2017	Renovate Building 1 to Relocate Short Stay	1,936	1,760		1,760
20	Roseburg	OR	BT	Replace Campus PA System	715	650	650	
20	Roseburg	OR	BT	Update Wayfinding Signage campus wide	980	900	900	
20	Roseburg	OR	BT	Replace Nurse Call System Building 81	275	250	250	
20	Roseburg	OR	BT	Replace Quonset Huts T6, T7, T8, T15 & T19	832	772	772	
20	White City	OR	SCIP 2016	Renovate Space, Building 210 Upper South for Clinical Areas	2,200	1,980		1,980
20	White City	OR	SCIP 2016	Retrofit Campus Wide Infrastructure Systems—Water, Sewer, & Storm	7,900	7,200		7,200
20	American Lake	WA	BT	Replace Building 148 Boiler	550	500	500	
20	American Lake	WA	BT	VCS Coffee Shop in Building 2	198	143	143	
20	American Lake	WA	OOC	Expand Blind Rehabilitation Building 2	1,485	1,376	1,376	
20	American Lake	WA	SCIP 2016	Am Lake Replace Boilers for Energy Efficiency	3,300	2,970		2,970
20	Seattle	WA	BT	Replace Flooring in B100 First Floor Core/Lobby	220	200	200	

20	Seattle	WA	BT	Renovate Main Entrance Canopy and Demo Smoking Shelter/Canopy	275	250	250	
20	Seattle	WA	BT	Replace Ceiling and Flooring in Bldg 23	165	150	150	
20	Seattle	WA	BT	Replace Flooring in Bldg 11 OR Rooms and Corridor	115	100	100	
20	Seattle	WA	BT	Renovate Rooms in Bldg 34 for Veterinary Treatment	286	260	260	
20	Seattle	WA	BT	Replace Flooring in Bldg 34 First Floor	65	50	50	
20	Seattle	WA	BT	Building 1 Sterilizer Installation	385	350	350	
20	Seattle	WA	BT	Renovate SCI Bathrooms	660	600	600	
20	Seattle	WA	BT	OR Mechanical Upgrades	550	500	500	
20	Seattle	WA	SCIP 2015	Renovate and Expand Seattle Sterile Processing Service	7,797	7,019	7,019	
20	Seattle	WA	BT	Replace 2 West Corridor Flooring	115	100	100	
20	Seattle	WA	SCIP 2016	Renovate Seattle B37 First Floor for VA Police	1,654	1,489		1,489
20	Seattle	WA	SCIP 2017	4W Surgical Specialty Care Clinic Expansion	4,686	4,296		4,296
20	Seattle	WA	BT	Install Wi-Fi in Patient Areas	825	750	750	
20	Seattle	WA	SCIP 2018	Replace Roofs—Seattle VA	4,675	468		468
20	Spokane	WA	CSI	Site Prep for Nuke Med SPECT/CT	660	630	630	
20	Spokane	WA	BT	Demolish Building 32	60	50	50	
20	Spokane	WA	CSI	Site Prep for MRI Replacement	250	200	200	
20	Spokane	WA	SCIP 2015	Correct Electrical and Communication Infrastructure Deficiencies	3,900	3,510	3,510	
20	Spokane	WA	BT	Install Hot Water Recirculation Loop for Acute Psychiatric Unit	495	450	450	
20	Spokane	WA	BT	CLC Remodel and Portico	714	650	650	
20	Spokane	WA	BT	Replace Elevators in Bldg 1 and 27	990	900	900	
20	Spokane	WA	SCIP 2016	Replace Boiler Plant	11,000	9,900		9,900
20	Walla Walla	WA	BT	Replace Steam Traps	440	400	400	
21	Fresno	CA	BT	Repair Mechanical Systems, Building 1 Sub-Basement	755	700		700
21	Fresno	CA	BT	Remodel ED for Observation Beds	550	200	200	
21	Fresno	CA	CSI	Expand Mental Health Center, Building 27	4,950	4,540	4,540	
21	Fresno	CA	SCIP 2016	Expand Chilled Water Capacity	9,600	8,800		8,800
21	Fresno	CA	BT	Install Skytron Ceiling Mount Booms in Surgical Suite, 3rd Floor, Building 1	375	300	300	
21	Fresno	CA	BT	Install USP800 Chemo Compounding Room, 3rd Floor, Building 24	410	360	360	
21	Fresno	CA	BT	Remodel Building 24, 1st Floor	990	800	800	
21	Fresno	CA	SCIP 2018	Renovate Outpatient Clinic Basement for Emergency Department Observation Bed Suite	5,010	501		501
21	Livermore	CA	BT	Repair Main Water Line, LVD	65	65		65
21	Martinez	CA	BT	Renovate Outpatient Clinic Office Space, Building 778, Fairfield	880	800	800	
21	Martinez	CA	SCIP 2014	Correct Campus Security Deficiencies and Renovate for Sterile Storage Supply	2,000	1,800		1,800
21	Martinez	CA	Pending OOC	Investigate Seismic Capacity Building 21	3,100	100		100
21	Menlo Park	CA	BT	Renovate Tele radiology, Bldg 334	870	800	800	
21	Palo Alto	CA	OOC	Create 60kV Substation and Infrastructure	30,000	30,000	30,000	
21	Palo Alto	CA	BT	Expand Emergency Preparedness Capabilities, PAD Campus	550	500	500	
21	Palo Alto	CA	BT	Construct Bump Out for Major Construction Team	550	500	500	
21	Palo Alto	CA	BT	Create Surface Parking at Stockton	800	750	750	

Planned 2018 Non-Recurring Maintenance Projects—Continued

VISN	Location	ST	Project Type	Project Name - Short Description	Total Estimated Cost ($000)	Planned FY 2018 Obs ($000)	"First Bite" ($000)	"Second Bite" ($000)
21	Palo Alto	CA	SCIP 2017	Construct Consolidated Fisher House Central Reception Building	3,575	2,300		2,300
21	Palo Alto	CA	SCIP 2015	Replace Chillers in Building 100	4,824	4,000		4,000
21	Palo Alto	CA	SCIP 2013	Improve Emergency Sustainment capabilities -South Campus Generator	2,788	2,600	2,600	
21	Palo Alto	CA	BT	Create Additional Patient & Staff Parking at PAD	950	850	850	
21	Sacramento	CA	BT	Renovate for Clean Room Expansion, Building 652	560	500	500	
21	San Francisco	CA	BT	Upgrade Sanitary System on East Side of Campus	990	890		890
21	San Francisco	CA	Pending OOC	Replace Building 3, 200 Chillers, insulate ductwork	2,076	1,750		1,750
21	San Francisco	CA	OOC	Replacement of Bldg. 200 Roof System	1,500	1,500	1,500	
21	San Francisco	CA	SCIP 2015	Renovate and Consolidate Clinical Programs on the Ground Floor of the Main Hospital	3,685	3,500		3,500
21	San Francisco	CA	OOC	Renovate and Upgrade Patient Restrooms in Bldgs 200 and 203	1,500	1,200	1,200	
21	San Francisco	CA	BT	Correct Non-structural Components of B. 200 and 203	700	700		700
21	San Francisco	CA	CSI	Site Preparation for Bi-Plane	1,000	1,000		1,000
21	Honolulu	HI	BT	Renovate Pharmacy	700	600	600	
21	Honolulu	HI	BT	Finish Parking Structure Basement	558	475	475	
21	Honolulu	HI	BT	Replace Fire Alarm Panels	575	575		575
21	Honolulu	HI	BT	Upgrade Center For Aging HVAC System	990	990		990
21	Honolulu	HI	BT	Install Real-time Water Monitoring System—Legionella	235	175	175	
21	Las Vegas	NV	Pending OOC	CLC Patient Lift Installation	1,757	1,757		1,757
21	Las Vegas	NV	SCIP 2017	Modify Main Entrances in Building 1	1,841	1,690		1,690
21	Las Vegas	NV	BT	Back Up Cooling System for Critical Care Areas	879	790	790	
21	Las Vegas	NV	BT	Environmental Controls and Monitoring	572	520	520	
21	Las Vegas	NV	SCIP 2017	Water Line Improvement/Bypass	1,950	960	960	
21	Las Vegas	NV	OOC	Radiology and Surgical UPS	2,114	1,995	1,995	
21	Las Vegas	NV	OOC	Stairwell Safeguards	1,540	1,400	1,400	
21	Reno	NV	BT	MRI Upgrade Site Prep	400	400		400
21	Reno	NV	BT	Upgrade Mental Health Interlocking Doors (Study)	253	200	200	
21	Reno	NV	BT	Demolish Buildings 15, 138, F and K	646	600	600	
21	Reno	NV	BT	Convert Room for Blood Draw	15	15		15
21	Reno	NV	SCIP 2017	Expand Emergency Power Capacity at the Boiler Plant	1,390	1,300		1,300
21	Reno	NV	SCIP 2018	Replace damaged piping in clinical Building 1D.	5,500	550		550
21	Reno	NV	SCIP 2018	Repair critical electrical deficiencies in Clinical Building 1D	3,850	385		385
22	Phoenix	AZ	CSI	Renovate and Expand Women's Health Clinic	4,400	4,000	4,000	
22	Phoenix	AZ	SCIP 2018	Replace AHUs at CLC and Main Building	3,300	330		330
22	Phoenix	AZ	SCIP 2016	Renovate Inpatient Ward 2C	4,504	4,104		4,104

22	Phoenix	AZ	OOC	Renovate 6D for Inpatient Ward	4,000	3,600	3,600	
22	Phoenix	AZ	BT	OI&T Electrical Upgrades	990	900	900	
22	Phoenix	AZ	Pending OOC	Remodel Dietetics Kitchen	3,411	3,029		3,029
22	Phoenix	AZ	SCIP 2016	Site Stormwater Correction	1,760	1,600		1,600
22	Prescott	AZ	SCIP 2014	Perform Retro-commissioning and Repair of Building Control Systems	825	750	750	
22	Prescott	AZ	SCIP 2016	Repair/Resurface Roads, Ph 4	1,107	992	992	
22	Prescott	AZ	Pending OOC	Renovate Buildings 12-17 (Thermal Envelope)	1,400	1,300		1,300
22	Prescott	AZ	BT	Replace Heating Systems for Outer Buildings, Phase 1	940	880	880	
22	Prescott	AZ	OOC	Repair/Replace Main Steam Riser from Boiler Plant	1,050	900	900	
22	Tucson	AZ	BT	Replace Air Handlers (B60)	990	900	900	
22	Tucson	AZ	BT	Correct Safety Deficiencies, B4	401	350	350	
22	Tucson	AZ	SCIP 2017	Legionella DOM Water Loop Repairs, B-30 & B-67	1,200	950	950	
22	Tucson	AZ	OOC	Renovate for Pathology Morgue and IT, B-38 Basement	2,420	2,200	2,200	
22	Tucson	AZ	OOC	Replace Air Handling Units for Critical Care and Sterile Processing	3,300	3,000	3,000	
22	Tucson	AZ	OOC	Upgrade Information Technology Server Room	1,815	1,650	1,650	
22	Tucson	AZ	OOC	Replace Ancillary Boiler Plant Equipment & Controls	1,430	1,345	1,345	
22	Tucson	AZ	BT	Replace SPS and Logistics Dumbwaiters (B-57)	655	600	600	
22	Loma Linda	CA	BT	Renovate 4SW Bathrooms	880	800	800	
22	Loma Linda	CA	BT	Correct Steam Distribution Deficiencies	801	720	720	
22	Loma Linda	CA	BT	Renovate Stairwells	600	550	550	
22	Loma Linda	CA	SCIP 2016	Replace Main Stormwater, Waste & Vent Piping	3,000	2,700		2,700
22	Loma Linda	CA	SCIP 2018	Correct Environmental Controls & Security Deficiencies in IT rooms	2,500	250		250
22	Long Beach	CA	SCIP 2015	Physical Security Access Control	1,650	880	880	
22	Long Beach	CA	OOC	Correct Carpet-Wall Finish Deficiency B150 SCI	3,960	3,600	3,600	
22	Long Beach	CA	SCIP 2012	Install Emergency Management Generator, Phase 2	5,498	5,000	5,000	
22	Long Beach	CA	OOC	B126OP Basement-Correct FCA Deficiencies and Remodel	4,015	3,650	3,650	
22	Long Beach	CA	SCIP 2016	B126 Renovate & Upgrade Hemodialysis Infrastructure	4,950	4,455		4,455
22	Long Beach	CA	BT	Metasys System	800	720	720	
22	Long Beach	CA	SCIP 2018	Correct Legionella Deficiencies—Bldg 1	4,400	440		440
22	Long Beach	CA	SCIP 2018	Correct Electrical Site Security Deficiencies	5,203	520		520
22	Long Beach	CA	SCIP 2018	Renovate ICU Bldg 126 3rd Floor	6,600	660		660
22	Long Beach	CA	SCIP 2018	Renovate Bldg 126 8th Floor North for Private/Semi Private Beds	9,200	920		920
22	Los Angeles	CA	BT	Replace Fire Alarm System in LAACC	910	821	821	
22	Los Angeles	CA	SCIP 2018	Replace Water Main and Valves	3,795	380		380
22	San Diego	CA	SCIP 2016	Bldg 2 Remodel- Emergency Bus &Switchgear Modifications	9,020	8,200		8,200
22	San Diego	CA	SCIP 2017	Emergency Department Exterior Access & Signage	2,310	2,100		2,100
22	Sepulveda	CA	SCIP 2016	Upgrade Information Technology Closets Sepulveda	1,650	1,500		1,500
22	West Los Angeles	CA	BT	Replace B158 Fire Alarm	770	700	700	
22	West Los Angeles	CA	SCIP 2016	Upgrade Information Technology Closets WLA North Campus Six Buildings	1,500	1,350		1,350
22	Albuquerque	NM	OOC	Abate Asbestos B-41	1,760	1,600	1,600	

Planned 2018 Non-Recurring Maintenance Projects—Continued

VISN	Location	ST	Project Type	Project Name - Short Description	Total Estimated Cost ($000)	Planned FY 2018 Obs ($000)	"First Bite" ($000)	"Second Bite" ($000)
22	Albuquerque	NM	OOC	Install Legionella Corrections	2,500	2,250	2,250	
23	Des Moines	IA	SCIP 2015	Design/Construct Security Gates	1,660	1,500		1,500
23	Des Moines	IA	BT	Repair Roads/Walks for Safety	820	672	672	
23	Des Moines	IA	SCIP 2016	Upgrade OR Chilled Water Cooling System	1,756	800	800	
23	Des Moines	IA	SCIP 2016	Install New Emergency Generator System	1,900	1,750		1,750
23	Des Moines	IA	CSI	Site Prep to Replace Two CTs	1,080	930	930	
23	Des Moines	IA	SCIP 2015	Upgrade Existing and Construct New Elevators	3,990	3,600		3,600
23	Des Moines	IA	SCIP 2018	Renovate and Expand Primary Care Infusion and Oncology Center	1,240	124		124
23	Iowa City	IA	Pending OOC	Replace Deficient Mechanical Systems (AHU)	2,200	2,000		2,000
23	Iowa City	IA	SCIP 2017	Modernize Existing Chillers	3,850	3,450		3,450
23	Iowa City	IA	SCIP 2015	Replace Defective Steam Traps and Correct Condensate Over pressurization	6,100	5,500		5,500
23	Iowa City	IA	OOC	Upgrade and Expand Hospital Security Systems	2,250	2,050	2,050	
23	Iowa City	IA	OOC	Correct Life Safety Deficiencies	9,900	9,000	9,000	
23	Minneapolis	MN	SCIP 2018	Renovate Outpatient Mental Health (1L)	4,300	430		430
23	Minneapolis	MN	SCIP 2018	Recommission of Main Hospital HVAC Systems	1,000	100		100
23	Minneapolis	MN	CSI	Site Prep—Multi-Site DR Rooms	5,000	4,000	4,000	
23	Minneapolis	MN	SCIP 2017	Construct Clinical Research Wings	3,300	3,000		3,000
23	Minneapolis	MN	CSI	Upgrade Cath Labs 2 and 3	2,200	2,000	2,000	
23	Minneapolis	MN	SCIP 2016	Renovate Inpatient Mental Health	2,600	2,300		2,300
23	St Cloud	MN	SCIP 2018	Renovate Primary Care Clinic Building 4	8,203	820		820
23	St. Cloud	MN	SCIP 2016	Renovate Building 4 Basement for Sterile Processing Services and Sterile Processing and Distribution.	7,150	6,500		6,500
23	St. Cloud	MN	SCIP 2017	Relocate Rehab Functions	6,204	564	564	
23	St. Cloud	MN	SCIP 2016	Upgrade Information Technology Closets for Security	4,965	4,500		4,500
23	St. Cloud	MN	OOC	Install Ground Source Heat Pump System for Building 28	5,433	5,000	5,000	
23	St. Cloud	MN	SCIP 2016	Renovate Building 4 East Side for Women's Clinic	2,900	2,636		2,636
23	St. Cloud	MN	SCIP 2015	Renovate Building 2, First Floor for Residential Rehabilitation Therapy Program	4,987	4,545		4,545
23	St. Cloud	MN	SCIP 2014	Replace Windows, Buildings 4, 8 & 9	1,580	1,500		1,500
23	Fargo	ND	CSI	Perform Site Prep for Urology Equipment in OR #4	316	287	287	
23	Fargo	ND	BT	Install Instrument Air and RO Water in SPS	202	182	182	
23	Fargo	ND	BT	Replace N&FS Ceiling System	220	200	200	
23	Fargo	ND	SCIP 2015	Renovate 2nd Floor Bldg 46 for Medical Specialties	2,640	2,400		2,400
23	Fargo	ND	SCIP 2017	Replace Boiler Plant	8,250	7,500		7,500
23	Fargo	ND	SCIP 2017	Renovate Bldg 1 First Floor for PT/OT and Prosthetics	4,840	4,400		4,400

23	Omaha	NE	BT	Construct SPS Scope Processing Area	206	186		186
23	Omaha	NE	SCIP 2016	Construct Central Energy Plant	36,027	35,640		35,640
23	Omaha	NE	BT	Replace Overhead Paging Systems—Omaha and Grand Island	30	30		30
23	Fort Meade	SD	BT	Upgrade Boiler Plant Automation Equipment	330	300		300
23	Fort Meade	SD	SCIP 2016	Renovate and Consolidate Inpatient Function Building 113	7,490	6,590		6,590
23	Fort Meade	SD	SCIP 2016	Relocate Sterile Processing Service and Endoscopy	5,265	4,778		4,778
23	Hot Springs	SD	BT	Canteen Entry Upgrades Design	175	150		150
23	Sioux Falls	SD	BT	Electrical and Fire Suppression Upgrades	700	500	500	
23	Sioux Falls	SD	SCIP 2015	Renovate 5th Floor Surgery	3,909	3,519	3,519	
23	Sioux Falls	SD	Pending	Mechanical Upgrades	2,200	200		200
	Various		Various	Below Threshold/Urgent Projects		121,374		121,374
				Total VHA Planned NRM Projects	2,549,939	1,870,000	600,000	1,270,000

Question 17. Please provide a list of the projects and their associated funding levels included in the $862 million for the activation of new and enhanced health care facilities. Specifically break out the additional projects included in the $364 million "second bite" for 2018 advance appropriations.

Response. See attached list of projects.

Planned 2018 Non-Recurring Maintenance Projects

VISN	Project Name	FY 2018	New or Replacement?	Actual or Estimated Construction Completion/ Lease Acceptance Date
1	Boston, MA—Community-Based Outpatient Clinic Lease	$7,945,835	Replacement	7/31/2018
2	Syracuse, NY—Spinal Cord Injury	$986,452	Replacement	6/1/2013
2	Brick, NJ—Community-Based Outpatient Clinic	$10,986,303	Replacement	6/1/2020
2	Manhattan, NY—Hospital Restoration and Renovation	$1,819,563	Replacement	10/31/2019
2	Canandaigua, NY—New Construction and Renovation Phase 1.	$3,890,735	Replacement	1/31/2023
2	Rochester, NY—Health Care Center—Major Lease	$13,614,553	Replacement	9/30/2019
4	Butler, PA—Health Care Center Lease	$1,398,248	New	6/12/2017
5	Perry Point, MD—Replacement Long Term Care	$1,200,000	Replacement	7/31/2021
6	Fayetteville, NC—Health Care Center Lease	$12,489,421	New	9/30/2016
6	Charlotte, NC—Health Care Center Lease	$27,008,337	New	2/28/2016
6	Winston-Salem, NC—Health Care Center Lease	$28,702,513	New	12/31/2015
7	Expand Cobb City, AL—Community-Based Outpatient Clinic	$7,599,157	New	6/1/2020
7	Birmingham, AL—Clinical Annex/Outpatient Clinic Lease	$4,884,076	New	7/31/2015
7	Huntsville, AL—Outpatient Clinic Lease	$5,590,275	Replacement	12/15/2015
7	Savannah, GA—Community-Based Outpatient Clinic Lease	$9,058,563	Replacement	2/1/2017
8	New Port Richey, FL—Lease Consolidation	$2,311,438	Replacement	6/1/2020
8	Bay Pines, FL—Mental Health/Inpatient-Outpatient Improvements.	$8,329,187	Replacement	8/30/2020
8	Tallahassee, FL—Outpatient Clinic Lease	$21,491,622	Replacement	7/31/2016
8	Brandon (South Hillsborough), FL—Outpatient Clinic (Tampa) Lease.	$20,946,907	New	10/1/2018
8	Orlando, FL—New Medical Facility	$63,549,984	New	11/30/2015
8	Tampa, FL—Polytrauma and New Bed Tower	$36,230,637	New	1/31/2021
9	Louisville, KY—Replacement Med Center/Regional Office	$1,195,634	Replacement	1/6/2023
10	Terre Haute, IN—Health Care Center	$200,000	Replacement	2/1/2022
10	St Joseph County VA Clinic, IN—Outpatient Clinic	$26,100,912	New	10/31/2017
12	Green Bay, WI—Health Care Center	$37,326,024	Replacement	8/10/2015
15	St. Louis, MO—Med Facility Improve & Expansion	$5,951,843	Replacement	11/15/2018
15	St. Louis, MO—Clinic	$773,726	Replacement	10/31/2017
15	Cape Girardeau, MO—Clinic Expansion	$773,726	Replacement	5/31/2019
16	Mobile, AL—Outpatient Clinic Lease	$8,332,515	Replacement	12/1/2018
16	Biloxi, MS—Building 1 & 2 Renovation	$3,240,933	Replacement	5/31/2018
16	New Orleans, LA—Restoration/Replacement Medical Facility	$134,346,907	Replacement	2/28/2018
16	Springfield, MO CBOC	$23,256,953	New	6/30/2018
16	Lafayette, LA—Outpatient Clinic Lease	$4,864,834	New	9/30/2016
17	San Antonio, TX—Polytrauma Renovation Project	$6,931,830	Replacement	12/31/2013
17	McAllen, TX—Outpatient Clinic	$17,059,566	New	4/28/2014
19	Missoula, MT—CBOC Lease	$95,736	Replacement	1/31/2022
19	Denver, CO—Replacement Medical Center Facility	$87,487,356	Replacement	7/1/2018
20	American Lake, WA—Seismic Corrections of Building 81	$240,000	Replacement	9/4/2023
20	Seattle, WA—B101 Mental Health	$1,857,268	Replacement	3/22/2018
20	Walla Walla, WA—New OPC and Renovation 86	$1,100,000	Replacement	1/6/2020
20	East Portland, OR—Community Based Outpatient Clinic	$3,074,444	Replacement	8/1/2016
20	Eugene, OR—Community-Based Outpatient Clinic Lease	$6,541,941	Replacement	12/31/2015
20	Seattle, WA—Correct Seismic Deficiencies B100	$80,000	Replacement	5/19/2016
20	Honolulu, HI—ALOHA (459)	$6,500,000	New	5/1/2020
21	Las Vegas, NV—New Medical Facility	$43,565,383	Replacement	3/7/2016
21	Chico, CA—Replace Lease for Expiring CBOC	$4,079,638	Replacement	4/1/2020
21	Redding, CA—Replace Lease for Expiring CBOC	$15,421,608	Replacement	6/1/2020
21	Reno, NV—Building 1 Seismic	$200,000	Replacement	4/26/2021
21	San Francisco, CA—Correct Seismic Deficiencies in Buildings 1,6,8 & 12.	$14,823,000	Replacement	9/1/2022
21	Livermore, CA—Livermore Realignment (Palo Alto)	$500,000	New	7/4/2023

Planned 2018 Non-Recurring Maintenance Projects—Continued

VISN	Project Name	FY 2018	New or Replacement?	Actual or Estimated Construction Completion/ Lease Acceptance Date
21	Palo Alto, CA—Polytrauma (Polytrauma-Ambulatory Care Center).	$2,000,000	New	6/30/2017
21	Palo Alto, CA—Radiology (Polytrauma-Ambulatory Care Center).	$500,000	Replacement	7/2/2018
21	Palo Alto, CA—Research (Polytrauma-Ambulatory Care Center).	$4,300,000	Replacement	4/1/2019
21	Monterey, CA—Health Care Center Lease	$1,500,000	New	2/28/2017
21	San Jose, CA—Outpatient Clinic Lease	$15,700,000	Replacement	12/31/2017
21	Mission Valley, CA—Clinic	$21,365,246	New	6/1/2020
22	San Diego, CA—Spinal Cord Injury/Long Term Care	$31,959,139	Replacement	9/15/2025
22	Chula Vista, CA—Clinic	$7,483,329	Replacement	5/31/2019
22	Loma Linda, CA—Health Care Center Lease	$5,140,552	New	6/30/2016
22	Long Beach, CA—Out Patient 126	$7,104,443	Replacement	11/1/2019
22	Long Beach, CA—Seismic Correction—Mental Health & Community Living Center.	$1,871,545	Replacement	7/13/2021
22	Los Angeles, CA—Seismic Corrections—12 Buildings	$6,571,450	Replacement	12/24/2024
22	West Los Angeles, CA—New Bed Tower	$1,581,592	Replacement	2/15/2030
22	Bakersfield, CA—Community-Based Outpatient Clinic Lease	$5,018,194	Replacement	5/1/2021
	Subtotal	$858,051,072		
	VA Central Office Direct Field Support (PCAC/VACASE)	$4,115,722		
	Grand Total	$862,166,794		

Note 2: Activation Funding (AF) covers multiple requirements to bring these projects into full operational status; i.e., furniture, fixtures, equipment, and support to plan and outfit each health care facility. Additionally, AF is utilized to cover additional clinical and administrative staff to provide new and expanded services, and supports other operating expenses; i.e., utilities, maintenance, etc. Based on the scope and complexity of the project, AF typically is allocated 2-3 years prior to the construction start date, and 2-3 years post construction completion date based on the activation phasing schedule. Within the VHA portfolio of activation projects, there are some projects that require activation support and funding beyond the typical period of activation funding allocation. These are activation funding estimates and may require adjustments based on changes in the construction and activation schedules.

Question 18. Please provide the weights assigned to the criteria and sub-criteria in the Strategic Capital Investment Planning Process Decision Model contained on Page 10–3 of Volume IV of the Budget Justification.

Response. Below are the definition and weights associated with the criteria and sub-criteria of the SCIP 2018 Decision model.

STRATEGIC CAPITAL INVESTMENT PLANNING PROCESS DECISION CRITERIA

Improve Safety, Compliance, and Security: VA is dedicated to ensuring its Clients (Veterans) and Customers (VA Staff) are being served and/or work in a safe and secure environment. Mitigating the destruction and injury caused by natural or man-made disasters (including seismic, hurricane, flooding, blast, etc.); ensuring problems or injuries caused by the potential failure of critical building systems are avoided; improving compliance with safety and security laws, Federal Information Security Management Act (FISMA) standards, building codes, and regulations (including operating room, supply processing and distribution, inpatient privacy standards, PACT, and Research functional deficiencies for VHA; counselor offices, hearing rooms, and public/non-public separation for VBA and equipment rooms for OIT); mitigating threats to persons (physical security) on a VA facility (duress alarms for VBA); and ensuring VA mission critical buildings are able to provide service in the wake of a catastrophic event are of paramount importance.

The three sub-criteria that projects are measured against with respect to Improving Safety and Security are:

- Safety/Compliance (Excludes Seismic)
- Physical and Building Security/Emergency Preparedness
- Seismic

Fixing What We Have (making the most of current infrastructure/extending useful life): VA is committed to managing its buildings in order minimize the extent to which deficiencies in infrastructure (including IT infrastructure) and other areas impact the delivery of benefits and services to Veterans, such as Central Office rent reduction efforts, depletion dates for National Cemeteries and VBA's Trans-

formation Initiative. For infrastructure deficiencies, facility condition assessments (FCA) evaluate the condition of VA buildings using scores A through F and the criticality of building sub-systems.

The three sub-criteria projects are measured against with respect to Fixing What We Have are:

- Reduce Facility Condition Assessment Deficiencies (critical)
- Reduce Facility Condition Assessment Deficiencies (non-critical)
- Other Self-Identified Gaps (gaps not defined in existing criteria)

Increasing Access: Serving Veterans is at the core of VA's mission. We strive to increase access for Veterans (our Clients) by reducing the time and distance a Veteran must travel to receive the best quality services and benefits; ensuring Veterans have access to National Cemeteries, providing virtual access to benefits); providing adequate supporting structures at VA facilities, such as parking facilities and gravesite locators; by increasing our ability to handle workload; and by enabling VA staff (our Customers) to work more efficiently.

The four sub-criteria that projects are measured against with respect to increasing access are:

- Client (Veteran) Access to Services
- Customer (Internal) Access to Services
- Support Structures (includes parking deficiencies)
- Utilization/Workload

Right-Sizing Inventory: In order to provide the highest quality service to Veterans at the right time and in the right place, VA is managing its space inventory by removing excess VA-owned space via demolition, sale or transfer, building new space, collocating (VHA, VBA, NCA, and Staff Offices using the vacant or underutilized space of another office), leasing new space, converting underutilized space of one type to another type, to better suit its mission, and using space efficiency strategies such as but not limited to teleworking, cubicle reconfiguration, converting to new space standards, and expanded office hours to reduce the need for space.

The four sub-criteria projects are measured against with respect to Right-Sizing Inventory are:

- Space—New Construction/Renovation/Conversion/Lease
- Space—Disposal (via demolition, sale, or transfer only)
- Space—Collocation
- Space—Space Efficiency Strategies

Ensure Value of Investment: As a steward of the public's trust VA is responsible for making capital investments in the most cost-effective way possible by ensuring new capital investments optimize operating and maintenance costs, in order to create the best value.

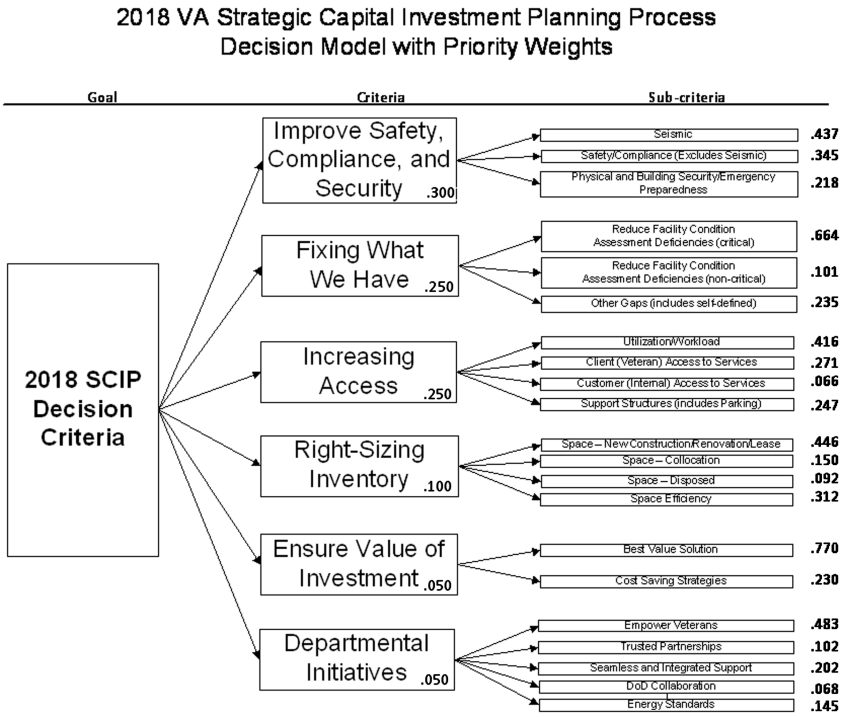
The two sub-criteria that projects are measured against with respect to Ensure Value of Investment are:

- Cost Saving Strategies—identification, quantification, and description any cost savings realized with the implementation of this project.
- Best Value Solution—completion of a cost-effectiveness analysis (CEA) on the Status Quo and required alternatives is mandatory for Major Construction, Minor Construction, and Lease projects; if the chosen option does not have the best net present value (NPV) an explain for why the chosen option is the better value is also required

Departmental Initiatives: For improved management and performance across the Department, capital projects should contribute to performance goals from the Department's strategic plan, including DOD collaboration and complying with energy standards established in law and Executive Orders.

The five sub-criteria that projects are measured against with respect to Strategic Requirements are:

- Empower Veterans to Improve Their Well-being
- Enhance and Develop Trusted Partnerships
- Manage and Improve VA Operations to Deliver Seamless and Integrated Support
- DOD Collaboration
- Energy Standards



OFFICE OF TRANSITION, EMPLOYMENT AND ECONOMIC IMPACT

Question 19. Please provide the number of Direct and Management Direction and Support FTE for the Office of Transition, Employment, and Economic Impact (OTEEI) for fiscal year 2017 and the request for fiscal year 2018.

Response. For FY 2017, OTEEI was allocated 40 full-time employees (FTE) with 10 slots designated as supervisors or program managers. On November 1, 2016, OTEEI was realigned under VBA's Benefits Assistance Service (BAS) and the Office of Economic Opportunities (OEO). Of this total, 23 FTE were realigned under BAS, 7 FTE were realigned under OEO, and the remaining FTE were realigned to other mission essential functions. No FTE was allocated for FY 2018 as OTEEI no longer exists.

Question 20. Please provide the total administrative costs for OTEEI for fiscal year 2017 and the request for fiscal year 2018.

Response. OTEEI was provided $199,000 in operating budget for FY 2017. These funds were reallocated to BAS and OEO, to support mission functions. In FY 2018, there was not a separate budget submission for OTEEI as those duties have been dispersed between other business lines in VBA.

Question 21. Please provide a list of the programs and other functions for which OTEEI is responsible, including the annual cost or expenditure per program, for fiscal year 2017 and the request for fiscal year 2018.

Response. OTEEI is no longer an existing organization. BAS assumed responsibilities for the Transition Assistance Program while OEO continues to collaborate with Department of Labor (DOL), non-profits, and the private sector with the goal of helping Veterans reach their full economic potential.

EDUCATION SERVICE

Question 22. The Budget Justification noted that Education Service has indefinitely delayed implementation of the Veterans Approval, Certification, Enrollment, Reporting, and Tracking System (VA-CERTS) due to funding constraints.

a. What functions would VA-CERTS provide to Education Service and to school certifying officials?

Response. VA-CERTS would provide a modernized way for schools to send enrollment information to VA. Training institutions would be able to access VA data to include chapter 33 eligibility percentages, which is not currently available in the existing legacy system. With the completion of VA-CERTS, it would allow VA to consolidate two legacy systems into one agile and accessible system.

b. How would VA-CERTS improve the administration of education benefits compared to the current system?

Response. Improvements would allow for schools to have the ability to see VA data in order to verify that schools were paid the correct tuition and fees rates. VA-CERTS would also incorporate the ability to certify multiple enrollments for students at one time, as opposed to entering one enrollment at a time. In addition, a newer system would eliminate the need for duplication of work for VA employees by combining the Web Enabled Approval Management System and VA-ONCE. Currently, VA employees have to enter similar information into both systems.

c. What is the cost to complete and fully implement VA-CERTS, and when will VA make a decision on completing it?

Response. The cost to implement VA-CERTS is not known at this time. When initially conceived in 2014 its estimated cost of completion was $39M. Currently, the Office of Information and Technology is in the process of re-engineering education systems—eliminating the Business Delivery Network (BDN), a 51-year-old COBOL-based mainframe system and consolidating all education processing and payments into Long Term Solution (LTS) and VETSNET/FAS (Financial Accounting Services). This elimination of a critical legacy system and the resulting consolidation of capabilities, beginning now and running through 2018, will greatly facilitate VA's ability to conduct system enhancements going forward. Due to the aggressive timeline for accomplishing this work, it is vitally important to not introduce additional changes or enhancements during this period to avoid additional complexity and risk. Implementation of VA-CERTS capabilities could begin once this initial effort is complete. VA will be in a better position to estimate costs, timing and how to best implement the capabilities conceived for VA-CERTS at the end of this calendar year once the engineering plan for the initial effort is solidified and implementation well underway.

Question 23. The Budget Justification stated VA is working toward "a fully automated system for all education claims."

a. What is Education Service's goal for automating original claims in the Long Term Solution?

Response. The current average processing time for original claims is 22 days. By fully automating original claims, VA would be able to provide even faster service for some beneficiaries. VA's long-term goal is for a beneficiary to be able to obtain an eligibility determination electronically, as opposed to waiting until VA manually adjudicates a claim and then mails a letter regarding the eligibility determination. By full automating the original claims process, there would be a savings to the government because it would eliminate the costs of paper, postage, envelopes, and mail handling.

b. What is the cost to complete development of the Long Term Solution in order to fully automate all education claims?

Response. The cost to complete development of LTS is not known at this time. We have, however, included projections of $37.5M in our budget planning for FY19–21. Currently, the Office of Information and Technology is in the process of re-engineering education systems—eliminating the BDN, a 51-year-old COBOL-based mainframe system and consolidating all education processing and payments into LTS and VETSNET/FAS. This elimination of a critical legacy system and the resulting consolidation of capabilities, which is beginning now and will run through 2018, will greatly facilitate VA's ability to conduct system enhancements going forward. Due to the aggressive timeline for accomplishing this work, it is vitally important to not introduce additional changes or enhancements during this period to avoid additional complexity and risk. Implementation of LTS enhancements could begin once this initial effort is complete. VA will be in a better position to estimate costs, timing and how to best implement LTS enhancements at the end of this calendar year once the engineering plan for the initial effort is solidified and implementation well underway.

c. How many man hours were spent processing original claims in fiscal year 2016 and how many are expected to be spent in fiscal year 2017 and fiscal year 2018? What is the average cost of a man hour to process original claims?

Response. VA does not track the specific number of man hours that are spent processing various types of claims. However, we track the number of claims that are processed, and in 2016, we processed 356,756 "original" claims of all benefit types combined. Our current time to process an original claim is approximately 22 days.

Prior to automating supplemental claims in September 2012, the average timeframe for processing a claim was 21 days for supplemental and 36 days for originals; presently we are operating at 8 days for supplemental and 22 days for original claims. We would expect a similar benefit to our timeliness if we automate original claims.

Chairman ISAKSON. Thank you, Dr. Shulkin. We appreciate your attendance today.

I want to start off with my questions on the appeals process. I have consistently said that any change in the process to improve it must include an acceleration in dealing with the 470,000 veterans whose claims are pending today at the VA. Would you agree with that?

Secretary SHULKIN. I would like to see that happen.

Chairman ISAKSON. Well, I am going to give you the same question, once we give you a chance to make a commitment on that.

If both appeals reform and budget requests are adopted in this budget, would VA be able to begin accelerating decisions for those 470,000 appeals that are pending?

Secretary SHULKIN. The appeals that are in the Board of Appeals are the ones that we are most concerned about. If the Senate votes to move the appeals modernization forward, as I think you are saying, Mr. Chairman, we will have a process to expedite those from the time that the law passes moving forward.

You are asking about the legacy claims——

Chairman ISAKSON. Right.

Secretary SHULKIN [continuing]. And appeals. We do not have a plan to make significant progress on those. We are going to have to whittle away at them. The budget this year will add 142 more staff to the board. That will allow us to make incremental progress, but I think to deal with the backlog, we would be looking at 2026 before we dealt with the backlog.

The one hope that I have, Mr. Chairman, rather than adding a large number of staff to deal with the backlog, is that we will give current veterans who are in the appeals process the option of opting into the new process, and if they choose to opt in—but it is going to have to be their choice—they would be able to have their appeal dealt with in the expedited fashion, in the faster fashion.

It is my hope to be able to accelerate the backlog, to encourage veterans, who unfortunately right now would have to wait years to get decisions, to opt into the new process.

Chairman ISAKSON. Well, first of all, let me commend you because you just gave a patently honest answer to my question, not that I had expected anything else.

Secretary SHULKIN. Mm-hmm.

Chairman ISAKSON. But it is easy for a department head sometimes to talk department-ese——

Secretary SHULKIN. Mm-hmm.

Chairman ISAKSON [continuing]. Where we think we heard one thing and we heard something else, but what I heard you say, in effect, as far as those legacy appeals are concerned, this really is

not going to do much, even if it is adopted, to take those legacy claims and move them forward.

Secretary SHULKIN. Yes.

Chairman ISAKSON. Which means we will still have 470,000 veterans claims out there that are old. One of them is 25 years old. I know that.

Secretary SHULKIN. At least. At least.

Chairman ISAKSON. That is the oldest legacy claim.

Secretary SHULKIN. Yes.

Chairman ISAKSON. Eventually, he will die, and we will get that one solved, but we have got 469,999 more we have got to.

I hate to—I am going to quote now what I have heard secondhand, and I will say up front this is secondhand. I have been told that the VA recently told the Congressional Budget Office that VA's plan is to, "very gradually," address the 470,000 legacy appeals if appeals reform is passed. Is that the plan, and how long would that take? I heard your answer being yes, it is probably going to be very gradual, and yes, it would be 2026 before we got to it?

Secretary SHULKIN. Yes, yes. Mr. Chairman, let me just add that we share that frustration. I find it really difficult to tell people who have submitted into the appeals process that they have 6 years to wait on average to get a response.

So, I have asked the question: how much more would it take to get that backlog address?

Chairman ISAKSON. And the answer is?

Secretary SHULKIN. I am not sure you want to know because I was astounded by how much it was.

Chairman ISAKSON. I want to know.

Secretary SHULKIN. Around $800 million.

Chairman ISAKSON. Senator Sanders, Senator Tester, Senator Heller, Senator Boozman, Senator Moran, everything we do as a Committee—Senator Manchin—will pale in comparison to the hell we are going to catch if it is going to cost $800 million to handle those claims before 2026. The appeals, we are going to clean up appeals prospectively in the future with what this budget proposes, but for the legacy appeals that sit out there, they are going to still be out there.

Secretary SHULKIN. Yes.

Chairman ISAKSON. The anger is going to get louder and the frustration deeper. So, we really need—you need to know the number—$800 million will do it—and we need to be prepared to try to find some way to do that because all that—all that is going to happen is there are a lot of people that are going to get worse, more and more anguish, less and less service, and it is going to cause us more and more problems with our new programs we try to bring in place.

Thank you for being candid about that. I want all of us to be aware as Members of this Committee what we are dealing with, and we have got to make the hard decisions. One of them is going to be to get those legacy claims done and not let them build up in the future because when you do put your new program in that is going to solve all the problems prospectively—it sure as hell better!—because if we fix the ones that are back there and then we

have another buildup, we are going to be madder than a wet hornet. Is that not right, Jon?

Senator TESTER. That is a fact.

Secretary SHULKIN. Mm-hmm.

Chairman ISAKSON. Now, very quickly—I took much time on that, but I thought that ought to be out on the table.

When a veteran, when an American citizen signs up in the United States military and commits themselves to a period of service, carries out that service, and it meets the qualification necessary for them to go for VA health care in their retirement or when they leave the service, then we are obligated as a nation to pay for those benefits. Is that not correct?

Secretary SHULKIN. That is correct.

Chairman ISAKSON. Does anybody up here at the dais disagree with that? [No response.]

This is not a trick, by the way. I am just trying to get everybody engaged.

We did Choice, and Senator Sanders and Senator McCain did a great job of leadership 36 months ago on that. We did Choice to address the appointment backlog, the wait time periods, and things of that nature. We did some good things, which brought about some problems, which we have illuminated and have begun to solve.

We are now in a situation—and you alluded to it in your remarks—where you need to find some money to finish out Choice in this current budget period by moving some money from one part of the VA budget to the other.

I just want to make sure I am right on this. You have seven accounts that fund health care benefits; is that correct?

Secretary SHULKIN. Community Care.

Chairman ISAKSON. Community Care, but there are seven accounts?

Secretary SHULKIN. Yeah, seven. Right.

Chairman ISAKSON. One of those is Choice. One of those is Community Care, care in the community. So, you have enough money; you are not asking for new money to be given to you by appropriators or by the Congress. You are asking to move existing appropriated money for health care benefits under one stovepipe in the VA to another stovepipe to achieve balance, but there is no new appropriation. Am I correct?

Secretary SHULKIN. That is correct. We have enough money to be able to make sure that all veterans will get the care that they need.

We need your help to figure out the best solution about how to get more money into the Choice account.

Chairman ISAKSON. I am raising this only as a good talking point for all of us on the Committee to have a discussion, which I am sure we will have on this, but I want to get that point also. We sometimes get bogged down in legi-speak, words like "mandatory" and "discretionary" and this acronym and that acronym, when it is all the same money in the case you are talking about. It is for veterans health care benefits. It is in your current appropriations. It is not any new money. We are not raising any expenditure to the taxpayer. We are just trying to meet our obligation to our veterans.

So, we need to find the way to do that on not just a stop-gap manner but permanently, and one of those ways might be to see to it that all the veterans benefits for health care are paid out of one account and is under the Secretary of the VA. Is that not correct?

Secretary SHULKIN. That would make sense to me, Mr. Chairman.

Chairman ISAKSON. Senator Tester.

Senator TESTER. Thank you, Mr. Chairman.

Once again, thank you for being here, Dr. Shulkin.

You talked about—and I want to just follow up on the Chairman's questions. You talked about in your opening statement Choice being down to $821 million and the fact that there was additional dollars in Community Care that you wanted to transfer over.

You had put out a rule or edict. I do not know what you want to call it. What is it called?

Secretary SHULKIN. A directive?

Senator TESTER. A directive. That is better. A few days ago that directive said you wanted to go to the original intent on Choice, which would dry up a lot of how the dollars were spent. Then, a day or two later, you rescinded that.

Thank you for the breakfast yesterday. We had a great breakfast, and we talked yesterday about potentially doing a fix legislatively.

I was told today that another directive was put out today that reinstated that rule to go back to the initial. Is that correct?

Secretary SHULKIN. Let me try to be accurate about what happened. We noticed that there was an imbalance in our two checking accounts.

Senator TESTER. Yes.

Secretary SHULKIN. On Friday, we sent out a directive saying——

Senator TESTER. Right.

Secretary SHULKIN [continuing]. Stop spending from this account.

Senator TESTER. Right.

Secretary SHULKIN. OK. Start spending from this account.

Senator TESTER. Correct.

Secretary SHULKIN. We were afraid after seeing that directive that we were going to confuse the field——

Senator TESTER. Bingo.

Secretary SHULKIN [continuing]. And so we rescinded that memo.

Senator TESTER. That is correct. Right.

Secretary SHULKIN. The field, once we rescinded the memo, said, "OK. We get it. You are rescinding the memo, but will you give us some direction about how we should spend out of both of these accounts? because we still do have money in the Choice account. We have more money in Community Care."

So, we sent out four principles about the appropriate use of Choice and the appropriate use of Community Care funds, while we are working with you to figure out the best solution about how to get the appropriate money in each of those checking accounts.

Senator TESTER. Did those four principles—I do not have a problem here.

Secretary SHULKIN. Yeah.

Senator TESTER. All I want is predictability because I think it is important.

Did those four principles tell the folks to go back to the original use of Choice?

Secretary SHULKIN. It told them—it told them to use Choice for the appropriate use of Choice, which is clearly as you legislated, which is 40 miles, 30 days, and to use Community Care for the original use that they were using it for.

Senator TESTER. OK. With all due respect, the directive was put back in place, and by the way, I do not have a problem with the first directive. I do not have a problem with staying the way it was. It has got to be driving your folks on the ground and it is going to be driving our veterans crazy if it is yes, no, yes. Then, in a week, when we fix this, it will be no again, so that is all I ask.

That uncertainty, by the way—and I will not speak for everybody on this Committee, but I have a notion that it will be this way for everybody on the Committee—does not add confidence to the VA moving forward. I will just tell you. Do you get my drift?

Secretary SHULKIN. Absolutely. Let me just say and——

Senator TESTER. Yes.

Secretary SHULKIN. Listen, I would not disagree or argue with you.

Senator TESTER. Yes.

Secretary SHULKIN. The Choice Program has been difficult to administer——

Senator TESTER. Yeah, yeah.

Secretary SHULKIN [continuing]. Difficult to understand——

Senator TESTER. Yep.

Secretary SHULKIN [continuing]. And very complex.

The first memo was rescinded——

Senator TESTER. Yeah.

Secretary SHULKIN [continuing]. And remains rescinded because what it said is "Do not go to Choice." We do not mean that. What we have tried to do is provide guidance to say, "You can use choice, and we want you to use Choice appropriately, but we have Community Care funds. We want you to use those."

We understand——

Senator TESTER. OK.

Secretary SHULKIN [continuing]. But it is different than the first memo.

Senator TESTER. OK. I would just say this, communication is a very good thing, we need to have communication. The breakfast we had yesterday was very, very important.

Secretary SHULKIN. Mm-hmm.

Senator TESTER. I think everybody who was at that breakfast will do it, and hopefully, we can have more of them. But, there was never an indication of this happening at the breakfast yesterday, or we could have talked about it some more. I do not want to micromanage the VA.

Secretary SHULKIN. Mm-hmm.

Senator TESTER. It is your baby. You would hang me out to dry if I tried to do that, and rightfully so. We just need predictability, that is all.

By the way—when I say we, I mean this Committee—but more importantly are the people sitting behind you who need that predictability.

Secretary SHULKIN. Mm-hmm. Absolutely.

Senator TESTER. Otherwise things are going to go upside-down pretty quick.

I have got a bunch more questions, but I will refer to the next person in line.

Secretary SHULKIN. OK.

Chairman ISAKSON. Senator Moran.

HON. JERRY MORAN, U.S. SENATOR FROM KANSAS

Senator MORAN. Chairman, thank you. I want to be in the position agreeing with Senator Tester and disagreeing with Senator Tester.

Senator TESTER. Uh-oh.

Senator MORAN. The memos are different, and there is a significant consequence to the difference.

Secretary SHULKIN. Yes.

Senator MORAN. When we visited about the first memo, the consequence of that would be that the third-party administrators would have no role to play, and the networks potentially could go away. Lie dormant?

Secretary SHULKIN. Exactly.

Senator MORAN. The second memo says Choice is alive and well——

Secretary SHULKIN. Absolutely.

Senator MORAN [continuing]. And it is to be used in these circumstances, which are the ones that were defined by the original Choice Act.

Secretary SHULKIN. Right.

Senator MORAN. I do not actually know what—why that is different than how it was being used. How is Choice being used different than 40 miles and 30 days?

Secretary SHULKIN. Because we were also putting everything that we could through Choice, especially services that were not being offered at the VA.

So, Senator Moran, you have it correct. That was exactly what we tried to do between the first and second memos. Senator Tester is pointing out that we have some work to do in getting our communications a little bit better.

Senator MORAN. That is the part I was going to agree with Senator Tester.

Secretary SHULKIN. Yes. I agree with him too.

Senator MORAN. Because on that point——

Secretary SHULKIN. Yes.

Senator MORAN [continuing]. I would make the case on behalf of Senator Tester that——

Secretary SHULKIN. Right.

Senator MORAN [continuing]. We had a hearing on Wednesday on Choice.

Secretary SHULKIN. Yes.

Senator MORAN. Your first memo goes out on Thursday or Friday.

Secretary SHULKIN. Friday.

Senator MORAN. This conversation never occurred with people who care a lot about Choice but care a lot about veterans.

Secretary SHULKIN. I will say everything that both of you have said is accurate, and I will tell you—and I hope that you——

Senator SANDERS. You are quite the politician, I must confess. [Laughter.]

Secretary SHULKIN. Yeah.

I will tell you that, look, my integrity is very important. On Wednesday, Senator, I did not know this information. I learned about it on Thursday.

Senator MORAN. I assumed that was the case.

Secretary SHULKIN. Yes. Thank you.

Senator MORAN. Let me then again try to highlight why keeping Choice in existence—and it is not just a matter of transferring. How we transfer the money or what pot of money it comes from is an important issue, and that revolves around whether or not Choice has a future today and again when we potentially reauthorize its existence into the future.

When I say that it matters, because if Choice is not being used, then our intermediaries are not being paid, the network that has been established under Choice goes away, and you have Community Care but no Choice and no network, no third-party intermediary. It is not just a matter of transferring money back and forth. It is a matter of making sure that Choice is viable so that the network stays in place. Does that make sense?

Secretary SHULKIN. Yes. We worked very hard to do that, and I agree with you. We want to keep that in place.

Senator MORAN. A part of this that I still am confused about, because your response in regard to Chairman Isakson was that we just need transfer authority. I certainly have been in these hearings enough to know that you have said that more than once, and I think that is something that we are interested in. It makes no sense to have unneeded barriers.

Secretary SHULKIN. Mm-hmm.

Senator MORAN. We also need to make certain that this issue of mandatory is handled in a way that, again, Choice is mandatory, and that money has to stay available so that the program stays viable.

Here is what I wonder, is that just—and, again, in response to the Chairman, I think you said, "We are not asking for any new money."

Secretary SHULKIN. Right.

Senator MORAN. My understanding is that you have about $2 billion in the Community Care account. Is that an accurate number?

Secretary SHULKIN. Unobligated, yes.

Senator MORAN. Unobligated. So, at some point in time—and I do not know how soon that is, maybe the VA does—that money becomes scarce. The fix can only last so long before both the Choice account and the Community Care account are insufficient to meet the community, the health care needs through Community Care. Is that true?

Secretary SHULKIN. We have enough money to get us through the end of the fiscal year in both—if we could balance the accounts cor-

rectly, we could make it through till the end of the year to get Community Care paid for in both Choice and internal Community Care.

Senator MORAN. So, the $2.9 billion in the fiscal year 2018 Budget Request is not needed until fiscal year 2018?

Secretary SHULKIN. I am going to defer to my CFO, but I would have said yes.

Mr. YOW. Yes, sir. That is a requirement that is for next year. Now, the one caveat is in the budget, we assumed we were going to carry over $626 million of this year's Choice money into next year. Our actual requirement for 2018 is $3.5 billion. We are going to consume that $626 million, we think now, before the end of this year, so we will have a hole next year of about $600 million.

Senator MORAN. That hole exists in mandatory dollars, not discretionary dollars?

Mr. YOW. Yes, sir.

Senator MORAN. Which then means this Committee has to act to authorize additional mandatory spending for whatever the account is then called.

Mr. YOW. Yes, sir.

Senator MORAN. Is that true?

Mr. YOW. Unless we were to find some other offset somewhere in our direct appropriated discretionary funds.

Senator MORAN. I guess my takeaway is, assuming that your budget numbers are right, Mr. Yow and Mr. Secretary, that there is no emergency is what you are telling us? That Choice will continue between now and the end of the fiscal year without any additional input of money as long as there can be a transfer of, I suppose, discretionary spending into the mandatory account.

Secretary SHULKIN. Yeah.

Senator MORAN. Is that true?

Secretary SHULKIN. The last part that you said is true, but if there is no action at all by Congress, then the Choice Program will dry up by mid-August.

Senator MORAN. You have no ability, in your view, to fix the transfer issue, the discretionary and the mandatory, two components, to combine those into an account without legislative authorization?

Secretary SHULKIN. That is correct.

Senator MORAN. So, the emergency is not more money.

Secretary SHULKIN. Right.

Senator MORAN. The emergency is changing the law to allow you to spend money that you have, although it certainly sounds like it creates a likelihood of fiscal shortfall, dollar shortfall in fiscal year 2018, even if we appropriate the $2.8 billion in the President's request.

Secretary SHULKIN. I think everything you said is correct, and as Mr. Yow said, we are not seeking, though, additional monies. If we needed to, we will identify the offset to the $600 million for 2018.

Senator MORAN. The Chairman has his finger on the——

Chairman ISAKSON. No.

Senator MORAN. I think I have had my fair shot. We may have another chance. Thank you.

Chairman ISAKSON. Well, that is very helpful, and I apologize, Senator Sanders. I am going to take 1 minute just to clarify a couple of points.

Dr. Shulkin, I am a veteran. I served in the military in Afghanistan. I served my years to necessarily make me eligible for VA health care. I am a veteran. I am in VA health care. If I go to the VA hospital for a medical need related to my service or to just regular health care, you are obligated as head of the VA to pay for it and deliver that health care to me the best possible way possible. Is that not right?

Secretary SHULKIN. Yes.

Chairman ISAKSON. So, it is mandatory that you do that. You do not have the discretion as director of the VA to not provide me with health care because you did not get enough money?

Secretary SHULKIN. Correct.

Chairman ISAKSON. You have the obligation to manage the money you have, and if you need more come to get more money appropriated. Is that not correct?

Secretary SHULKIN. Yes.

Chairman ISAKSON. That is why when we talk about mandatory and discretionary; I do not think it is a matter of discretion if a veteran's health care is at risk for not having enough money. We have got to find the money, and it is mandatory that we provide that money.

Secretary SHULKIN. I would agree.

Chairman ISAKSON. What you are talking about in transferability is after we decide to put X number of dollars in however many accounts that are in the VA, you want to be able to take money out of any of those accounts to pay for the benefit of that veteran without having to go to a secondary step within the VA to get money removed—moved by somebody else because something is named "mandatory" or named "discretionary."

Secretary SHULKIN. Correct.

Chairman ISAKSON. Is that correct?

Secretary SHULKIN. Yes.

Chairman ISAKSON. I just want to make sure I had that right. I am not sure I said it right, but——

Secretary SHULKIN. You said it perfectly.

Chairman ISAKSON. It is clear to me now. Clear as mud, anyway.

Secretary SHULKIN. OK.

Chairman ISAKSON. Senator Sanders.

HON. BERNIE SANDERS, U.S. SENATOR FROM VERMONT

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

Dr. Shulkin, great to see you.

On page 3 of your testimony, you point out, I think, what most veterans organizations and veterans know, by and large, the VA has a pretty good health care system. You quote a study published by the *Journal of the American Medical Association (JAMA)*, where researchers compared hospital-level quality care on 129 VA hospitals with over 4,000 non-VA hospitals, and you found that you have better outcomes in the VA on six of nine patient safety indicators, and the other three were about the same. That is pretty good.

I mean, that speaks pretty well for the system that you are running, despite all of the criticism we hear every day. True?

Secretary SHULKIN. Yes. Yes, sir.

Senator SANDERS. Let me ask you a question that has always fascinated me. Maybe you can give me an answer. I held a hearing a few years ago on the Health Committee talking about preventable deaths in American hospitals. According to—I am looking at an article right now in the *New England Journal of Medicine*, and they say that hospital medical errors are the third leading cause of death in the United States. 700 people every single day die in this country from hospital medical errors. How is the VA doing compared to non-VA hospitals on that issue?

Secretary SHULKIN. Well, as the article in *JAMA* suggested, the VA is actually performing better on patient safety—and patient safety is defined by medical errors—than, on average, the private sector. Of course, every hospital in America, including VA, are always looking for ways to get better, but the VA has systems in place that help it perform better than many of the private-sector hospitals.

Senator SANDERS. Well, congratulations for that. I know that the veterans appreciate that, which takes me to the point that Senator Tester made a moment ago, and that is what we hear every time there is a hearing with veterans, they like VA health care.

Secretary SHULKIN. Mm-hmm.

Senator SANDERS. What I do not want to see—and I think Senator Tester—many of us do not want to see the shifting of funds that go to traditional VA health care moved to the Choice Program. Regarding the Choice Program, we have had long discussions. We will continue to discuss that.

I am a little bit distressed that a significant amount of money in President Trump's budget is going to Choice, not quite so much going to traditional VA.

Another question. You mention on page 9 what is obvious. You say that VHA is the largest health care system in the U.S. in an industry where there is a national shortage of health care providers. We have a major doctors crisis, especially in certain areas: primary health care relief, maybe psychiatry/psychology.

Secretary SHULKIN. Those are the two biggest, yes.

Senator SANDERS. OK. A couple of years ago when I helped work on the major veterans bill, we put—we expanded a program for medical education. It was the Section 302 of the Health Professionals Educational System Program. What that does, essentially, Mr. Chairman, is—what it does is help. As you know, medical school is now outrageously expensive, which is a very serious problem.

I talk to young doctors who are $3–400,000 in debt. OK? They are probably not going to go to work at the VA. They are going to go work where the money is. I would like to see that program expanded. What it does is provides debt forgiveness. You want to work for the VA for X number of years; we will forgive the debt that you have incurred at medical school. Is that an idea that makes sense to you?

Secretary SHULKIN. Senator Sanders, both of the ideas that you said and that the Ranking Member talked about make a great deal

of sense to me. I do not want to see VA care diluted because we are getting more veterans treated in the community. I want to see more veterans treated in the community because they need the care and VA cannot provide it right now.

So, what we are proposing and hoping to work with you in this new Choice Program are the two things you have talked about. Right now, we are restricted to a 1 percent transfer from care in the community back into the VA or vice versa. We would like to see that aperture open so that we could actually take money that was in the budget for sending veterans out and reinvesting more of it into the VA. We think that is very important. It should be done at the local level when every local VISN makes its decision about what services the VA needs to strengthen in.

On the GME issue, graduate medical education, I could not agree with you more. The program that you were helpful in crafting was a great success.

Senator SANDERS. Is it working well?

Secretary SHULKIN. It is. It is. We need to do more of it. We are proposing exactly what you are saying, which is creating more GME spots. The country needs them. VA would pay for them, and in exchange, it would be like the military or public health service.

Senator SANDERS. Or the National Health Service Corps.

Secretary SHULKIN. Or the National Health Service Corps. Afterwards, they would give 5 years back to the VA.

Senator SANDERS. Right.

So, Mr. Chairman, this is an issue where I think we can go a long way in attracting excellent physicians and nurses, perhaps——

Secretary SHULKIN. Yeah.

Senator SANDERS [continuing]. Into the VA by doing a debt—expanding the debt forgiveness program, which I understand is already working well. I would look forward to working with you on that.

Last question is—I am quoting from a publication called *Families USA*: "Cutting Medicaid would hurt veterans. Efforts in Congress to cut Medicaid jeopardize a critical source of health coverage for veterans. Approximately 1.75 million veterans, nearly 1 in 10, have Medicaid as a source of coverage."

If the Republican health care plan goes through—and I am going to do everything I can to see that it does not, but if it does go through and Medicaid is cut by over $800 billion in a 10-year period, I assume that means that a lot more veterans are going to be flocking into the VA. Am I correct on that?

Secretary SHULKIN. I would think so. We are a safety-net organization, and we tend to have veterans without other health access come to the VA. I do not want to sound like a politician, but, you know, as the Chairman said, our role is to provide that care. We would need to do that.

Senator SANDERS. So, if veterans lost their Medicaid, there is a reasonable possibility, many of them would turn to the VA for care.

Secretary SHULKIN. I believe so.

Senator SANDERS. And you need additional health to accommodate that large number of veterans?

Secretary SHULKIN. Yes.

Senator SANDERS. Thank you very much.

Chairman ISAKSON. Thank you, Senator Sanders.

Senator Rounds.

HON. MIKE ROUNDS, U.S. SENATOR FROM SOUTH DAKOTA

Senator ROUNDS. Thank you, Mr. Chairman.

Mr. Secretary, last week, we had a rather—I guess I would call it a spirited discussion about the Emergency Care Fairness Act, and under the VA's Fiscal Year 2018 budget proposal, a budget line to pay for emergency care is still lacking. However, the VSOs' *Independent Budget* has included a recommendation of $1 billion for 2018.

I guess my question, sir, would be, what is the status of the *Staab* appeal, which is the appeal on the Emergency Care Fairness Act, the way that it is being interpreted, and at what point will the VA formally request the necessary funds to pay for the emergency care for our veterans?

Secretary SHULKIN. Well, first of all, Senator, I appreciated the interchange that you and I had. I think that you were making excellent points, and you were actually on the right side of this issue.

We have done two things since we talked last. First, we have completed all of the regulations to be able to move forward with payment of the *Staab* claims, and we have now transmitted them to the Office of Management and Budget. That part is complete, so that is moving forward.

Senator ROUNDS. That is good news.

Secretary SHULKIN. The second thing is that after considering what you said and also I think Senator Blumenthal, I have decided to voluntarily withdraw the appeal to the *Staab* case.

Senator ROUNDS. Oh, that is great news, Mr. Secretary. I think what that means is the last time we checked, there were 370,000 claims outstanding that now can expect to receive payment for the emergency room care that they have expected since 2010?

Secretary SHULKIN. Well, we still have to go through the rulemaking process. That is why we transmitted those rules to OMB, and they need to go through the process. I do not want to set time expectations, but yes, we are moving in that direction to adhere to the judge's ruling on this.

Senator ROUNDS. That is a very positive development. For those 370,000 individuals, this is great news. Any possibility of expediting that rulemaking process?

Secretary SHULKIN. We did. We got the rules over there very fast, and what happens now, we will certainly encourage the administration and be supportive of that.

Senator ROUNDS. I cannot tell you how glad I am to hear that. I appreciate the fact that you have taken the time to get personally involved in this and to work through that issue. I think that is what veterans want to see coming from the VA, to be focused on what the veterans need, what the veterans care should be, and then when we make a promise, we honor that promise. I think that is what veterans are expecting from the VA, and I think this is a major first step in that. Thank you very, very much for your work on it, your attention to this, which I think will pay dividends for the entire organization for years to come, so thank you.

Mr. Chairman, I would yield back time.
Thank you, sir.
Secretary SHULKIN. Thank you.
Senator ROUNDS. That is great news.
Secretary SHULKIN. Good.
Senator BOOZMAN [presiding]. Thank you, Senator.
Senator Manchin.

HON. JOE MANCHIN III, U.S. SENATOR FROM WEST VIRGINIA

Senator MANCHIN. Thank you, Mr. Chairman.

Secretary Shulkin, recently, you announced that you would be scrapping the current electronic health care record system (EMR) and adopting the same system that DOD uses from the Cerner Corporation based in St. Louis. While I am certainly in favor of making it easier on veterans transitioning from DOD to VA, my concern is that speed of this decision will have second- and third-order effects that could be detrimental. My questions to you are: are you concerned that there will be increased risk in having one company manage all these records? What if Cerner becomes the Health Net of electronic health records?

Secretary SHULKIN. Wow. Well, first of all, I think in making a decision of this magnitude, there are absolutely risks involved with it. I have to tell you, I thought the risks were greater to do nothing.

Senator MANCHIN. OK.

Secretary SHULKIN. That considering the maintenance required on VistA, the expense that will be required, and our lack of ability to maintain qualified software developers within VA, the risk of doing nothing was worse.

I think that DOD went through a strong due diligence process. I think that they selected a stable platform. We have benefited a lot from their due diligence and expertise, and that was one of the reasons why I went in that direction. There is always a risk, Senator, especially when you transfer systems, so——

Senator MANCHIN. Here is another part.

Secretary SHULKIN. Yeah.

Senator MANCHIN. I have got two more parts to this.

Secretary SHULKIN. Yeah.

Senator MANCHIN. By waiving the bidding process, which you just spoke about, how are you guaranteeing Cerner is not taking the VA for what we would consider a little bit of a ride?

Secretary SHULKIN. Well, because all that I have done is start the process of negotiations. We have not committed to any funding. We have not committed to the contractual——

Senator MANCHIN. How will you know if the price is competitive if you have nothing to compare it to?

Secretary SHULKIN. Well, we certainly know the price that DOD paid. We know the price that we are currently paying to maintain our systems, and we are going to be seeking the best way to do this for taxpayers.

Now, most of the cost of a transfer of system is actually in internal change management, not in software licensing prices.

Senator MANCHIN. I notice it is not in your budget right now.

Secretary SHULKIN. Right.

Senator MANCHIN. I was going to ask, how are you going to absorb the cost?

Secretary SHULKIN. We are going to have to go to the appropriators and lay out a plan so that they could decide whether they believe this is also a good decision.

Senator MANCHIN. Well, we know this hearing is about care in the community. While ensuring the records transfer between DOD and VA, it is important we must also ensure that records transfer and their operability between VA and non-VA providers is just as seamless. Will Cerner be undertaking that as well?

Secretary SHULKIN. Yes. What I said in the decision on the EMR is that while it is a decision to move forward with a common platform with DOD, this will not be the DOD system. VA's needs are much different in that we have to be interoperable with our community partners, and many, many—in fact, 80 percent of our community partners are not necessarily on the Cerner platform. So, we are going to have to create a system that does several things that the DOD does not. We are not going to be scrapping VistA. We are going to have to connect into and maintain our 30-year database, and we are going to have to be interoperable with community partners.

Senator MANCHIN. Very quickly, I have one more, and then I have a real quick question. There is no Assistant Secretary of IT, nor is there an Under Secretary for Health. So, how are you undertaking this without those positions filled?

Secretary SHULKIN. Well, fortunately, we have very competent acting people in those roles, but we look forward to getting those roles permanent.

Senator MANCHIN. You feel like you have the personnel to do it?

Secretary SHULKIN. I feel like we are very lucky to have very competent acting people, but I need to have permanent people in those roles soon.

Senator MANCHIN. My other question is concerning the opioid epidemic, which is the number 1 problem I have in my State——

Secretary SHULKIN. Yes.

Senator MANCHIN [continuing]. Not just with the general population, but my veterans——

Secretary SHULKIN. Yeah.

Senator MANCHIN [continuing]. With my veteran community. What I am concerned about, what the new non-VA care redesign looks like, I am looking for assurances that when we do new provider agreements on any contracts with non-VA care providers, we are going to be making sure that they understand that VA will not tolerate the over-prescription of opioids. More or less, we have a lot of pill mills; they get these people hooked, and they keep them hooked. How are you going to ensure or how—what is your oversight? Are you prepared for this?

Secretary SHULKIN. Well, I have to say I do not think we are doing a good enough job in this. I think the country needs to do a lot better.

Senator MANCHIN. We have challenges within the VA ourself.

Secretary SHULKIN. Yes.

Senator MANCHIN. We know that, and you all have been addressing that——

Secretary SHULKIN. Right, right.

Senator MANCHIN [continuing]. And I appreciate it. A lot more needs to be done. You have very little control when you go out into the private sector.

Secretary SHULKIN. I think we have really made good progress in the VA on the oversight. We have seen the 33 percent reduction in opioid use since 2010. We monitor patterns of prescribing. I have the concern about going out into the community that you have.

Senator MANCHIN. What I am saying is the contracts that you write, if I am a provider——

Secretary SHULKIN. Yeah.

Senator MANCHIN [continuing]. If I am a non-VA provider, where the new act lets that person come to me, I contract with the VA to take care of these people.

Secretary SHULKIN. Mm-hmm.

Senator MANCHIN. Are there conditions on that if I prescribe? Do I have to follow prescription guidelines? Are you going to be monitoring that as far as opioid prescription guidelines?

Secretary SHULKIN. Today, there are not those requirements. I think this is a really good area for us to come back to you with some thoughts on.

Senator MANCHIN. Sir, we need your help on this——

Secretary SHULKIN. I know. Yep.

Senator MANCHIN [continuing]. Because you are on the front lines.

Secretary SHULKIN. Thank you.

Senator MANCHIN. Thank you.

Thank you, Mr. Chairman.

Chairman ISAKSON [presiding]. Thank you, Senator Manchin.

Senator Heller.

HON. DEAN HELLER, U.S. SENATOR FROM NEVADA

Senator HELLER. Mr. Chairman, thank you.

Mr. Secretary, thanks for being here.

Secretary SHULKIN. Thank you. Sure.

Senator HELLER. Glad to have you here.

I want to talk about the budget for just a minute, if I may; specifically, I want to talk about the individual unemployability (IU) cuts.

Secretary SHULKIN. Yeah.

Senator HELLER. Can you explain the rationale of the thought process that reduced this?

Secretary SHULKIN. Yes, Senator Heller, my starting point on this is that we always have to do better for our veterans, and we have to deliver on our commitments that we have to our veterans. The President's budget includes significant increases in both discretionary and mandatory funds and makes Choice a permanent part of funding.

But, we have a responsibility to use our current funds in a way that makes the best sense for veterans and for taxpayers. So, we proposed a part of the process that would revise the individual unemployability benefit.

The budget is a process, and this was part of a menu of opportunities that we had for thinking how we could make the budget

process better. As I began to listen to veterans and their concerns—VSOs in particular—it became clearer that this would be hurting some veterans and that this would be a takeaway from veterans who cannot afford to have those benefits taken away. I am really concerned about that.

So, what I would like to say is that this is part of a process. We have to be looking at ways to do things better, but I am not going to support policies that hurt veterans. I would look forward to working you and all the Members of the Committee on figuring out how we can do this better. We have budget numbers and targets that we have to hit, but we should not be doing things that are going to be hurting veterans that cannot afford to lose these benefits.

Senator HELLER. I appreciate hearing that. Do you know how many veterans would have been affected by this change?

Secretary SHULKIN. Yes. We have 300,000, Jamie?

Mr. MANKER. Yes. There are 300,000 that are in receipt of IU, about 330,000. About 210,000 of those are over the age of 60 and, therefore, would have been affected.

Senator HELLER. Would have been.

Secretary SHULKIN. Yeah.

Mr. MANKER. Correct.

Senator HELLER. It would not have been—it would have been retroactive?

Mr. MANKER. It would have been point forward, but to include all veterans in receipt of IU. So, when you say retroactive, I do not believe we would pull any benefits that we have distributed back. However——

Senator HELLER. Right. No, no. I am just saying that if you had the benefit, you could lose the benefits——

Secretary SHULKIN. Yes. Yes.

Mr. MANKER. Yes, sir. That is correct.

Senator HELLER [continuing]. Even if you are currently receiving it?

Mr. MANKER. That is correct.

Secretary SHULKIN. Yes. That was the proposal, and—but we do look forward to working with you to figure out how we could do this better.

Senator HELLER. I appreciate your concern for that.

Do you know what the average is per veteran on this IU, what the average intake is?

Mr. MANKER. The average payment?

Senator HELLER. Yeah.

Mr. MANKER. It is roughly $1,600.

Senator HELLER. Roughly $1,600.

Mr. MANKER. Yes, sir. That is on top of—you have to be rated between 60 percent to 100 percent, and it takes you to a temporary 100 percent. Sixteen percent is—or beg your pardon—60 percent is roughly $1,600.

Senator HELLER. All right.

Mr. MANKER. It is about 13 or more.

Senator HELLER. You can understand the financial burden that $1,600 may pose for an individual, and what I am more concerned about is, of course, their long-term retirement. They may have not

prepared or been prepared if in believing that that $1,600 might be there is I think the concern.

Secretary SHULKIN. I think that is the issue, and this is why we had identified this as an opportunity. I think if we were designing this system from the beginning, we would not have used unemployment insurance to fund people's retirement. I think that was the conflict.

The end result is that is the benefit, and to withdraw this benefit from people who rely on that money is something that would be very difficult to do.

Senator HELLER. Well, I appreciate your concern for this.

Can I change topics for just minute——

Secretary SHULKIN. Mm-hmm.

Senator HELLER [continuing]. And make sure I understood this correctly? Did you say that you had a decision-ready claim in 3 days?

Secretary SHULKIN. We have had 12 of them so far, I think. Yes.

Senator HELLER. Twelve of them.

Secretary SHULKIN. Yes. So, on September 1 we are going to be rolling that out across the country.

Senator HELLER. I mean, that is big news.

Secretary SHULKIN. That is big news.

Senator HELLER. I am glad because I have been working with this issue for years; and to think that you could actually turn one around in 3 days is pretty incredible.

Mr. MANKER. That is a big deal. We are piloting in St. Paul right now, again, with a couple of our VSOs. If the VSO brings in the claim ready to be decided, we know——

Senator HELLER. Right. It has got to be ready. I get it.

Mr. MANKER. No further development and we decide the claim.

Senator HELLER. We had a previous Secretary who said that he could get the claims down to zero by—I think it was 2015. What is the status now? If this works as well as——

Secretary SHULKIN. I can tell you I will not say that. [Laughter.]

No. I mean, so——

Senator HELLER. No predictions. No predictions——

Secretary SHULKIN. Yeah.

Senator HELLER [continuing]. On where the claims will be.

Secretary SHULKIN. No. We right now—we are at about 90,000?

Mr. MANKER. As of this morning, it was 94,000 that we had.

Senator HELLER. Yeah. That is about what my notes say, too.

Secretary SHULKIN. Yeah.

Senator HELLER. There are about 1,200 of them in Nevada.

Secretary SHULKIN. Yeah, yeah. I think our goal, Jamie, is by the end of the calendar year to about 70,000?

Mr. MANKER. That is right. That is right.

Secretary SHULKIN. These decision-ready claims, we think will take 10 to 15 percent of them off. So, we will not start rolling them out till September, but that will begin to whittle that down. We hope in 2 years to be down below around half of where we are now.

Senator HELLER. OK, OK.

Mr. Secretary, thank you, and, Mr. Chairman, thank you for the time.

Chairman ISAKSON. Thank you, Senator Heller.

Senator Murray.

HON. PATTY MURRAY, U.S. SENATOR FROM WASHINGTON

Senator MURRAY. Thank you, Mr. Chairman, and thank you all for being here.

Secretary Shulkin, in last year's budget request, the VA estimated that it would need $725 million in fiscal year 2017 and $840 million in 2018 for the Veteran Caregiver Program, yet in the first budget of the Trump administration, you plan to only use $521 million in 2017 and $604 million in 2018. Those are cuts of about 30 percent. Meanwhile, I am hearing from so many of my constituents, as I am sure everybody is, of caregivers being dropped from the program with no explanation and no justification. An investigation by NPR found the Charleston Medical Center actually dropped 94 percent of its caregivers; 83 percent in Prescott, AZ; and 83 percent in Augusta, GA.

It seems to me, watching this, that this is just another way the Administration is balancing its budget on the backs of veterans in need. How do you explain those numbers?

Secretary SHULKIN. Well, let us just talk about the three things quickly that you said. What was reported on in Charleston is completely unacceptable; 95 percent of revocation of caregiver benefits, unacceptable. That is why we suspended the program, and today, there are no revocations across the country going on until we get the guidelines better understood and in better shape.

Senator MURRAY. That is the freeze that you are talking about?

Secretary SHULKIN. That is the—right, right. That is the freeze.

Senator MURRAY. That is only a temporary measure——

Secretary SHULKIN. It is a temporary measure——

Senator MURRAY [continuing]. And I think you did the right thing.

Secretary SHULKIN [continuing]. Until we revise policy, because I will not accept giving benefits and then taking 94 percent of them away. That is ridiculous.

The second thing is, is that on the right amount of money to request? We only spent—even though $750 million was in the budget, we only spent $521 million. So, in budget planning for next year, they requested $600 million, which is a modest increase from where we are.

Our hope, as you know—and you have been a tireless advocate for this—is to expand caregiver benefits, and we do plan on working with you with that. We hope by expanding caregiver benefits, particularly to older veterans, who today are not getting the benefit the way that they should, that we actually find that that is going to be cost effective, because remember we pay for long-term care.

Senator MURRAY. Right.

Secretary SHULKIN. My plan is to be responsible to taxpayers. I am going to seek to expand caregiver benefits to older veterans, but I am going to pay for it myself without asking the taxpayers to increase the bill.

Senator MURRAY. OK. Well, the Ranking Member and I wrote to you a couple months ago suggesting a series of important reforms. Those issues have not been addressed, and I would just like to see

the freeze extended until all of those issues in that letter were discussed. Can you do that?

Secretary SHULKIN. Yeah. Do you happen to have the date of the letter? If not, I will find it.

Senator MURRAY. It was about 2 months ago.

Secretary SHULKIN. Two months ago. Of course, absolutely.

Senator MURRAY. OK. Let me go to the shortfall in the Choice Program. I know that you wrote to TriWest and Health Net telling them to return referrals for care, including for veterans that are currently waiting for care. How many veterans are going to be affected by that?

Secretary SHULKIN. We ask—when they cannot appoint an appointment within a period of time in the contract, we ask them to return it. They are returning large numbers to us.

Do you know, Mark?

Mr. YOW. I do not. I am sorry.

Secretary SHULKIN. This is an ongoing process. Before, they would just wait until—it took weeks and weeks to give an appointment. We have said, "If you cannot give an appointment within 5 business days for a routine appointment, return them to the VA so we can take care of the veteran." It is a big percent that we get back.

Senator MURRAY. It is a big percent?

Secretary SHULKIN. Yeah.

Senator MURRAY. Do you know how long care is going to be delayed for veterans as a result of that?

Secretary SHULKIN. Well, this is actually speeding up care. Rather than letting a veteran stay out there in the Choice Program, schedulers return them to the VA, and then the VA Community Care Program goes out and tries to find an appointment.

Senator MURRAY. OK. Well, I am very concerned about where the money is going to come from, from this——

Secretary SHULKIN. Yeah.

Senator MURRAY [continuing]. And how you are going to get the money to continue non-VA care. It seems to be two different stories here. Transfer authority is what I am hearing from this year? Correct? Well, if you transfer money from this year, then what you are doing is impacting what you thought——

Secretary SHULKIN. Yes.

Senator MURRAY [continuing]. Was going to be a carryover for next year. So, will you not need additional money for next year?

Secretary SHULKIN. Yeah. Look, the problem of having these two separate checking accounts and predicting where you need the money is, frankly, impossible. That is why we want to work to get the program into a single Community Care account.

We are going to—these guys are going to help make the best predictions possible. Mr. Yow is going to help us understand the right amount of money to transfer over to predict it, but——

Senator MURRAY. But, it will impact 2018, so we need real numbers here. We cannot do our job if we do not know what the costs are.

You know, I am already hearing from veterans in my State about the delays and burdens they are seeing as a result of this. I had veterans in Walla Walla who are being told they will have to drive

8 hours round-trip to Portland or Seattle just for some simple imaging tests as a result of this. I am hearing a lot more. We are happy to get those to you, but this is having an impact. I want you to know that and we want to know where this money is coming from. So, we will follow up with you on that, but I think this Committee needs to be aware of that.

Secretary SHULKIN. OK.

Senator MURRAY. OK. I am running out of time—or I am way over time. I have other questions, Mr. Chairman, which I will submit for the record. But, I am deeply concerned about that.

Secretary SHULKIN. Yes.

Chairman ISAKSON. Listening to all these questions about checking accounts and authorities reminds me of the question I was asked yesterday on my 49th wedding anniversary. Somebody asked my wife and I to what we would attribute 49 years together. I said we never had a joint checking account where both of us had to sign, so we never had those arguments. Let us not ever get in that situation with the VA either.

Secretary SHULKIN. OK.

Chairman ISAKSON. Senator Boozman.

HON. JOHN BOOZMAN, U.S. SENATOR FROM ARKANSAS

Senator BOOZMAN. Thank you, Senator Isakson and Senator Tester.

Thank you for being here, and we appreciate our veterans' advocates who are going to testify shortly for being here also.

Senator Sanders talked to you about the problem with the fact of providers, and so many people are at the age now where a big group of baby boomers that are aging out, they practice because they like, and medicine has gotten more complicated and stuff. I think we are going to see a bunch of those actually decide to do something else or not do anything.

The idea of increasing—well, first of all, I agree that the fact that we can reward people for going in is a great idea, and I think it actually would work. I think we have good evidence of that.

The problem is actually creating new slots versus taking slots away for veterans. If you could work with some of your counterparts—and the VA is a huge entity.

Secretary SHULKIN. Mm-hmm.

Senator BOOZMAN. This is a huge problem for the country, besides the VA, but if you could craft a situation where you could actually increase the medical school classes and then also the residencies, which are a huge problem too, that would be a great deal.

Secretary SHULKIN. Yes.

Senator BOOZMAN [continuing]. With your relationship with the teaching hospitals——

Secretary SHULKIN. Right.

Senator BOOZMAN [continuing]. I think that could be done. It is going to take some work, but that truly could be a great legacy.

Secretary SHULKIN. Right. We are focused on the residency spots. The medical schools have actually increased the number of medical school spots because they have tuition that pays for it, so it is to their benefit.

The residency spots, as you know, are capped by Medicare.

Senator BOOZMAN. Right.

Secretary SHULKIN. What you did in the Choice Program that Senator Sanders help lead was expand those graduate medical education spots. That is what we need desperately.

Senator BOOZMAN. Yeah, very much so.

Secretary SHULKIN. Yeah.

Senator BOOZMAN. And, again, we need to do that——

Secretary SHULKIN. Yes.

Senator BOOZMAN [continuing]. With whatever it takes in the future or we are going to get ourselves in trouble.

$8.4 billion in mental health, 6 percent increase. That is great. Mental health has improved so much in the VA in the last years. We are not at the point where we are just writing prescriptions like so many providers, not just in the VA, but throughout the country giving a prescription. That simply does not work.

On the other hand, we need to go farther. How are we going to prioritize that 6 percent as far as increasing our ability to provide good care?

Secretary SHULKIN. Well, we have targeted to hire a thousand mental health professionals. This year to date we are seeing 58,000 more mental health appointments than we did last year at this time.

We are expanding our tele-mental health programs. We have just, as you know, this past year given full practice authority to our advanced practice nurses. Many of them will be putting their skills to work in behavioral health and expanding the training. As Senator Sanders said, psychiatry and psychology and nursing, all are areas of shortages that we can use more help in, not only in the VA, but the entire country, quite frankly.

We need to do a lot more. I think you are right. We have prioritized mental health, but it is an area that needs a lot more help.

Senator BOOZMAN. You talked about the core mission of the VA, the foundational services that make the VA unique. Can you walk us through those or what you feel those are?

Secretary SHULKIN. Yes. These are the services that make me so strongly believe that a strong VA is essential for veterans and for the country, because I believe that without the types of services that the VA provides, you cannot find those in the private sector. If we just turned our veterans over to the private sector, they would really be lost.

These are services that veterans have a high predilection for: post-traumatic stress, behavioral health issues, spinal cord injury, prostheses or orthotics, polytrauma. Comprehensive primary care and behavioral health care services are clearly foundational as well. Environmental exposures, blind rehab—I do not want to leave out a group because I know I will offend them, but these are things that the VA does extraordinarily well that you would not find easily, except in very specialized geographies where there are centers of excellence. So, it is important that we keep those strong.

Senator BOOZMAN. In your testimony also, you talked about Community Care and how doctors will make decisions on providing care in VA facilities versus in the community due to clinical need and

what is best for the veteran. How do we—how do you do this? How do you make sure that with—we have an institution, somewhat of—well, we have a bureaucracy. How do you make sure that those decisions are based on what is best for the veterans as opposed to what is best for the facility?

Secretary SHULKIN. Well, I think—I wish that there was an easy answer to that.

What we have to do as an organization is get out of the way of the doctor and the provider making those decisions together, so we need to get rid of the administrative rules and the third parties in between. That is what we saw in the Choice Program. We were having veterans call Call Centers of people who did not know them, and that was frustrating the veteran. What we have learned is to de-layer the process, get it back into the exam room or now, in more modern terms, you know, the tele-monitors. Let the doctor, the patient, the provider of the patient make the decisions together in a partnership about what is best for them. That is the system we are trying to design now.

Senator BOOZMAN. Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Boozman.

Senator Tillis.

HON. THOM TILLIS, U.S. SENATOR FROM NORTH CAROLINA

Senator TILLIS. Thank you, Mr. Chair. Mr. Chair, I am going to be married 30 years, 2 weeks from today. We have a slightly different approach to longevity. We do have a joint account; I just do not have access to it. [Laughter.]

Chairman ISAKSON. That works also.

Senator TILLIS. I am not even allowed to go out of network to get an ATM withdrawal.

Thank you all for being here. I am actually running between committees. We have an Acting Committee going on right now, and we are talking about supporting caregivers, the Hidden Heroes Project that Senator Dole is heading up, and it is critically important. I will not spend time talking about it here, but one thing that was striking in Senator Dole's opening testimony was the fact that there is about $14 billion a year in caregiving being donated by these husbands and wives and sons and daughters that we need to find a way to provide support over time.

I understand that in order for us to do that, we have to talk about the resources and make sure that we are not shifting our attention away from so many other pressing things, but it is something I look forward to talking about in a future hearing.

Dr. Shulkin, I want to know how we are doing. Some of the estimating, I have got to believe some of the uncertainty with respect to accounts, and how much we need in one or the other—one thing——

Secretary SHULKIN. Yeah.

Senator TILLIS [continuing]. It is a fluid situation based on factors that are different across the country. Another one may have to do with having the right resources in place so that you can actually get to that information pretty quickly. How are we doing on getting your—I understand the CIO nominee, I think, has withdrawn their name from consideration. How are we doing on trying

to get that administration stacked up so that you have got a good organization, permanent organization under you?

Secretary SHULKIN. Well, not only the CIO, but the CFO candidate. If we are attracting a good viewing audience, we need help. We need people to want to come and help serve.

Senator TILLIS. A permanent CFO is going to be pretty important to get in some of your financial——

Secretary SHULKIN. It really will.

Senator TILLIS [continuing]. Financial planning in order and getting your financial processes and planning processes in order, so——

Secretary SHULKIN. Yes.

Senator TILLIS. I think you have touched on something important. Hopefully, somebody can step forward.

Secretary SHULKIN. Yes.

Senator TILLIS. I know it is a sacrifice and you need somebody that is highly skilled, but we have got to get those positions filled. I, for one, think it will be one of the ways we can get back on track for the transformation effort.

I am not going to spend much more time because I am going to get back to the other Committee, but I am going to echo again what I said in the last Committee. I am sure that there are various factors that led to the shortfall in one account versus another.

Secretary SHULKIN. Yes.

Senator TILLIS. There are probably other things that we need to do to make sure that we are facilitating the process and not giving you additional distractions or uncertainty as you go through the financial planning. Please speak candidly to the Committee Members——

Secretary SHULKIN. Thank you.

Senator TILLIS [continuing]. And make sure when there are things that we can do or should not do that are getting in the way of you giving us definitive answers, so we can count on it also.

Secretary SHULKIN. Yeah.

Senator TILLIS. I also want to reiterate what—Senator Murray made several very good points. I agree with all of them. I think that she is absolutely right. The sooner you articulate what your funding levels are, the better, so that we can go and be advocates for it.

Secretary SHULKIN. Yeah. Thank you.

Senator TILLIS. Thank you, Mr. Chair.

Chairman ISAKSON. Thank you, Senator Tillis.

Senator Boozman—Senator Blumenthal. I am sorry.

HON. RICHARD BLUMENTHAL,
U.S. SENATOR FROM CONNECTICUT

Senator BLUMENTHAL. Thank you, Chairman.

First of all, I want to express my appreciation on the *Richard Staab* v. *McDonald* case.

Secretary SHULKIN. Thank you.

Senator BLUMENTHAL. I join my colleague, Senator Rounds, in——

Secretary SHULKIN. Yes.

Senator BLUMENTHAL [continuing]. Expressing my appreciation for your decision to withdraw the appeal and also join with him in asking for a quick rulemaking, which I know you will do.

On the VA's Vocational Rehabilitation and Employment Program, as you know, it provides career counseling and rehabilitative services to veterans with service-connected disabilities to overcome employment barriers. It also assists with postsecondary training at educational institutions.

I have been told by Connecticut University that there are delays in vocational rehab housing and education payments for service-disabled veterans. The VA has previously attributed those delays to lack of vocational rehabilitation counselors at the Hartford Regional Benefit Office and nationwide staffing shortages. The VA's purported goal ratio of vocational rehab counselor to client is one counselor per 125 veterans, but the average ratio in July 2015, I am told was one counselor to every 139 veterans, despite the payment delays and the VA's inability to meet the ratio.

The fiscal year 2018 budget makes cuts to this program; Vocational Rehabilitation is $13.8 million. You are probably more familiar with these numbers than I am, so I apologize for telling you something you already know. This decrease in requested funding seems unacceptable, particularly for those of us in Connecticut who see the results already of underfunding. I would like to know whether you plan to address the delays and your view of the apparent underfunding of this very valuable program.

Secretary SHULKIN. Senator, first of all, thank you for your outspoken leadership on the *Staab* case.

On terms of Vocational Rehab and Education, we may have different numbers, so I would like to go over it with you. We see a $1.5 million increase in the President's budget for these programs, but there are some staffing issues and delays in the Hartford region that we do want to get improved and we do want to fix. We think this is an important program. We believe in it, and we believe the President's budget adequately funds it.

But if you have different numbers and we are wrong, we will want to address that.

Senator BLUMENTHAL. Well, I would like my staff perhaps——

Secretary SHULKIN. Yes.

Senator BLUMENTHAL [continuing]. To get together with you all, but I think the overriding issue here is not necessarily even the numbers, because even if there is a slight increase, this is——

Secretary SHULKIN. Small.

Senator BLUMENTHAL. This program is so valuable, it ought to be a major increase and certainly not a reduction.

Secretary SHULKIN. Right.

Senator BLUMENTHAL. Again, this is not a criticism of the VA. In fact, on the contrary, it is saying you are doing great work. We do not want to see it diminished. We see these delays in Hartford and we would like your help in solving them.

Secretary SHULKIN. Yes. OK. We will follow up with you.

Senator BLUMENTHAL. I thank you.

Secretary SHULKIN. Yes.

Senator BLUMENTHAL. I do not know whether it has been asked, but I wonder if I could ask you again about the Veterans Benefit

Administration, whether you see real progress in reducing the claims backlog. I am guessing someone has asked about it already, and I apologize for bringing it——

Secretary SHULKIN. No. No, that is not a problem.

Senator BLUMENTHAL. What is your prognosis?

Secretary SHULKIN. Well, I will briefly just tell you we are at 94,000 now. We hope by the end of the year to be at approximately 70,000, and then a year following that or 2 years from now below about half the level, so 45,000.

We just announced that we have done 12 claims so far in 3 days, called "decision-ready claims." We are going to roll that process out nationally September 1. That will impact around 10 to 15 percent of our claims because they have to have all the information ready, they are presented, and we give a decision in 3 days. So, I think that we are making some progress.

We are trying to actually look at some breakthrough ways to do better, but as of today, I have given you the most accurate information we have.

Senator BLUMENTHAL. The progress that you are making is the result of a different—reforms in the process——

Secretary SHULKIN. Yeah.

Senator BLUMENTHAL [continuing]. Or is it more resources or a combination?

Secretary SHULKIN. The budget—the budget stays flat for next year, so it is not in VBA. It is not necessarily more resources, although they have added in the past couple of years.

I would say the major changes are process improvements. There is something called the National Work Queue, which is really allowing productivity adjustments. Therefore, you can distribute the workload across the country evenly. They have just enhanced and increased their productivity standards for the people who work in VBA, and they are doing a terrific job. We have a great staff who work in VBA, who are up to the challenge, and we are seeing improvements. It is mostly process improvement, but over the past couple of years, they had added to their staff.

Senator BLUMENTHAL. Well, I want to thank you for your focus. As you know, this is a problem that has continued to——

Secretary SHULKIN. Mm-hmm.

Senator BLUMENTHAL [continuing]. Bedevil us over many years, so I am glad that you are making those process changes. And there may be some breakthrough——

Secretary SHULKIN. Yes.

Senator BLUMENTHAL [continuing]. Changes in the foreseeable future?

Secretary SHULKIN. Yes, yes.

Senator BLUMENTHAL. Thank you.

Secretary SHULKIN. Thank you.

Senator BLUMENTHAL. Thank you, Mr. Chair.

Chairman ISAKSON. Thank you, Mr. Blumenthal.

I have been asked by Senator Sanders and Senator Tester to be able to make brief statements, so I am going to waive any time I might have and recognize Senator Tester and then Senator Sanders for their statement and/or question.

Senator TESTER. Thank you, Mr. Chairman.

I have beaten this horse in the past. We have to beat it one more time. OK?

Secretary SHULKIN. Sure.

Senator TESTER. The VSOs we are going to hear from next want to have the VA as a primary care provider. I have heard it over and over again. Senator Sanders talked about it. Others have talked about it in this Committee.

I have been in public life long enough to know that if you want to know where things are headed, you follow the money.

Secretary SHULKIN. Mm-hmm.

Senator TESTER. The fact that we have 1.2 percent increase for in-house medical care and 33 percent for outside medical care is disturbing.

Moving forward, because you have said over and over again to me, "Do not worry about this, Jon. It is going to be fine. We are going to make the VA the best it can be, and the VA is going to fill in the gaps," we just need to drive that point home because we are going to hear from a panel of VSO representatives. I have got a notion that they are going to talk about VA care, and they are going to be reasonably complimentary and talk about other ways we can fix it.

Number 2, this is an authorization committee. Concerning electronical-IT funding, you have got $200 million in this budget. You should be asking this Committee to plus that budget up. You need to do it so it represents the money that you are going to be dumping out to Cerner for the DOD electronic platform that we all support you doing, by the way.

Secretary SHULKIN. Mm-hmm.

Senator TESTER. I think it is really important that we are honest with ourselves, and I will tell you why. I happen to be on both Committees, and I do not want to get nailed and say, "You know what? The Authorization Committee did not do that, and these spendthrift appropriators are just dumping money in." I would just say we need to have a budget that accurately reflects what we need to do. In this case, we know this IT thing is going to cost some dough.

Secretary SHULKIN. Mm-hmm.

Senator TESTER. So, we need to act accordingly.

The last thing is we are going to have Carl Blake from Paralyzed Veterans of American (PVA), LeRoy Acosta from Disabled American Veterans (DAV), Carlos Fuentes from Veterans of Foreign Wars (VFW), and John Rowen from Vietnam Veterans of America (VVA), up here in a second. I just want to thank those guys for their service. We had said earlier that we need to take our direction from the VSOs. I am not going to be able to be here, although I am going to try to get back before the end, and we do need to take the direction from the veterans. I think it is critically important, so thank you all.

Secretary SHULKIN. Senator Tester, thank you, and, you know, the one thing is we are always clear on where you stand and appreciate that.

I do want to try to work with you and your staff because we have different numbers than you have in terms of the Community Care

and internal care. You know, we have an interest in making sure the VA is the best system.

The ability to transfer more—right now, we are limited at 1 percent—would help us a great deal, and that is something we will continue to work with you on.

Senator TESTER. I would just say, we are going to work with you on that, too. Johnny and I both agreed to that.

I think that, as I said to you at the breakfast yesterday, you can outsource care, but you cannot outsource responsibility.

Secretary SHULKIN. No, that is right.

Chairman ISAKSON. Senator Sanders.

Senator SANDERS. Thanks very much.

I want to touch on briefly what is a terrible, terrible national crisis, and that is the opioid epidemic. I think in the past, the DOD and the VA were criticized for an overdependence on opioids.

Secretary SHULKIN. Sure.

Senator SANDERS. I know that there has been some significant changes. I have been pleased to go to VA hospitals around the country and see very robust programs regarding alternative complementary medicine—yoga, nutrition, and so forth and so on.

Secretary SHULKIN. Yes.

Senator SANDERS. Can you say a word about how the VA can lead this country away from opioids, although obviously sometimes they are necessary, into less type of dependent drug approaches?

Secretary SHULKIN. Yeah. I will try to do it briefly, but I will tell you I published an article on this 4 or 5 months ago in the *Journal of the American Medical Association* about the VA's approach, because I think it is a national example that others can learn from.

We started this work in 2010, where we identified problems before the rest of America did, as the VA often does, and we did this through a multifactorial approach. We essentially now monitor the patterns of all of our providers, and we give them feedback on how they perform compared to their peers.

Senator SANDERS. If they are overprescribing.

Secretary SHULKIN. If they are overprescribing.

We do academic detailing, where pharmacists go out and actually teach our providers the ways to use opioids appropriately.

We have our patients sign informed consent, so that they are part of the process when they get an opioid.

We participate in the State prescription data monitoring programs. It is mandatory that our providers do that.

We are providing alternatives such as you said, complementary care. In fact, the best practice for us in the country—I do not know if you know this—is actually White River Junction, where we have a 50 percent reduction in opioid use, using those exact techniques, complementary medicine.

Senator SANDERS. Acupuncture.

Secretary SHULKIN. Acupuncture, yoga, mindfulness, biofeedback. I mean, you know, mind-body type of techniques, and so we are trying to get others to be as good as we are doing in White River Junction.

We are working in a number of these areas, and of course, we are trying to work on research with the FDA and NIH on non-addictive narcotics as well, because we think that is important.

Senator SANDERS. Good. Thank you very much.

Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Sanders.

Thanks to all of you. It has been very helpful and informative.

I would ask you to be excused, and our second panel may come forward.

Secretary SHULKIN. Thank you.

[Pause.]

Chairman ISAKSON. Let me thank Secretary Shulkin and his staff for their testimony and their support and the continued response to Committee. We are very grateful for that.

Let me welcome our second panel, and I will begin with the introductions: Mr. Carl Blake, Associate Executive Director, Government Relations, Paralyzed Veterans of America; Mr. LeRoy Acosta, Assistant National Service Director, Disabled American Veterans; Mr. Carlos Fuentes, Director, National Legislative Service, Vietnam—Veterans of Foreign Wars; Mr. John Rowan, National President, Vietnam Veterans of America.

Mr. Blake.

You are each recognized for 5 minutes.

STATEMENT OF CARL BLAKE, ASSOCIATE EXECUTIVE DIRECTOR, GOVERNMENT RELATIONS, PARALYZED VETERANS OF AMERICA

Mr. BLAKE. Mr. Chairman, thank you for the opportunity to testify today. With your approval and the Committee's approval, we would like to submit our fiscal year 2018 *Independent Budget Report* into the official hearing record.

Chairman ISAKSON. Without objection.

[The report can be found online at: http://www.independentbudget.org/2018/FY18_IB_BudgetBook_6.6.17.pdf]

Mr. BLAKE. Thank you.

I think I would like to spend my time talking a little bit about what we have heard today rather than just specifically the recommendations that are included in our budget report.

Let us recap. I appreciate Senator Heller bringing up the question about IU. Although I would say it is not readily apparent, the VA has said for sure that it is going to drop that proposal altogether, it sounds like the Secretary is willing to discuss it further and see where this goes from here.

I appreciate Senator Manchin and also Senator Tester for bringing up the question about the electronic health record (EHR) modernization and Cerner.

Senator Rounds continues to beat the drum about the *Staab* ruling.

Senator Moran really started to probe at the question about holes that seemed to be appearing in the VA's budget.

I appreciate that the Secretary has made the commitment he has as it relates to the EHR modernization, doing the right thing on the *Staab* ruling, and trying to address issues like the caregiver expansion. It is not an easy job. I do not envy the position he is placed in.

Let us forget for minute, let us just set aside the fact that it sounded like to me, we may be staring a budget shortfall right in

the face just for this current fiscal year based on this transferability problem and moving money between Community Care and Choice. All those things historically have added up to a shortfall somewhere.

Let us look at fiscal year 2018. I think that is a good way to sort of snapshot the bigger hole that VA has to deal with.

Senator Heller mentioned IU. IU and its proposal was presumably going to fund a large majority of Choice going forward, in perpetuity as it were, at least $3.2 billion. If we assume that that is not going to happen, that is $3 billion in Community Care under Choice that has to be addressed somehow. It is not addressed in the discretionary part of the VA's budget.

It is all well and good to say we have enough money; $3 billion is a lot of money to say that we have enough.

Senator Manchin and Senator Tester mentioned the Cerner decision. I think on policy, that is probably the right decision to make for VA and for DOD, but I read an article recently that said the Department of Defense's obligation under Cerner is something on the order of $9 billion, I think, in the life cycle of that program. It also said that VA's obligation will be at least three to four times that great. How does the VA's budget rationalize that point? I am sure it does not.

Senator Rounds mentioned *Staab*. It is the right thing to do, what the Secretary said. I think he knows it, and he is acting upon that. I was actually sort of amused that he said they expedited the rulemaking process. I think he said it went to OMB. That is where the expedited process goes to die. He said last week it might take 9 months. OMB will be on the clock for the next 9 months, I am sure, knowing their track record.

That aside, the *Staab* ruling has already left VA with an obligation in previous years of at least $2 billion. Where is that money which is going to pay for that issue?

The average in subsequent years is a billion dollars, 1.1, 1.08, something in that range. Where is that money? It is not in the VA budget either.

Now we are keeping score. We have a $3.2 billion IU hole for Choice. We have an approximately $1 billion hole for *Staab*, and then we have the Cerner issue. We do not even know what that hole looks like.

I could also make the argument that looking out into fiscal year 2019 that budget is certainly short because the Community Care account in that budget alone is less than the projection for 2018, and the Choice plan has it at exactly the same dollar figure, approximately $3.5 billion. Are we going to decrease Community Care usage in 2019? I think we all at this table know that is not going to happen.

Right now, the VA could be staring at a huge hole in its budget for 2018, and we have expressed this to the appropriators. Unfortunately, because of the timing and everything, the appropriators have already moved forward on the House side. They are going to mark up their MILCON/VA bill tomorrow, and none of these questions are answered, yet the VA is left with billions of dollars in unanswered questions. It is not enough to simply say, "We have

enough money. We can move it around." That is not true. That is just simply not true.

Mr. Chairman, I appreciate the opportunity to testify. I would be happy to answer any questions you may have.

[The prepared statement of Mr. Blake follows:]

PREPARED STATEMENT OF CARL BLAKE, ASSOCIATE EXECUTIVE DIRECTOR OF GOVERNMENT RELATIONS, PARALYZED VETERANS OF AMERICA

CHAIRMAN ISAKSON, RANKING MEMBER TESTER, AND MEMBERS OF THE COMMITTEE, As one of the co-authors of *The Independent Budget* (*IB*), along with DAV and Veterans of Foreign Wars, Paralyzed Veterans of America (PVA) is pleased to present our views regarding the funding requirements for the delivery of health care for the Department of Veterans Affairs (VA) for FY 2018 and advance appropriations for FY 2019. On the following page, we have included a side-by-side comparison of funding recommendations previously appropriated for FY 2017 recommended by the Administration by the *IB* for FY 2018, as well as the advance appropriations for FY 2019.

VA Accounts for FY 2018 and FY 2019 Advance Appropriations

	FY 2017 Appropriation	FY 2018 Advance Approps	FY 2018 Admin Revised	FY 2018 IB	FY 2018 Advance Approps	FY 2018 IB Advance Approps
Veterans Health Administration (VHA)						
Medical Services	45,505,812	44,886,554	45,918,362	64,493,555	49,161,165	69,450,838
Medical Community Care	7,246,181	9,409,118	9,663,118		8,384,704	
Subtotal Medical Services	52,751,993	54,295,672	55,581,480	64,493,555	57,545,869	69,450,838
Medical Support and Compliance	6,524,000	6,654,480	6,938,877	6,657,955	7,239,156	6,793,408
Medical Facilities	5,321,668	5,434,880	6,514,675	5,796,343	5,914,288	6,562,579
Subtotal Medical Care, Discretionary	64,597,661	66,385,032	69,035,032	76,947,853	70,699,313	82,806,825
Medical Care Collections	3,558,307	3,627,255	3,271,000		3,277,000	
Choice Program**	2,900,000		3,500,000		3,500,000	
Total, Medical Care Budget Authority (including Collections)	68,155,968	70,012,287	75,806,032	76,947,853	77,476,313	82,806,825
Medical and Prosthetic Research	675,366		640,000	713,200		
Millions Veterans Program				65,000		
Total, Veterans Health Administration	68,831,334	70,012,287	76,446,032	77,726,053		
General Operating Expenses (GOE)						
Veterans Benefits Administration	2,856,160		2,844,000	3,134,540		
General Administration	345,391		346,891	406,454		
Board of Veterans Appeals	156,096		155,596	158,196		
Total, GOE	3,357,647		3,346,487	3,699,190		
Departmental Admin/Misc. Programs						
Information Technology	4,278,259		4,055,500	4,361,502		
National Cemetery Administration	286,193		306,193	291,085		
Office of Inspector General	160,106		159,606	162,545		
Total, Dept. Admin/Misc. Programs	4,724,558		4,521,299	4,815,132		
Construction Programs						
Construction, Major	528,110		512,430	1,500,000		
Construction, Minor	372,069		342,570	700,000		
Grants for State Extended Care Facilities	90,000		90,000	300,000		
Grants for State Vets Cemeteries	45,000		45,000	46,000		
Total, Construction Programs	1,035,179		990,000	2,546,000		
Other Discretionary	201,000		180,214	203,000		
Total, Discretionary Budget Authority (including Medical Collections)	78,149,718		85,484,032	88,989,375		

**Choice Program funding for FY 2018 includes the expected carryover of $600 million from the previous fiscal year as well as $2.9 billion in new funding for the program. All Choice program funding is currently scored as a mandatory cost for VA.

The *IB*'s recommendations include funding for all discretionary programs for FY 2018 as well as advance appropriations recommendations for medical care accounts for FY 2019. The full budget report, released by *The Independent Budget* in March, addressing all aspects of discretionary funding for the VA can be downloaded at

www.independentbudget.org. The FY 2018 projections are particularly important because previous VA Secretary Robert McDonald admitted last year that the VA's FY 2018 advance appropriation request was not truly sufficient and would need significant additional resources provided this year. We hope that Congress will take this defined shortfall very seriously and appropriately address this need. Our own FY 2018 estimates affirm this need.

We appreciate the fact that the Administration's recently released budget request for FY 2018 includes some increases in discretionary dollars for the Medical Care accounts above what had been previously provided through advance appropriations. Before addressing our specific budget recommendations, it is important for us to address the notion that VA does not need any additional resources, based on the expansive growth of overall VA expenses in the last 10 years. These ideas are not grounded in thorough analysis of demand and utilization of VA health care. Perhaps Congress can explain how the VA can take on significantly more demand for services both inside VA and in the community, and yet meet that demand and utilization with less resources—an assertion peddled by some organizations. While VA has seen substantial growth in its funding needs over the last decade, much of that is reflected in mandatory benefits to include the implementation of the Post-9/11 GI Bill. The fact is demand for health care services and actual utilization continue to rise at a significant rate. It may be possible to wring some efficiency savings out of VA to free up additional resources to address growing demand, but history has proven that process will not be sufficient to provide all of the resources VA needs to deliver on its promise to the men and women seeking health care and benefits.

We also believe it is necessary to consider the projected expenditures under the Choice program authority that the previous Administration planned in FY 2017 and how that impacts the baseline that will dictate the funding needs for FY 2018. The previous Administration assumed as much as $5.7 billion in spending through the Choice program in FY 2017, on top of the Medical Services discretionary funding and the newly created Medical Community Care account. That amount was revised to approximately $2.9 billion. This means that the VA projected to spend more than $59.0 billion in Medical Services and more than $71.0 billion in overall Medical Care funding in FY 2017. These considerations inform the decisions of *The Independent Budget* to establish our baseline for our funding recommendations for both FY 2018 and FY 2019.

Earlier this year, the Administration also indicated that it intends to request as much as $3.5 billion in additional funding for the Choice program to keep it operating at least through the end of FY 2018. That amount has since been revised to $2.9 billion for FY 2018 (actually $3.5 billion when considering the already available $600 million left over from the original authorization), as well as $3.5 billion for FY 2019 and beyond. However, this recommendation begs the question: does this recommendation suggest that the Choice program as currently designed should continue in perpetuity? Certainly no reasonable person supports that idea. We believe that Congress must reject continued funding of this program through a mandatory account and place it in line with all other community care funded through the discretionary Community Care account established previously. This will eliminate competing sources of funding for delivery of health care services in the community, while maintaining visibility on spending through the Choice program.

Moreover, we strongly oppose the decision to curtail Individual Unemployability (IU) benefits for veterans with significant service-connected disabilities simply as a means to fund the continuation of the Choice program. It is beyond comprehension that the Administration would propose such a benefit reduction in order to pay for a flawed funding mechanism for a program (Choice) that sometimes provides health care access to non-service-connected disabled veterans. Does this Committee really believe that veterans with disabilities rated between 60 percent and 90 percent should be the source of funding for the Choice program? Eliminating IU benefits for veterans over the age of 62 provokes numerous questions for us. Will veterans who have statutorily protected evaluations (the 20-year rule) also be subject to reduction? Will those dependents using Chapter 35 education benefits based on their sponsor's IU rating be forced to drop out of school? Will those veterans on IU who are covered by Service-Disabled Life Insurance at no premium be forced to now pay premiums in order to keep coverage? What about state benefits, such as property tax exemptions or state education benefits that are based on 100 percent VA disability ratings? How will this proposal affect efforts to combat veteran suicide and homelessness? We hope that you will reject this proposal in the strongest terms.

For FY 2018, the *IB* recommends approximately $77.0 billion in total medical care funding. Congress previously approved only $70.0 billion in total medical care funding for FY 2018 (which includes an assumption of approximately $3.6 billion in medical care collections). The Administration's budget request includes a not-insignifi-

cant overall medical care funding recommendation of approximately $75.2 billion. However, we remain concerned that this level of funding will not keep pace with the continually increasing demand and utilization. The *IB*'s recommendation also considers the approximately $1 billion VA is expected to have remaining in the Veterans Choice Fund and expected demand for care, including community care, that will not diminish or go away if the Choice Program expires. *The Independent Budget* recommends approximately $82.8 billion in advance appropriations for total Medical Care for FY 2019.

MEDICAL SERVICES

For FY 2018, *The Independent Budget* recommends $64.5 billion for Medical Services. This recommendation includes:

Current Services Estimate	$60,897,313,000
Increase in Patient Workload	1,595,242,000
Additional Medical Care Program Cost	2,001,000,000
Total FY 2018 Medical Services	$64,493,555,000

The current services estimate reflects the impact of projected uncontrollable inflation on the cost to provide services to veterans currently using the system. This estimate also assumes a 1.5 percent increase for pay and benefits across the board for all VA employees in FY 2018. It was previously reported that the new Administration would like to consider a 1.9 percent Federal pay raise.

Our estimate of growth in patient workload is based on a projected increase of approximately 90,000 new unique patients. These patients include priority group 1–8 veterans and covered non-veterans. We estimate the cost of these new unique patients to be approximately $1.4 billion. The increase in patient workload also includes a projected increase of 58,000 new Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) enrollees, as well as Operation New Dawn (OND) veterans at a cost of approximately $242 million. The increase in utilization among OEF/OIF/OND veterans is supported by the average annual increase in new users through the third quarter of FY 2016.

Additionally, *The Independent Budget* believes that there are medical program funding needs for VA that must be considered. Those costs total approximately $2.0 billion.

Long-Term Services and Supports

The Independent Budget recommends $535 million for FY 2018. This recommendation reflects the fact that there was a significant increase in the number of veterans receiving Long Term Services and Supports (LTSS) in 2016. Unfortunately, due to loss of authorities—specifically fee-care no longer being authorized, provider agreement authority not yet enacted, and the inability to use Choice funds for all but skilled nursing care—to purchase appropriate LTSS care particularly for home and community-based care, we estimate an increase in the number of veterans using the more costly long-stay and short-stay nursing home care.

Prosthetics and Sensory Aids

In order to meet the increase in demand for prosthetics, the *IB* recommends an additional $320 million. This increase in prosthetics funding reflects a similar increase in expenditures from FY 2016 to FY 2017 and the expected continued growth in expenditures for FY 2018.

Women Veterans

The Medical Services appropriation should be supplemented with $110 million designated for women's health care programs in FY 2018. These funds will be used to help the VA deal with the continuing growth in women veterans coming to VA for care, including coverage for gynecological, prenatal, and obstetric care, other gender-specific services, and for expansion and repair of facilities hosting women's care to improve privacy and safety of these facilities. The new funds would also aid VHA in making its cultural transformation to ensure women veterans are made to feel welcome at VA, and provide means for VA to improve specialized services for preventing suicide and homelessness and improvements for mental health and readjustment services for women veterans.

Reproductive Services (to Include IVF)

Last year, Congress authorized appropriations for the remainder of FY 2017 and FY 2018 to provide reproductive services, to include in vitro fertilization (IVF), to service-connected catastrophically disabled veterans whose injuries preclude their ability to conceive children. The VA projects that this service will impact less than 500 veterans and their spouses in FY 2018. The VA also anticipates an expenditure of no more than $20 million during that period. However, these services are not directly funded; therefore, the *IB* recommends approximately $20 million to cover the cost of reproductive services in FY 2018. We are pleased to see that the Administration does retain the authority to provide reproductive services in its budget proposal.

Emergency Care

Recently, the VA has received serious scrutiny for its interpretation of legislation dating back to 2009, which required it to pay for veterans who sought emergency care outside of the VA health care system. *The Richard W. Staab* v. *Robert A. McDonald* ruling handed down by the US Court of Appeals for Veterans Claims last year, places the financial responsibility of these emergency care claims squarely on the VA. Although VA continues to appeal this decision, it is not expected to prevail in this case leaving itself with a more than $10 billion dollar obligation over the next 10 years. The *Staab* ruling is estimated to cost VA approximately $1.0 billion in FY 2018 and about $1.1 billion in FY 2019, which the *IB* has included in our recommendations. We are disappointed to see that the Administration's proposal continues to ignore its growing obligation to cover the cost of emergency care as dictated by the *Staab* decision.

FY 2019 MEDICAL SERVICES ADVANCE APPROPRIATIONS

The Independent Budget once again offers baseline projections for funding through advance appropriations for the Medical Care accounts for FY 2019. While the enactment of advance appropriations for VA medical care in 2009 helped to improve the predictability of funding requested by the Administration and approved by Congress, we have become increasingly concerned that sufficient corrections have not been made in recent years to adjust for new, unexpected demand for care. As indicated previously, we have serious concerns that the previous Administration significantly underestimated its FY 2018 advance appropriations request. This trend cannot be allowed to continue, particularly as Congress continues to look for ways to reduce discretionary spending, even when those reductions cannot be justified.

For FY 2019, *The Independent Budget* recommends approximately $69.5 billion for Medical Services. Our Medical Services advance appropriations recommendation includes:

Current Services Estimate	$66,334,946,000
Increase in Patient Workload	$1,589,892,000
Additional Medical Care Program Cost	$1,526,000,000
Total FY 2019 Medical Services	$69,450,838,000

Our estimate of growth in patient workload is based on a projected increase of approximately 78,000 new patients. These new unique patients include priority group 1–8 veterans and covered nonveterans. We estimate the cost of these new patients to be approximately $1.3 billion. This recommendation also reflects an assumption that more veterans will be accessing the system as VA expands its capacity and services and we believe that reliance rates will increase as veterans examine their health care options as a part of the Choice program. The increase in patient workload also assumes a projected increase of 62,500 new OEF/OIF and OND veterans, at a cost of approximately $272 million.

As previously discussed, the IBVSOs believe that there are additional medical program funding needs for VA. In order to meet the increase in demand for prosthetics, the *IB* recommends an additional $330 million. We believe that VA should invest a minimum of $120 million as an advance appropriation in FY 2019 to expand and improve access to women veterans' health care programs. Our additional program cost recommendation includes continued investment of $20 million to support extension of the authority to provide reproductive services to the most catastrophically disabled veterans. Finally, VA's cost burden for paying emergency care claims dictated by the Staab ruling will require at least $1.1 billion in FY 2019 alone.

MEDICAL SUPPORT AND COMPLIANCE

For Medical Support and Compliance, *The Independent Budget* recommends $6.7 billion for FY 2018. Our projected increase reflects growth in current services based on the impact of inflation on the FY 2017 appropriated level. Additionally, for FY 2019 *The Independent Budget* recommends $6.8 billion for Medical Support and Compliance. We have concerns about the significant growth in these administrative account functions recommended by the Administration (nearly $300 million in FY 2018 and an additional $300 million in FY 2019) as these areas have been shown to be bloated on numerous occasions in the past. These dollars could certainly be better spent providing direct care services to veterans.

MEDICAL FACILITIES

For Medical Facilities, *The Independent Budget* recommends $5.8 billion for FY 2018. Our Medical Facilities recommendation includes $1.35 billion for Non-Recurring Maintenance (NRM). Likewise, *The Independent Budget* recommends approximately $6.6 billion for Medical Facilities for FY 2019. Our FY 2019 advance appropriation recommendation also includes $1.35 billion for NRM. We are pleased to see the Administration recommending real funding for this account in FY 2018 (approximately $6.5 billion), but we are concerned that the Budget Request reflects the continued trend of reducing the recommendation in the advance appropriation year ($5.9 billion in FY 2019) in order to seemingly hold down discretionary projections.

MEDICAL AND PROSTHETIC RESEARCH

We are very disappointed to see the major cut in funding for the Medical and Prosthetic Research program in the Administration's Budget Request—from $675 million in FY 2017 to $640 million in FY 2018. The VA Medical and Prosthetic Research program is widely acknowledged as a success on many levels, and contributes directly to improved care for veterans and an elevated standard of care for all Americans. We recommend that Congress appropriate $713 million for Medical and Prosthetic Research for FY 2018. Additionally, under the President's Precision Medicine Initiative, the IBVSOs recommend $65 million to enable VA to process one quarter of the MVP samples collected, for a total research appropriation of $778 million.

Thank you for the opportunity to submit our views on the FY 2018 VA Budget Request. We would be happy to answer any questions the Committee may have.

Chairman ISAKSON. Thank you very much for your testimony.

Mr. Acosta.

STATEMENT OF LEROY ACOSTA, ASSISTANT NATIONAL SERVICE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. ACOSTA. Mr. Chairman, Members of the Committee, as co-author of the *Independent Budget (IB)*, along with VFW and PVA, DAV is pleased to present our views regarding fiscal year 2018 funding requirements for veterans' benefits programs.

Today, I will focus on critical funding needs for VBA's Compensation Service, Vocational Rehabilitation and Employment, and the Board of Veterans Appeals. I will also cover our strong opposition to a couple of ill-conceived and unacceptable administration proposals to scale back veterans' disability compensation.

Mr. Chairman, the *IB* recognizes that VBA has made significant progress in reducing the disability claims backlog. VBA is processing more claims than ever before, yet workload continues to rise. To manage current and future workload, the *IB* recommends an additional 1,750 FTEE for VBA's Compensation Service, which would require an increase of approximately $183 million.

VA's Voc Rehab Service also needs additional funding. Over the past few years, program participation has increased by 15 percent overall, and based on historical trends, it would increase by another 5 percent in fiscal year 2018. To meet rising demand and to achieve and sustain the 1–to–125 counselor-to-client ratio estab-

lished for Voc Rehab by law, the *IB* recommends an additional 266 FTEE, which would require a $32 million increase.

Overall, the *IB* recommends total funding for VBA be increased by $278 million, a 10 percent increase in order to fund these two staffing increases and maintain current service levels for the rest of VBA.

Unfortunately, the administration has recommended an outright cut in funding for VBA of $12 million. For overall funding, that is $300 million less than that recommended by the *IB*.

We urge the Committee to support our recommended funding levels to continue VBA's progress in delivering earned benefits to veterans, their families, and survivors.

Mr. Chairman, VBA has made significant progress on its claims backlog. One consequence has been an alarming increase in a backlog of appeals for denied claims. Today, there are over 450,000 appeals pending either at VBA or the board, and it takes almost 6 years on average for a decision by the board.

Fortunately, the IBVSOs have been part of a stakeholder work group with VA to develop and enact comprehensive reform of the appeals process. S. 1024, the Veterans Appeals Improvement and Modernization Act of 2017, is built upon the stakeholder framework and has received broad bipartisan support.

We urge you to move forward expeditiously and pass this legislation. The House has passed similar legislation earlier this year. Enactment of this legislation would lead to a more modern, responsive, and flexible appeals system, one that will provide veterans with quicker decisions on appeals while fully protecting veteran's due process rights. Even with passage of appeals reform, however, the board will continue to require resources commensurate with workload.

Last year, Congress authorized the board to increase this FTEE by 242 to an authorized staffing level of 922 FTEE. The board has not yet filled all those positions. For fiscal year 2018, the *IB* expects the board to continue hiring, to fill all authorized positions, and we do not recommend further staffing increases while this new legislation is being approved and implemented.

Moving forward, the board and Congress must carefully monitor implementation of a new appeal system to ensure that staffing remains adequate to meet future workload demands.

Finally, Mr. Chairman, DAV and the *IB* enthusiastically oppose two legislative proposals in the administration's budget. First, we strongly oppose the proposal to round-down COLAs for 10 years, which would hurt our Nation's injured and ill veterans, their families and survivors. The cumulative effect of this proposed tax would cost beneficiaries nearly $2.7 billion over 10 years. We urge this Committee and the entire Congress to soundly reject it.

Furthermore, we adamantly object to the proposal that will cut off eligibility for VA's individual unemployability, or IU, simply because disabled veterans reach an age in which they might qualify for Social Security retirement benefits.

Mr. Chairman, total compensation for IU is not a retirement benefit. It is provided for as compensation for veterans who suffer lifelong service-connected disabilities and are determined unable to work. Furthermore, this would also lead to veterans losing ancil-

lary benefits that result from a total disability rating, such as dependents educational assistance, CHAMPVA, commissary and exchange privileges, and in many cases, State benefits such as property tax exemptions.

We call on Members of this Committee and the entire Congress to soundly reject these dangerous proposals that would be harmful to disabled veterans.

That concludes my testimony. I would be happy to respond to any questions that you or Members of the Committee may have.

[The prepared statement of Mr. Acosta follows:]

PREPARED STATEMENT OF LEROY ACOSTA, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE: As one of the co-authors of *The Independent Budget* (*IB*), along with Veterans of Foreign Wars (VFW) and Paralyzed Veterans of America (PVA), DAV is pleased to present our views regarding fiscal year (FY) 2018 funding requirements to support the Department of Veterans Affairs (VA) ability to process and deliver timely, accurate benefits to veterans, their families and survivors.

GENERAL OPERATING EXPENSES (GOE)

Veterans Benefits Administration $3.135 billion

The Veterans Benefits Administration (VBA) account is comprised of six primary divisions. These include Compensation; Pension; Education; Vocational Rehabilitation and Employment (VR&E); Housing; and Insurance. The increases recommended for these accounts primarily reflect current services estimates with the impact of inflation accounting for most of the increase. However, the *IB* recommendations for Compensation and VR&E also reflect a significant increase in requested staffing to meet the rising demand for those benefits. The *IB* recommends approximately $3.135 billion overall for VBA for FY 2018, an increase of approximately $279 million over the enacted FY 2017 appropriations level. The *IB* recommendation includes an increase of $183 million above current services in the Compensation account, and approximately $32 million above current services in the VR&E account to provide for approximately 2,000 new full-time equivalent employees (FTEE) to address rising workload.

Compensation Service Personnel 1750 New FTEEs $183 million

VBA continues to produce record numbers of claims while maintaining an emphasis on quality. Over the past few years, VBA has made significant progress in reducing the disability compensation backlog, which at its peak, stood at over 600,000 claims in March 2013. Today, the claims backlog stands at just over 90,000 claims, a decrease of more than 85 percent from its peak. However, there has recently been a rise in the overall disability claims inventory and the amount of time it takes to process both claims and appeals. These increases can be attributed to multiple factors, including an increase in the number of claims and appeals being filed, the lack of adequate resources to keep pace with demand and the curtailing of mandatory overtime to reduce the claims backlog.

In 2009, VBA issued claims decisions on 2.74 million medical issues; that number more than doubled to 5.76 million in FY 2016, but was less than FY 2015 when it issued 6.35 million decisions on medical issues. In March 2013, VBA required roughly 282 days to process a claim. At the close of FY 2016, VBA reported that on average, it took 123 days to process a claim; however, in FY 2015, VBA reported that it took, on average, 92 days to complete a claim. In FY 2015, total inventory stood at about 352,000 claims; today VBA has a total inventory close to 400,000 claims. Furthermore, VBA has an inventory of nearly 584,000 non-disability rating claims, such as, claims for changes in dependent or marital status.

It will require a combined focus on technology and staffing levels for VBA to provide veterans and their dependents with more timely and accurate claims decisions. For FY 2018, the *Independent Budget* veterans service organizations (IBVSOs) recommend an additional 1,750 FTEE to manage VBA's overall rising workload. Furthermore, since VBA stopped utilizing mandatory overtime for claims processing, the true need for additional personnel has become more evident. Of the overall increase in personnel, we recommend 1,000 FTEE be dedicated to processing appeals pending at VBA in an effort to eliminate the backlog of 380,000 appeals in VBA over

the next three years. Depending on progress this year, further personnel increases may be necessary to reduce the appeals backlog at VBA. In addition, we recommend 350 FTEE be dedicated to addressing the growing backlog of non-rating related work, such as dependency claims. An additional 300 FTEE should be dedicated for claims processing to address the incremental rise in the claims inventory and backlog and 100 FTEE dedicated to staffing the Fiduciary program to meet the growing needs of veterans participating in VA's Caregiver Support programs. This recommendation is based on a July 2015 VA Inspector General report on the Fiduciary program that found, "...Field Examiner staffing did not keep pace with the growth in the beneficiary population, [and] VBA did not staff the hubs according to their staffing plan...."

VR&E Service Personnel 266 New FTEEs $32 million

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

VR&E also operates its VetSuccess on Campus (VSOC) program at 94 college campuses.

Over the past few years, program participation has increased by 15 percent overall: increasing by 7.3 percent in FY 2015, 3.8 percent in FY 2016, and an estimated 4 percent in FY 2017. As VBA continues to expand VR&E eligibility to more veterans, due to increased claims processing and the award of new service-connected disabilities due to new presumptive disabilities, we project that total program participation for FY 2018 will grow by at least 5 percent for total caseload of close to 155,000.

Last year, Congress enacted Public Law 114—223, which authorizes the Secretary to use appropriated funds to ensure the ratio of veterans to full-time employment equivalents does not exceed 125 veterans to one full-time employment equivalent, a goal that VA has not met for many years. In July 2015, VR&E reported that its average Vocational Rehabilitation Counselor (VRC)-to-client ratio had risen to 1:139. However, in both FY 2016 and FY 2017, the Administration flat-lined the VR&E request for direct personnel at 1,442. In order to achieve and sustain a 1:125 counselor-to-client ratio in FY 2018, we estimate that VR&E would need 266 new FTEE, for a total workforce of 1,550 FTEE, to manage an active caseload and provide support services to 155,000 VR&E participants. At a minimum, three-quarters, of the new hires should be VRCs dedicated to providing direct services to veterans. This increase in personnel would address expected growth in VR&E claim filings and program participation, as well as collateral duties performed by VRCs outside of general case management. It is also essential that these increases be properly distributed throughout all of the VR&E program to ensure that VRC caseloads are equitably balanced among VA Regional Offices.

GENERAL ADMINISTRATION

Board of Veterans' Appeals $158 million

Faced with a rising appeals backlog that could no longer be ignored, last year Congress authorized the Board of Veterans' Appeals (Board) to increase its FTEE by 242 over FY 2016 levels, bringing their total authorized staffing to 922 FTEE for FY 2017; however, the Board has not yet hired to their full authorized level. For FY 2018, the IBVSOs recommend no additional increases in FTEE; but note, the Board must be permitted to hire its full complement of 922 FTEE. Further, as the number of claims processed annually continues to rise as a result of the increased capacity of VBA, the number of appeals filed annually will grow commensurately. In order for the Board to keep pace with this new incoming workload alone, not including those appeals already in the system, FTEE levels will have to be adjusted accordingly, though appeals reform legislation could alleviate some of that need in the future.

The IBVSOs thank Chairman Isakson, Senators Blumenthal, Tester and the other cosponsors for introducing the Veterans Appeals Improvement and Modernization Act of 2017 (S. 1024), legislation that would fundamentally reform and streamline the overall appeals process. Similar legislation, H.R. 2288, was introduced and passed in the House. These measures include provisions that reflect significant efforts and the consensus of a working group formed in March 2016 that consisted of the IBVSOs, other VSO stakeholders, and leaders within VBA and the Board. Regardless of potential passage of this legislation the Board will continue to require

resources commensurate with workload, especially to process legacy appeals remaining at the time of enactment of new appeals reform legislation. Further, the Board must be funded and empowered to continue pursuing information technology (IT) modernization solutions that best meet the specific workflow needs of the Board, while ensuring it also supports seamless integration with the Veterans Benefits Management System and other IT systems used by VBA and the Court of Appeals for Veterans Claims. Given the potential for significant and positive impact this would have on veterans' ability to receive more timely decisions, we look forward to the Committee passing appeals modernization, followed swiftly by enactment.

COST OF LIVING ROUND DOWN

The Administration's budget proposal released on May 23, 2017, contains a provision that would round down cost-of-living adjustments (COLAs) for our Nation's injured and ill veterans and their families and survivors for a period of 10 years. DAV and our *IB* partners are strongly opposed to this rounding down provision. Veterans and their survivors rely on their compensation for essential purchases such as food, transportation, rent, and utilities. It also enables them to maintain a marginally higher quality of life.

Rounding down veterans' COLAs unfairly targets disabled veterans, their dependents and survivors to save the government money or offset the cost of other Federal programs. The cumulative effect of this provision of law would, in essence, levy a 10-year tax on disabled veterans and their survivors, reducing their income each year. When multiplied by the number of disabled veterans and recipients of Dependency and Indemnity Compensation or DIC, hundreds of millions of dollars would be siphoned from these deserving individuals annually. All totaled, VA estimates, this proposed COLA round down would cost beneficiaries close to $2.7 billion over 10 years. Congress must reject this ill-conceived proposal.

INDIVIDUAL UNEMPLOYABILITY AND SOCIAL SECURITY OFFSET

We also note there is, unfortunately, a new proposal included in the President's budget that would impact the VA's Individual Unemployability or IU program which allows VA to pay certain veterans disability compensation at the 100 percent rate, even though VA has not rated their service-connected disabilities at the total level. Specifically, the proposal would terminate existing IU ratings for veterans when they reach the minimum retirement age for Social Security purposes (62), or upon enactment of the proposal if the veteran is already in receipt of Social Security retirement benefits. The IBVSOs vehemently oppose this proposal.

As the Members of this Committee know, Congress delegated to the Secretary of Veterans Affairs the authority to adopt and apply a schedule of rating disabilities pursuant to section 1155 of title 38, United States Code. In accordance with VA regulation promulgated by the Secretary, total disability exists when any veteran is determined by VA to be unable to secure and maintain substantially gainful employment by reason of service-connected disability, regardless of age. (See 38 CFR, section 4.16(b).) IU is based on the impact of the individual's own circumstances and it is an exception to the "average person standard" of the rating schedule. As a prerequisite for an IU rating, a veteran generally must have a disability rated 60 percent or higher under the rating schedule.

Total compensation for IU is not a retirement benefit. Properly applied, the rules require a factual showing that the service-connected disability is such as to be incompatible with substantially gainful employment, regardless of age. Today, many people, including the President, members of the Cabinet and members of Congress, work well beyond the minimum or "normal" retirement age. Some continue to work because they love their job, while others may be forced by financial requirements to continue to work.

This proposal is especially detrimental to the well-being of ill and injured veterans and their families because it forces a totally disabled veteran to take their social security benefits at the minimum age of 62, when the benefit is a small fraction of what he or she would receive at normal retirement age (65 to 67) or at age 70. Further, since the level of social security benefits is based on what an individual has paid into the fund, a veteran who was severely or totally disabled at a young age may not have paid sufficient funds to receive a level of benefits at the minimum age, or any age for that matter, to live a comfortable life because of reduced earnings due to service-related disabilities.

We also remind the Committee that the loss of IU for many veterans would also have a negative impact on a veteran's family due to the concurrent loss of ancillary benefits. Once the total disability rating for IU is reduced at age 62, the veteran and his or her family will lose Chapter 35 benefits for Dependents Education Assist-

ance program, essential health care benefits from the Civilian Health and Medical Program of the VA (CHAMPVA) for dependents, Commissary and Exchange privileges and, in many cases, state benefits such as property tax exemptions. This damaging proposal should be rejected by Congress as it lacks compassion for the men and women who served our country and were severely disabled as a result of that honorable service.

In summary, a final point I would like to make is that benefits received from the VA, or based on military retirement pay and other Federal programs have differing eligibility criteria as compared with the earned payments of Social Security. Reducing a benefit provided to a disabled veteran in receipt of IU due to receipt of a different benefit offered through separate Federal benefit program is simply an unjust forfeit of an earned, necessary benefit.

Mr. Chairman, thank you for the opportunity to submit testimony and to present the views of the IBVSOs regarding FY 2018 funding requirements to support the VA's ability to process and deliver benefits to veterans, their families and survivors. I would be happy to respond to any questions that you or Members of the Committee may have regarding this statement or our recommendations.

Chairman ISAKSON. Thank you very much, Mr. Acosta.

Mr. Fuentes.

STATEMENT OF CARLOS FUENTES, DIRECTOR OF THE NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. FUENTES. Chairman Isakson and Members of the Committee, on behalf of the men and women of the VFW and its Auxiliary, I would like to thank you for the opportunity to present our views on VA's budget.

The VFW is glad the administration has proposed a 6 percent increase in VA's discretionary budget. We certainly support the continued focus on expanding access to health care; expediting decisions on benefits, claims, and appeals, increased focus on combating veteran suicide and addressing the stigma associated with mental health; ensuring VA is ready and able to care for women veterans who are the fastest-growing cohort of the veteran population. However, I would like to make it clear the VFW strongly opposes efforts to claw back benefits from our most severely disabled veterans to pay for such improvements.

In the past week, nearly 40,000 letters and e-mails from VFW members and supporters have been sent to Members of Congress opposing the administration's proposal to revoke individual unemployability benefits for veterans who are unable to work because of their service-connected disabilities. The VFW opposes the IU proposal and the COLA round-down proposal and other measures to balance the budget on the backs of our Nation's veterans.

We are also concerned with the administration's request to make the Veterans Choice Program a permanent mandatory program, which could possibly lead to the gradual erosion of the VA health care system.

The continued failure by Congress to eliminate sequestration has forced the administration's proposed cuts to veterans programs in order to expand the Choice Program under mandatory spending instead of including it in discretionary Community Care accounts.

Sequestration and draconian spending caps limit our Nation's ability to provide servicemembers, veterans, and their families the care and benefits they have earned. The VFW calls on this Committee to join our campaign and finally end sequestration and do

away with Federal budget processes based on arbitrary budget caps.

In partnership with our *Independent Budget* co-authors, DAV and PVA, I would like to focus some of my remarks on VA's construction and National Cemetery administration budget request. For more than a decade, the IBVSOs have warned Congress and VA that perpetual underfunding has allowed VA's infrastructure to erode while its capacity has swelled from 81 percent in 2004 to as high as 121 percent in 2012. We continue to believe that this need for space and chronic underfunding of major construction projects could force VA to ration care.

VA's budget request says that improving the condition of VA's facilities through major construction projects accounts for the largest resource need to keep pace with the growing demand for VA outpatient care, yet the administration's major construction request only funds one VHA major construction project.

The IBVSOs believe that VA has requested an adequate amount for its fiscal year 2018 major medical leases needs; however, Congress must find a way to quickly authorize leasing projects. There are now 27 major medical facility leases awaiting congressional authorization, 18 of which have been waiting since 2015. Delays in authorization of these leases has a direct impact on VA's ability to provide timely care to veterans.

The National Cemetery Administration has a sacred duty to provide our Nation's veterans a final resting place that honors their service. In 2016, NCA entered more than 130,000 veterans and eligible family members. The number of interments is expected to increase until 2022. Other factors have placed additional demands on NCA, and the IBVSOs are glad to see the administration's request for NCA as higher than our recommendation, which I believe may be one of the only ones. We commend VA for continued commitment to NCA's mission.

Mr. Chairman, this concludes my testimony. I am happy to answer any questions that you and the Members of the Committee may have.

[The prepared statement of Mr. Fuentes follows:]

PREPARED STATEMENT OF CARLOS FUENTES, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

CHAIRMAN ISAKSON, RANKING MEMBER TESTER AND MEMBERS OF THE COMMITTEE, On behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, thank you for the opportunity to present the VFW's views on the Department of Veterans Affairs' (VA) Fiscal Year (FY) 2018 appropriations and FY 2019 advance appropriations.

The VFW is glad to see President Trump has proposed a six percent increase in VA's FY 2018 discretionary budget compared to FY 2017. However, we feel his proposal falls short of what VA needs to keep pace with demand for health care and benefits. The VFW thanks the Administration for its commitment to community care, long-term care, mental health care, woman veterans and efforts to prevent and eliminate veteran homelessness.

However, we are very concerned that the Administration's request to make the Veterans Choice Program a permanent mandatory program could lead to a gradual erosion of the VA health care system. What is more concerning is that the Administration has chosen to make permanent a flawed program by ending Individual Unemployability benefits for certain severely disabled veterans who are unable to work due to their service-connected disabilities and round down cost of living disability pay increases, a proposal which the VFW has opposed in the past and continues to strongly oppose.

The Administration has also proposed a cap on the amount of tuition and fees that may be paid under the Post-9/11 GI Bill for programs of education in which a public institution of higher learning enters into an agreement with another entity to provide such education. Currently, third party training programs that contract with public schools are able to charge unlimited fees since public schools have no set dollar amount cap.

A couple of years ago, it came to light that some contracted flight training programs were charging exorbitant fees, which far exceeded the cost of an average in-state education. The VFW supports the Administration's proposal to place a reasonable cap on these sorts of training programs.

The continued failure of Congress to eliminate sequestration has forced the Administration to propose cuts to veteran benefits and cap GI Bill expenditures in order to expand the Choice Program under mandatory spending instead of including the program in its discretionary community care account. In testimony before the Senate and House Committees on Appropriations, Secretary of Veterans Affairs David J. Shulkin has indicated that VA would like all its community care money to come from one account, instead of having two separate accounts for the same purpose and not having the flexibility to use both accounts in accordance with veterans' demand for community care. The VFW agrees with Secretary Shulkin and urges Congress to consolidate VA's community care programs and to fund such programs through VA's discretionary appropriations account.

Sequestration and its draconian spending caps limit our Nation's ability to provide servicemembers, veterans, and their families the care and benefits they have earned and deserve. The VFW calls on the Committee to join our campaign to finally end sequestration and do away with a Federal budget process based on the arbitrary budget caps, which significantly limit the government's ability to carry out programs that experience spikes in demand, such as VA health care. To the VFW, sequestration is the most significant readiness and national security threat of the 21st century, and despite almost universal congressional opposition to such haphazard budgeting, Congress has failed to end it.

The VFW, in partnership with our Independent Budget (*IB*) co-authors—Disabled American Veterans (DAV) and Paralyzed Veterans of America (PVA)—produces annual budget recommendations for each of VA's discretionary appropriation accounts and compares them to the Administration's request. PVA has submitted testimony covering Veterans Health Administration (VHA) appropriation accounts and DAV has covered the *IB*'s recommendations for the Veterans Benefits Administration accounts. I will focus my remarks on VA's construction and National Cemetery Administration (NCA) appropriations.

Major Construction:

FY 2018 *IB* Recommendation—$1.50 billion
FY 2018 Administration Request—$512 million
FY 2017 Appropriations—$528 million

For more than a decade, the *IB* Veterans Service Organizations (IBVSOs) have warned Congress and VA that perpetual underfunding has allowed VA's infrastructure to erode while its capacity has swelled from 81 percent in 2004 to as high as 120 percent in 2010. We continue to believe that this need for space and chronic underfunding of medical services could lead VA to ration care.

The IBVSOs are working with VA to reform its construction process so facilities can be delivered on time and on budget. Previous errors must be corrected to ensure the issues in Aurora, Colorado, never occur again. However, Congress and the Administration must not ignore the growing capital infrastructure needs of the Department's health care system.

When VA asked its Veteran Integrated Service Networks (VISN) to evaluate what they need to improve its facilities to meet the increased outpatient demand, VA determined that "improving the condition of VA's facilities through major construction projects (96) accounted for the largest resource need."[1] Yet the Administration's major construction request for VHA is 36 percent less than FY 2017 and 85 percent less than actual expenditures in FY 2016.

When asked why VA is taking a strategic pause on major construction for VHA when its capital infrastructure continues to age and demand continues to increase, VA informed the IBVSOs that it simply did not receive the request that it needed for major construction because of sequestration budget caps. Congress must not

[1] Department of Veterans Affairs 2018 Budget and 2019 Advance Appropriations Requests, Volume IV: Construction, Long Range Capital Plan and Appendix. Long Range Capital Plan, page 8.3–8.

allow VA's inability to invest in its VHA's major construction to limit veterans' access to the health care they have earned and deserve by forcing veterans onto VA's community care programs and eliminating the choice to receive care at VA medical facilities.

Currently, VA has 24 major construction projects that are partially funded—some of which were originally funded in FY 2004—that need a clear path to completion. An additional three projects are in the design phase. Outside of the partially funded major projects list are major construction projects at the top of the FY 2017 priority list that are seismic in nature. These projects cannot take a strategic pause while Congress and VA decide how to manage capital infrastructure long-term. VA will need to invest more than $3.5 billion to complete all 24 partially funded projects. Of the top five projects on the priority list, two are seismic deficiencies, two support the core mission of VA—a mental health clinic and a spinal cord injury center—and one is an addition to an existing facility. The total cost of these five projects is $1.2 billion.

The IBVSOs recommend that Congress appropriate at least $1.5 billion for major construction in FY 2018. This amount will fund either the "next phase" or fund "through completion" all existing projects, and begin advance planning and design development on six major construction projects that are the highest ranked on VA's priority list.

Minor Construction:

FY 2018 *IB* Recommendation—$700 million
FY 2018 Administration Request—$343 million
FY 2017 Appropriations—$372 million

In FY 2017, Congress appropriated $372.1 million for minor construction projects. Currently, approximately 600 minor construction projects need funding to close all current and future year gaps within ten years. To complete all of these current and projected projects, VA will need to invest between $6.7 and $8.2 billion in minor construction over the next decade.

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

While this infusion of funds has helped, there are still hundreds of minor construction projects that need funding for completion. It is important to remember that these funds are a supplement to, not a replacement of, annual appropriations for minor construction projects. The IBVSOs recommend that Congress fund VA's minor construction account at $700 million in an effort to close all identified gaps within ten years.

LEASING

Historically, VA has submitted capital leasing requests that meet the growing and changing needs of veterans. VA has again requested an adequate amount—$270.1 million for its FY 2018 major medical leasing needs. While VA has requested adequate resources, Congress must find a way to authorize and appropriate leasing projects in a way that precludes the full cost of the lease being accounted for in the first year. There are now 27 major medical leases awaiting congressional authorization, 18 of which have been waiting since FY 2016 and six from FY 2017 that Congress must still authorize. Delays in authorization of these leases have a direct impact on VA's ability to provide timely care to veterans in their communities. Congress must authorize these leases.

National Cemetery Administration:

FY 2018 *IB* Recommendation—$291 million
FY 2018 Administration Request—$306.2 million
FY 2017 Appropriations—$286 million

The NCA, which receives funding from eight appropriation accounts, has the sacred duty to provide the brave men and women who have worn our Nation's uniform a final resting place that honors their service.

In a strategic effort to meet the burial and access needs of our veterans and eligible family members, the NCA continues to expand and improve the national cemetery system, by adding new and/or expanded national cemeteries. Not surprising, due to the opening of additional national cemeteries, the NCA is expecting an increase in the number of annual veteran interments through 2016 to more than 136,000, up from 125,180 in 2014; this number is expected to slowly decrease after

an expected peak of 138,000 in 2022. This much needed expansion of the national cemetery system will help to facilitate the projected increase in annual veteran interments and will simultaneously increase the overall number of graves being maintained by the NCA to 3.7 million in 2018 and 4 million by 2021.

Even as the NCA continues to add veteran burial space to its expanding system, many existing cemeteries are exhausting their capacity and will no longer be able to inter casketed or cremated remains. That is why the VFW is glad the see the Administration's FY 2018 budget request for the National Cemetery Administration is higher than what the IBVSOs have recommended and includes a seven percent increase from FY 2017 appropriations.

Factors that have placed additional demand on the NCA include an increase in the issuance of Presidential Memorial Certificates, which is expected to increase from approximately 654,000 in 2013 to more than 870,000 in 2017; the expected increase in the burial of Native American, Alaska Native, and Pacific Islander veterans; and the possible increase, thanks to local historians and other interested stakeholders, in requests for headstones or markers for previously unidentified veterans. That is why the IBVSOs are glad to see the Administration has requested $256 million in FY 2018 to fund six national cemetery expansion projects which would provide more than 161,000 new burial spaces for veterans.

With the above considerations in mind, *The Independent Budget* recommends $291 million for FY 2018 for the Operations & Maintenance of the NCA. The IBVSOs believe that this should include a minimum of $20 million for the National Shrine Initiative. The IBVSOs laud the Administration for providing NCA the first increase in this important initiative since FY 2013.

Mr. Chairman, this concludes my testimony. I will be happy to answer any questions you or the Committee members may have.

Chairman ISAKSON. Thank you, Mr. Fuentes. We appreciate it.

Mr. Rowan.

STATEMENT OF JOHN ROWAN, NATIONAL PRESIDENT, VIETNAM VETERANS OF AMERICA

Mr. ROWAN. Thank you, Mr. Chairman. Senator Sanders, nice to see you. Nice to see you, Senator. It is good to see you back. I missed you when I had my annual testimony this year.

Chairman ISAKSON. I missed you more than you might think. [Laughter.]

I am glad to be vertical again.

Mr. ROWAN. Yeah. Well, me too. I was coming out of the hospital when you were going in, I think.

Anyway, I would like to, first of all, thank you for the Accountability Act. It is an issue we have been dealing with since we started VVA, frankly, 35 years ago, calling upon Congress to take full accountability of all the VA operations, and hopefully, this will work. We support that bill.

IU, as was noticed, has got to be rescinded. That whole proposal is a classic budget-tier proposal that has no idea how it impacts on people. It is just a dollar amount to somebody in OMB, with effects beyond even what everybody understood the first time with this whole nonsense that Social Security was going to pick up the amount of money lost on IU, not even talking about the effects on the family members—the loss of dental care, the loss of CHAMPVA, loss of local benefits. As was mentioned earlier, tax abatements in New York City—we just got the expansion of our tax abatement for real estate, which would be cut significantly by that. So, that this has just got to be—one of the things we are calling upon, we would like—since the Secretary has alluded to the fact that they may agree with the idea that this should be shelved, we would love to see a joint effort between the VA and the leadership in both the Senate and the House Veterans' Affairs Committee

publicly denouncing this idea and saying we are not going to pass it, so that we can tell all those scared people out there, who have been sending me e-mails and letters about all of the horrors that they are concerned about. Let them know they have nothing to worry about. We have got to bring these people down about ten notches because they are climbing the walls right now. I mean, that is something I hope that the Committees, both in the Senate and the House, and the VA would take into consideration so they could publicly acknowledge that this was one bad idea.

The Choice Program is not a choice. It is a false choice, and I think we need to understand how it is done. I just came back from Idaho, where I met with my State council up in Sandpoint in northern Idaho. Almost everybody there utilizes the Choice Program because they are hundreds of miles from any VA facility, but they also can tell me all the problems they have with Choice in finding doctors who will take Choice, who will take the VA's money, who will even sign on because of problems. Now, we know they are trying to resolve those problems, but it is going to be a big issue for that.

The other thing is doctors. Where are they coming from? I can tell you, I live in New York City. My dermatologist that I had in my private medical program for 25 years just retired on me. I managed to outlive him and that was great. He is retired. I am still sick, and I have to go see the doctor. I called up my EmblemHealth, which is one of the largest health care providers in the country, and they could not find me a dermatologist that I could talk to—at the earliest in August, and really they were talking about October. That is a false choice. That is dermatology, which I think I could throw a stick out of my window and hit a dermatologist in New York City, but they are not there because they do not sign up with the VA. They will not take the VA's payments, just like we have seen in Medicare and Medicaid with problems with doctors not signing on. We are concerned about that. It really needs to be rethought significantly because the private sector is not ready whatsoever to take on the VA patients, no way.

The last thing—a couple of things I would—my other point also, the R&D budget has been cut. It should not be cut. It should be increased. We need more R&D for all of the programs that we have. We need to get more evidence-based programs testing on PTSD and how do we really handle it.

I cannot tell you all the different programs where folks tell me what a great panacea they have for PTSD; it sounds great. You know, I love my dogs, and yeah, they are helpful. Yes, they help some veterans, but without counseling, that does not end their problem. We need to get more evidence-based actions, research into these programs.

I am also concerned—we passed a bill last year that would look into the effects of toxic exposure on the children of Vietnam veterans and veterans that came after us. Where is that money going to come from if the R&D budget is cut? We got a nice bill passed after we fought for years. Where is the money? We need the money, and if the VA's budget is not there, how are we going to get that done?

Last, let me just say one quick thing about the Board of Veterans Appeals and the whole appeals process. It would go a lot quicker if the VA took outside doctors' opinions and did not have to redo everything that somebody came in with, with an outside doctor's opinion. That would be nice.

The other thing is we need to blow up the Board of Veterans Appeals. It just does not function. Nobody should lose 70 percent of the time, which the VA does every year. I have been in this position 12 years, and in 12 years, every year, our VSOs, 70 percent of the time, either get a remand or a direct payment from the Board of Veterans Appeals on cases we bring in—70 percent. We win; VA loses. Year after year after year, and I guarantee you, that is the same percentage with the rest of the gentlemen at this table. I will bet all of their VBA cases are around the same percentage. That is ridiculous.

The other problem is no precedence. Carl can put in a claim. I can put in a claim for the exact same thing. He gets Judge A. I get Judge B. We get two different opinions. They both go down. He wins; I lose. Too bad. His opinion does not account for anybody that follows after them if they have been approved, and neither does mine, for that matter. The denial does not either. It just keeps regurgitating the same programs over and over and over again, the same problems over and over and over again. We need to get the issue of precedence, like in any other court. Frankly, now that we understand the Court of Veterans Appeals, we are going to be very happy to look at them, the idea of doing class-action lawsuits at the Court of Veterans Appeals.

I would be happy to answer any and all questions that anybody may have. Thank you.

[The prepared statement of Mr. Rowan follows:]

PREPARED STATEMENT OF JOHN ROWAN, NATIONAL PRESIDENT, VIETNAM VETERANS OF AMERICA

GOOD AFTERNOON, CHAIRMAN ISAKSON, RANKING MEMBER TESTER, AND OTHER EXEMPLARY MEMBERS OF THE SENATE VETERANS' AFFAIRS COMMITTEE. Vietnam Veterans of America is pleased to have the opportunity to present our views on the President's Fiscal Year 2018 Budget and 2019 Advanced Appropriations Request for the Department of Veterans Affairs.

First off, VVA is pleased that the VA warrants increased funding to help meet the needs of the department and the veterans it assists in an array of areas designed to restore, as much as possible, those who have given of themselves—often at great cost to their health, to their sense of well-being, to their families. We know that you, the members and staff of this most important and hard-working committee, recognize this, and that you will be true to the sacrifices these men and women have made so that we all may live in a free society.

We do, however, want to commence our remarks with the one issue in the budget proposal that has been the source of great consternation not only to VVA but to the multitude of VSOs and MSOs. This is a proposal that has unleashed a firestorm of protest, of questions, concerns, and fears, by veterans and their spouses who have come to depend on this income.

INDIVIDUAL UNEMPLOYABILITY TERMINATION AND ELDERLY VETERANS

First and foremost, the Administration's proposal that would cap IU benefits for veterans rated 60–100 percent disabled at age 62 and terminate this benefit for those veterans currently receiving Social Security must be a non-starter. It is unfair and simply wrong to characterize IU and Social Security as duplicative. Veterans have earned both benefits, IU by virtue of their service in uniform and Social Security through working and contributing into the system.

The logic behind this proposition, which seems to arise from the depths of the Office of Management & Budget (OMB) every eight years or so, often at the beginning of a new administration, is that, at age 62, veterans can avail themselves of their Social Security benefits. This does not take into account, however, that if a veteran has been receiving IU for several years, there's a pretty good chance, if indeed not a likelihood, that s/he does not qualify for any serious Social Security income because s/he has not had a significant work history.

This piece of the Administration's budget proposal, if approved, would impact nearly every Vietnam-era veteran and their family whose survival depends on the income received from this earned benefit. This proposed change would cut the compensation of a married disabled veteran receiving 100% by dint of IU compensation to about $1,300 a month from just over $3,000 per month. Should any Member of Congress exhibit political naivete and vote to eliminate IU at age 62, tens of thousands of Vietnam veterans in their late sixties and seventies would be in jeopardy of not being able to meet their basic needs, which would lead, for many, to impoverishment, homelessness, even suicide.

According to the budget proposal, this provision would "save" the Compensation and Pensions account in the Veterans Benefits Administration an estimated $3.2 billion in 2018; $17.9 billion over five years; and $40.8 billion over ten. The savings would go toward funding the Veterans Choice program, which at present is confusing endeavor in many areas, which many veterans neither understand nor embrace.

Furthermore, there are 238,000 veterans 62 and older currently receiving 100% by dint of IU, and of those 178,000 are 67 and older. The plain fact is that the VA disability rating schedule for mental health, and particularly for Post Traumatic Stress Disorder (PTSD) has for many years been grossly unfair. In order to be rated at 100% for PTSD a veteran would need to be exhibiting symptomology of full blown dementia (which has nothing to do with PTSD!). Since these veterans should have been rated at 100% for PTSD, but were not because the rating schedule was faulty, they have continued to draw service-connected compensation at the 100% level. They have been unable to work, so have not paid much, if any,into Social Security. Social Security is NOT akin to service-connected compensation, but rather it is analogous to an annuity. The more you pay in to Social Security, the more you get out of it in monthly increments. The less you pay into the Social Security Trust fund, the less your monthly payments. VVA has talked to numerous Vietnam veterans who have not been able to work since they were blown up in the Vietnam War, but paid into Social Security before Vietnam, so that their monthly payments are as little as $25 per month.

The so-called "savings" achieved by means of this ruse would be illusory, because nearly every veteran in this situation would immediately re-apply seeking 100% service-connected disability without IU. This would result in a flood of claims at VA, and would once again create backlogs in processing of claims.

We strongly urge the Committees on Veterans Affairs to issue a bi-partisan declaration that his ill-advised move will not happen on your watch.

VA HEALTH CARE

The President's budget request for medical care is $4.6 billion greater than the FY'17 budget, representing a 7% increase in discretionary spending; also, $2.9 billion in new mandatory budget authority to continue, and to enhance, the so-called Choice Program. Undergirding this increase is the need to continue to improve access to care for the 6.8 million of the 9.2 million veterans enrolled in the VA healthcare system.

Now, we understand that Secretary Shulkin embraces funding for Choice which, if you'll recall, was never meant to be a solution to the long-standing problem of access to quality care for veterans who seek services from the VA. His goal is to integrate Choice into a local/regional program of Community Care, with significantly greater funding for the FY'19 budget.

We want to focus attention on two issues: collections from third party payers, and privatization.

In the recent past, the VA put forth overly optimistic assessments of the number of dollars it could recoup via third party collections (along with all the million$ that would be saved through "management efficiencies"). We hope this is not the case again.

The persistent call by some for privatization of VA health care should be quelled by a successful initiation and operation of the Community Care program. We know there is an unfortunate number of vacancies for clinicians—not only in the VA healthcare system but in private and public venues as well. It makes eminent good

sense to bring in qualified, credentialed professionals to fill voids caused by, in no particular order: retirement and/or resignation of VA clinicians; increased demand in certain VA medical centers; delayed delivery of care, and other problems.

CHOICE 2.0

VVA is concerned that the proposed budget does not provide enough funding for the new Choice currently in development. The Secretary is redesigning the program, altering it from an administrative system to a clinical one. We have some concerns, too, over the impact of proposed organizational changes in care delivery to veterans; how the high performing networks will function; and how this will then ease health care access. We understand that under the new proposal, providers will bring their networks with them, modeled after the Defense Department's Tri Care system.

Additionally, VVA has concerns about the consolidation of care authorities, a legislative ask that has been a priority for the agency. This authorization is needed, according to the VA, to move Choice forward, and yet this step has yet to be accomplished. The gist behind consolidating the care authorities was to make it simpler for veterans, employees, and providers to determine eligibility, and pay to providers more promptly, with less paperwork. The establishment of a mandatory pot of money for the Choice Program, with more than $2 billion in funding, seems to defeat the purpose of the care consolidation legislation.

CAREGIVERS EXPANSION

The budget for FY'18 shows the Caregivers program cost estimate decreased by $235.9 million due to a revision in the projected number of caregivers receiving stipend payments. VA dis-enrolled 7,000 caregivers earlier this year. VVA was stunned to hear that these dis-enrollments were seemingly haphazard and conducted in an effort to bring down the cost of the program. While the Secretary committed to do a look-back on some 300 cases to evaluate the accuracy of the actions of those in the field, the review has been extended for six weeks as he juggles priorities. There still has been no commitment to do a "look back" on all 7,000 cases, which VVA believes is demanded by simple justice. We, and you, must continue to monitor the progress of review and its outcome.

As we testified on March 9, 2017, we will work with legislators to enact a bill that encompasses qualified caregivers of veterans who served before 9/11. We are aware that this is a relatively expensive program. However, it is a bargain when compared to the cost of caring for many of these same veterans in an institutional setting.

NATIONAL CENTER FOR PTSD

VVA strongly supports the Center (NCPTSD), which leads the Nation (and indeed the world!) in research focused on war-induced PTSD and related mental health illnesses, and serves as the Nation's front-line resource center for information and education about PTSD research, not only for the VA and other mental health professionals, but for affected families and the general public. A strong and independent NCPTSD is essential.

MENTAL HEALTH

VVA also supports additional funding for the development and implementation of scientific, evidence-based, integrated psychosocial mental health programs, substance abuse recovery treatment programs, and suicide-risk assessment programs for all veterans, especially since Secretary Shulkin has publicly stated that veteran suicide is the VA's top clinical priority.

MEDICAL AND PROSTHETIC RESEARCH

VVA notes that the funding for Medical and Prosthetic Research for the 2018 budget request suffered a decrease of over $30 million. VVA has strong reservations concerning this decrease and recommends instead a significant increase instead. VA's research program is distinct from that of the National Institutes of Health in that it was created to respond to the unique medical needs of veterans. In this regard, it should seek to fund veterans' pressing needs for breakthroughs in addressing hazardous environmental exposures, post-deployment mental health issues, TBI, long-term care service delivery, and prosthetics to meet the multiple needs of the latest generation of combat-wounded veterans.

We respectfully thank you for the opportunity to present our views, and will be pleased to respond to any questions you might want to put to us.

Chairman ISAKSON. Thank you for your testimony.

I do not have a question. I have a proposition for you, though. I would like to find a time—and I would like my staff to listen to this—find time you and I could have lunch 1 day in the next 3 weeks or month because you piqued an interest in my mind. Your comments about the IU earlier, unemployment compensation recommendation, which is a nonstarter with you, and I think anybody else would tell you that is pretty much a nonstarter too. It is not hard to pass benefits. It is hell to take them back, and once you pace past them, you are not going to take them back, or if you do, you lose a lot more than what you get.

I also heard the comment, I think Mr. Acosta may have referred to his organization. Somebody did. Mr. Fuentes may have, about the COLA round-down. There are lots of things out there that over the period of years of the Veterans Administration and its existence and benefit existence and health care, where times have changed, things have changed. We probably ought to look at everything that we have out there, because there may be some pearls of wisdom. There may be some benefits in the scheme of things that are going to help us a lot more, applied a different way today than they were when they were passed. We need some folks who do not have any agenda except to help our veterans and solve our problems rather than going to court, to sit down and talk.

I will call you, and we will have that lunch.

Mr. ROWAN. I would love to.

Chairman ISAKSON. I am not avoiding you, Mr. Acosta or Mr. Fuentes. Bigger than everybody, I am not going to avoid him or Mr. Blake either. You made the comment that piqued the interest, so we will do that, because I think if we open a little one-on-one dialog, there may be in some of these things that we bring up, because staff brings them to us or the OMB brings it up or your organization. You are looking out for the best interest to your organization and its members, and I appreciate that. I serve them as a master, but I also serve the taxpayers as a master and other people. We ought to start having some meetings and talk some of this stuff through. We may end up finding no common ground anywhere; yet, we might find some pearls of wisdom. If we do, I would love to work with you and anybody else on doing that. We will try to set that up, Mr. Rowan.

Senator Sanders.

Senator SANDERS. Thanks, Mr. Chairman.

I should have known, but I had thought that we got rid of this round-down thing finally. I have been hearing about it probably from my first day in Congress. I was Chairman. We got rid of it. The idea of nickel-and-diming veterans did not seem a lot—so what you are telling me, Mr. Acosta or Mr. Fuentes, it is back again?

Mr. FUENTES. Yes, sir. Thank you very much for your leadership while you were Chairman of this Committee by really eliminating that COLA round-down or that practice.

Now the President's proposal, as Carl laid out, proposed to reinstate the COLA round-down as a way to pay for expansion of the Choice Program as a mandatory program.

Senator SANDERS. So, this is actually taking money away from VA benefits and using it in another purpose. How much would

this—if this were implemented, how much would it cost veterans? Anyone know?

I think, Mr. Acosta, you mentioned.

Mr. ACOSTA. Yes. The cumulative effect of this proposed tax would cost beneficiaries close to $2.7 billion.

Senator SANDERS. Over what? A 10-year period?

Mr. ACOSTA. Over 10 years.

Senator SANDERS. Wow. All right.

Mr. Chairman, I do not think we should be nickel-and-diming veterans. I mean, we have been through this for years. I thought we got rid of it, and it is sad to see that it is coming back.

Let me ask what I think is the elephant in the room, and that is the concern—and I know the numbers seem to be disputed and not quite the clarity we would like; but, the increase in appropriations for the Choice Program and the very, very modest increase for traditional VA care. Who wants to comment? Is that a concern of you guys? Mr. Blake, is that a concern? We will start with you.

Mr. BLAKE. Well, I think one of the concerns is—and the Secretary sort of addressed this in his comments. There were a lot of talks about our marriages and checkbooks. I think the bottom line is we believe that all of the Community Care should be streamlined under one authority, one account, and manage it that way.

I think I understand why they put Choice over here on the mandatory side. There are a number of reasons, things like discretionary caps that are holding down discretionary spending that place that at risk, but from the *Independent Budget* perspective, we believe they are still shorting even the larger discretionary pot. The differences for construction, in particular, which are tremendous, and when you take into account that outside of the health care accounts, virtually every other line item in the VA's budget takes a reduction of some type——

Senator SANDERS. Right, right. Let me get other comments, if I could.

Anybody else want to comment?

Mr. ACOSTA. Well, I concur with Mr. Blake.

Senator SANDERS. OK.

Mr. FUENTES. I would also just like to add, this whole notion of having a mandatory program and discretionary issues and not being able to transfer, I think it is more about, as Carl said, having one checkbook instead of requiring VA to have to balance both.

Ultimately, you are absolutely right, Senator. We cannot forget the need to invest in VA's ability to provide direct care, hire more physicians, expand facilities, because, ultimately, that is the preferred choice of veterans, and we need to continue that.

Senator SANDERS. John?

Mr. ROWAN. Yeah, I would just like to add, look, I have studied privatization. I worked for the city of New York as a manager for 26 years and the last 2 in the City Council in the Controller's office looking at all of those kinds of programs. I watched them privatize all kinds of things that never worked, because once you go outside and privatize, you are adding layers of bureaucracy and cost. You are not going to give it—you are not going to a doctor. You are going to a plan. The plan is going to be administrated by somebody who is making $2 million a year, and thank God our VA people are

not paid that much. They maybe should be, as I will tell you in my hospital care that I got at the VA Manhattan Hospital. But, that is not what we should be doing.

Senator SANDERS. OK. Let me ask you for your very brief thoughts on a crisis that is impacting Vermont, NH, and the whole bloody country, which is this opioid epidemic. My impression is that the VA is trying to do the right thing. What are your thoughts on that? Who wants to jump in there? Mr. Fuentes?

Mr. FUENTES. It is certainly an epidemic that must be addressed. We hear about anecdotes where veterans are being overmedicated.

One of our concerns, though, I think would be the reverse as well because what we have heard is cutting off veterans without proper alternatives, and we certainly do not want that either. We do not want an overcorrection, but we do want to eliminate overmedication.

Senator SANDERS. Other thoughts?

Mr. ACOSTA. I agree.

Senator SANDERS. OK. Mr. Chairman, thanks very much.

Chairman ISAKSON. Thank you, Senator Sanders. I want to again thank all our VSO members for coming. I know when you go after the big guy and he testifies and we take 2 hours grilling him and then everybody is gone and you are stuck with me and the Secretary, which I want to commend the Secretary for staying through both panels. We really appreciate it. Your words are heard. We appreciate your input. We look forward to working with you toward providing the benefits that are earned and deserved for our veterans and doing it in the most efficient way possible for the taxpayer. That is our ultimate goal as a Committee.

We thank you very much for your attendance today. The record will stay open for 7 days for any additional information you may want us to have. Now this Committee meeting stands adjourned.

[Whereupon, at 4:39 p.m., the Committee was adjourned.]

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOHNNY ISAKSON TO HON. DAVID J. SHULKIN, M.D., SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

INFORMATION TECHNOLOGY

Question 1. One of the Department of Veterans Affairs' (VA) motivations in moving to Cerner for the VA Electronic Health Record was the speed with which VA will be able to implement this solution. Please provide the Committee a broad timeline of VA's expectations in implementing the new system.

a. How is VA planning to utilize the Department of Defense to learn from their experience implementing a large information technology (IT) acquisition?

Response. VA is judiciously balancing the speed of implementation with risks to cost, schedule and performance objectives, and of course the care of our Veterans and other beneficiaries. VA has been working closely with DOD and ensuring alignment with commercial implementation best practices to optimize our prospective schedule. VA will be looking to go faster as our learning increases, and change management, training, and governance strategies take hold in support of greater deployment/implementation efficiencies. As an additional barometer of how aggressive VA is in their plan, DOD is deploying over a 7-year period under its 10-year contract with less than one-third of the size and substantially less complex than VA. VA will assess our full deployment (FD) strategy upon completion of Initial Operating Capabilities (IOC) roll-out over the first 18 months, and incorporate schedule efficiencies as warranted.

b. How much additional funding does VA anticipate requesting for the transition of Electronic Health Records?

Response. The VA requested to transfer $782 million in FY 2018 to implement the EHRM contract, PMO efforts and support infrastructure.

c. Given the large number of ongoing IT contracts that VA has, how does VA plan to evaluate the current projects to determine if they are necessary after the transition to Cerner?

Response. As part of the overarching EHRM effort, the Veterans Health Administration (VHA) and the Office of Information and Technology (OI&T) are evaluating health IT and related area projects and contracts currently underway to determine which efforts should continue, be paused, modified or canceled.

d. From an acquisition standpoint, does VA have the ability to modify contracts post-award, based on internal preferences, to change out solution components or team members that were selected under specific Request for Proposal criteria?

Response. Yes. This is a firm-fixed price contract with clearly delineated and discrete deployment schedules, timelines, and milestones. Though there are no "built-in" penalties, the VA Contracting Officer and Program Management Office (PMO) are authorized to withhold payments for failure to perform contracted services or deliver contracted capabilities in accordance with the terms and conditions of the contract. The issuance of task orders will be judiciously managed to ensure excessive risk to the achievement of cost, schedule and performance objectives is not injected into the EHR modernization portfolio.

e. If so, how does that affect liability and the burden of risk in the underlying contract? Do changes post-award shift the burden of risk from the prime contractor and team that was selected over to VA since the modification was made after the contract and terms were already awarded?

Response. Post-award contractual changes may shift the burden of risk; however, since task orders are intended to stay within the general scope of the basic contract, VA should be protected against liability claims. Moreover, and as detailed above, since VA does not intend to mandate the use of a specific product, partner or methodology in order to meet contractual requirements, it will be further protected against liability claims. If the use or incorporation of a particular product or methodology is required, then the parties will work toward a bilateral agreement whereby the prime contractor will maintain the burden of risk and the adherence to the requisite performance parameters.

f. How does VA plan to address elements such as time or cost overruns and increased protests due to requirements changes post-award, thus impacting the ability to provide timely solutions to our veterans for improving healthcare services?

Response. VA is already operating on the Veterans Health Information Systems and Technology Architecture (VistA) platform delivering the requisite capabilities. In the event of a protest, VA will continue to utilize the VistA platform to support Veterans until a protest is formally adjudicated. The indefinite delivery and indefinite quantity (IDIQ) type contract and site surveys in advance of deployment will support the identification of issues that could cause scope creep or negatively impact schedule in advance of committing resources.

CONSTRUCTION

Question 2. VA's testimony submitted for the hearing highlights VA's participation in the White House Infrastructure Initiative to explore ways to modernize and obtain upgrades to VA's real property portfolio. Please provide additional details on VA's participation in this initiative and the process VA is using to examine its real property portfolio.

Response. VA is participating in the White House Infrastructure initiative, and is working with the Office of Management and Budget (OMB) to explore methods to enhance the delivery of high quality care and services for Veterans in VA facilities. The Department will continue to keep Congress informed as the Infrastructure Initiative evolves.

Question 3. The fiscal year 2018 budget request includes $255 million for construction of six cemetery projects.

a. In terms of locations across the country and types of interments, please describe some the most immediate priorities for increasing veterans' access to National and State veterans cemetery options.

b. What would those needs be over the next decade if this funding request for expansion in fiscal year 2018 is provided?

Response. The National Cemetery Administration (NCA) administers burial and memorial benefits to Veterans and eligible family members worldwide. Currently, VA operates and maintains 135 national cemeteries in 40 states, and Puerto Rico, and is in the process of establishing new cemeteries. VA has also funded the establishment, expansion, or improvement of 105 state and tribal Veterans cemeteries in 47 states, Guam, and the Northern Mariana Islands (Saipan), through the Veterans

Cemetery Grant Program (VCGP). Combined, these cemeteries provide burial options to approximately 91.7 percent of the total Veteran population in all 50 states, Puerto Rico, and the U.S. Island Areas.

NCA's near term focus is establishing congressionally approved and planned cemeteries, increasing availability of state and tribal Veterans cemeteries, and keeping existing national cemeteries open through expansion.

New burial policies approved by the Congress in 2011 and 2013 support NCA's Long Range Plan for 18 new national cemeteries—including in urban and rural locations. Additionally, VA is establishing five new columbarium-only cemeteries to enhance burial access for approximately 2.4 million Veterans residing in densely populated areas. Moreover, NCA is improving burial access for Veterans residing in sparsely populated rural areas not meeting the criteria for new national cemeteries, and which are unlikely to receive a grant for a state Veterans cemetery. Eight such identified locations will serve an additional 133,000 Veterans.

Four of the 18 new cemeteries have already opened at Yellowstone County, MT (2014); Cape Canaveral, FL (2015); Tallahassee, FL (2015); and Omaha, NE (2016). NCA plans to open the remaining 14 (listed below) by 2021 at which point over 3 million Veterans and their families will have new access to burial options.

City	State	Uniquely Served Veterans within 75 Miles*	Type Interments
Cities with at least 80,000 Unserved Veterans within a 75 Mile Service Area			
Colorado Springs	Colorado	278,137	All Burial Options
Western New York (Buffalo)	New York	87,538	All Burial Options
Cities Targeted for Rural Initiative			
Twin Falls	Idaho	12,789	All Burial Options
Machias	Maine	3,381	All Burial Options
Elko	Nevada	4,964	All Burial Options
Fargo	North Dakota	24,855	All Burial Options
Cedar City	Utah	15,904	All Burial Options
Rhinelander	Wisconsin	19,109	All Burial Options
Cheyenne	Wyoming	17,103	All Burial Options
Cities Targeted for Enhanced Service (Urban Initiative)			
Los Angeles	California	539,163	Columbarium only
San Francisco	California	444,434	Columbarium only
Chicago	Illinois	557,861	Columbarium only
Indianapolis	Indianapolis	250,245	Columbarium only
New York	New York	782,139	Columbarium only

* The Veteran populations cited above are based on the Vet Pop 2016 model.

VA also helps fund new or expanded state and tribal Veterans cemeteries through the VCGP. NCA currently has no plans to establish more national cemeteries beyond the planned 18, but is committed to providing reasonable access to burial options through VCGP grants for state and tribal Veterans cemeteries. In total, we anticipate that by the end of 2018, 92.3 percent of the total Veteran population (over 20 million Veterans) will have access to burial options in national, state or tribal Veterans cemeteries, within 75 miles of their home. Shown below is a list of planned expansion and establishment VCGP projects funded through FY 2018.

2017 Grants for Construction of State Veterans Cemeteries

Cemetery	State	Type of Grant
Rocky Gap	Maryland	Expansion
Knoxville-2	Tennessee	Expansion
Higginsville	Missouri	Expansion
King	Wisconsin	Expansion
Springfield	Montana	Expansion
Middletown	Connecticut	Expansion
Hopkinsville	Kentucky	Expansion
Milledgeville	Georgia	Expansion
Radcliff	Kentucky	Expansion

2017 Grants for Construction of State Veterans Cemeteries—Continued

Cemetery	State	Type of Grant
Gallup	New Mexico	Establishment
Cass Lake	Minnesota	Establishment
Fort Yates	North Dakota	Establishment
Middle town	Connecticut	Operations and Maintenance
Maui	Hawaii	Improvement
Lanai	Hawaii	Improvement
Killeen	Texas	Improvement
Mission	Texas	Improvement
Hilo II	Hawaii	Improvement

2018 Grants for Construction of State Veterans Cemeteries

Cemetery	State	Type of Grant
West Hawaii	Hawaii	Expansion
Spanish Fort	Alabama	Expansion
Garrison Forest	Maryland	Expansion
Spring Lake	North Carolina	Expansion
Black Mountain	North Carolina	Expansion
Killeen	Texas	Expansion
Suffolk	Virginia	Expansion
North Little Rock	Arkansas	Expansion
Boscawen	New Hampshire	Expansion
Saipan	Northern Mariana Islands	Expansion
Jennings	Louisiana	Establishment
Angel Fire	New Mexico	Establishment

Existing Cemeteries:

In addition to increasing access through new national and grant-funded cemeteries, NCA maintains access at existing cemeteries through major and minor construction projects to develop additional gravesites and columbaria, or by acquiring more land. Requested funding for these initiatives varies based on projected burial workload and gravesite depletion forecasts. The FY 2018 budget includes $255.9 million in Major Construction funding for gravesite expansion at six national cemeteries, and advance planning and design activities. Gravesite expansion projects at National Cemetery of the Alleghenies, PA; Florida National Cemetery, FL; Abraham Lincoln National Cemetery, IL; National Memorial Cemetery of Arizona, AZ; Sacramento Valley National Cemetery, CA; and Calverton National Cemetery, NY will enable these cemeteries to remain open. Together, these cemeteries provide over two million Veterans with access to burial options. FY 2018 funding will be used to complete master planning, design, and construction in time for necessary modifications prior to the anticipated depletion of burial options, and to avoid a temporary closure at one or more cemeteries.

The FY 2018 request includes $98 million for minor construction projects to develop additional gravesites at existing cemeteries, support the urban and rural initiatives, acquire land, and make infrastructure improvements. NCA relies heavily on minor construction funding to develop additional gravesites for smaller scale projects to keep existing cemeteries open.

The enclosure provides information related to depletion of gravesites for national cemeteries projected to deplete gravesites within the next 10 years. Projects in italics represent those with an immediate need to prevent a burial option from closing. This list does not include gravesite expansion projects that are funded, currently underway, or not projected to deplete within 10 years.

NCA Depletion Rates: Cemeteries Projected to Deplete Within 10 Years and with Expansion Projects

			Last full year of interments with already-in progress expansion projects incorporated				
Cemetery	District	Operating Status	Full Casket (Traditional)	Pre-placed Crypts	In-Ground	Columbaria	* Planned Action
Leavenworth National Cemetery	MW	OPEN	2093	2045	2033	2024	Planned future year gravesite expansion project to mitigate depletion
Marion National Cemetery	MW	OPEN	2066	2023	2023	2028	Planned future year gravesite expansion project to mitigate depletion
Ohio Western Reserve National Cemetery	*MW*	*OPEN*	*2223*	*2024*	*2020*	*2023*	*Planned future year gravesite expansion project to mitigate depletion*
Rock Island National Cemetery	MW	OPEN	2045	2025	2032	2025	Planned future year gravesite expansion project to mitigate depletion
Biloxi National Cemetery	*CN*	*OPEN*	*2028*	*2022*	*2027*	*2027*	*NCA currently evaluating whether to acquire remote annex land or close*
Dallas - Ft. Worth National Cemetery	*CN*	*OPEN*	*2034*	*2024*	*2026*	*2024*	*Planned future year gravesite expansion project to mitigate depletion*
Fayetteville National Cemetery	CN	OPEN	2060	2026	2024	2024	Planned FY18 Minor Construction gravesite expansion project
Ft. Bliss National Cemetery	*CN*	*OPEN*	*2078*	*2023*	*2020*	*2047*	*Planned future year gravesite expansion project to mitigate depletion*
Ft. Gibson National Cemetery	*CN*	*OPEN*	*2065*	*2022*	*2025*	*2030*	*Planned future year gravesite expansion project to mitigate depletion*
Ft. Sam Houston National Cemetery	CN	OPEN	2030	2025	2029	2023	Planned future year gravesite expansion project to mitigate depletion
Ft. Sill National Cemetery	CN	OPEN	2441	2027	2022	2040	Planned future year gravesite expansion project to mitigate depletion
Ft. Smith National Cemetery	CN	OPEN	2148	2025	2023	N/A	Planned future year gravesite expansion project to mitigate depletion
Houston National Cemetery	CN	OPEN	2040	2027	2020	2024	Planned future year gravesite expansion project to mitigate depletion, FY 17 Minor for In-ground Cremains
Louisiana National Cemetery	*CN*	*OPEN*	*2276*	*2024*	*2030*	*2034*	*Planned future year gravesite expansion project to mitigate depletion*
Yellowstone National Cemetery	CN	OPEN	2029	2036	2025	2023	Planned future year gravesite expansion project to mitigate depletion
Ft. Richardson National Cemetery	*PC*	*OPEN*	*2064*	*2023*	*2023*	*N/A*	*Planned future year gravesite expansion project to mitigate depletion*
National Memorial Cemetery of Arizona	***PC***	***OPEN***	***2054***	***2022***	***2023***	***2022***	***FY18 Major Construction Funding Requested***
Roseburg National Cemetery	PC	OPEN	2097	2059	2024	2026	Planned future year gravesite expansion project to mitigate depletion
Sacramento Valley National Cemetery	***PC***	***OPEN***	***2075***	***2025***	***2024***	***2022***	***FY18 Major Construction Funding Requested***
Santa Fe National Cemetery	PC	OPEN	2032	2023	2022	2023	Land acquisition in progress to construct a replacement cemetery near Albuquerque

* Planned Action: remarks in this column reflect NCA operating plans and future projections that are subject to change.
Bold font indicates FY18 Major Construction funding requested. Italic font represents immediate priority to prevent closure of a burial option.

NCA Depletion Rates: Cemeteries Projected to Deplete Within 10 Years and with Expansion Projects

			Last full year of interments with already-in progress expansion projects incorporated				
Cemetery	District	Operating Status	Full Casket (Traditional)	Pre-placed Crypts	In-Ground	Columbaria	* Planned Action
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Ohio Western Reserve National Cemetery	*MW*	*OPEN*	*2223*	*2024*	*2020*	*2023*	*Planned future year gravesite expansion project to mitigate depletion*
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Biloxi National Cemetery	*CN*	*OPEN*	*2028*	*2022*	*2027*	*2027*	*NCA currently evaluating whether to acquire remote annex land or close*
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* Planned Action: remarks in this column reflect NCA operating plans and future projections that are subject to change.
Bold font indicates FY18 Major Construction funding requested. Italic font represents immediate priority to prevent closure of a burial option.

c. What would those needs be over the next decade if this funding request for expansion in fiscal year 2018 is provided?

Response. The enclosure provides information related to depletion of gravesites for those national cemeteries projected to deplete gravesites within the next 10 years. This information includes cemetery names, current operating status, and years in which specific burial options are projected to deplete. The projected depletion dates account for, and assume the completion of current, in-progress gravesite expansion construction projects on schedule. The depletion dates do not account for any potential future gravesite expansion construction projects. Bold highlights are the six cemetery expansion projects included in the 2018 Major Construction request of $255.9 million.

MEDICAL CARE

Question 4. VA's testimony submitted for the hearing indicates that, after becoming the Under Secretary for Health, Secretary Shulkin "discovered that years of ineffective systems and deficiencies in workplace culture led to [the access] problem." While VA has made strides in improving care to veterans, more work is needed.

a. What were some of the ineffective systems and deficiencies that contributed to the access issue?

Response. VA identified several factors that contributed to extended appointment wait times, including:

1. Increased patient requirements for care coupled with inadequate staffing levels of providers, nurses, and schedulers led to inability to keep up with the demand for care;
2. Inefficient clinic practices, lack of adequate training, and complicated legacy software led to high rates of scheduling errors; and
3. Lack of national oversight and local monitoring systems meant access red flags were not responded to in time and proactive strategies were not set in place.

b. What specific changes have been made to improve the system?

Response. Since 2015, VA embarked on its largest access transformation, a major part of which was the *MyVA* Access improvement endeavor. Subject matter experts across VA were sequestered for 4 weeks to identify ineffective systems and deficiencies contributing to VA access shortfalls, standardize national guidance, and implement strong practices. Through *MyVA* Access, VA developed a comprehensive approach toward systemic access improvements. Specific changes related to the aforementioned reasons are as follows:

1. Increased patient requirement for care coupled with inadequate staffing levels of providers, nurses, and schedulers led to inability to keep up with the demand for care.

Provider Recruitment and Productivity: VA prioritized active recruitment of healthcare providers and clinic staff—supported by the Veterans Access, Choice and Accountability Act of 2014. This resulted in increasing provider and nursing staff by approximately 12 percent over the past 2 FYs. Additionally, on January 13, 2017, VA full practice authority went into effect for all Advance Practice Registered Nurses (APRNs). This rule is expected to continue to grow and fill gaps with access coverage. VA also focused on improving productivity for existing providers. By assessing clinical workload by the community standard of work RVUs (work relative value units), VA marked a 13 percent increase in total clinical productivity (wRVUs) produced and an increase in physician productivity, wRVU per clinical full-time equivalents (FTE), of 9 percent from FY 2014 to April 15, 2017.

Utilizing internal resources: VA focused on increasing the use of telehealth for Primary Care and Mental Health. As a result, 12 percent of Veterans (727,000) receiving VA care from obtained 2.18 million telehealth appointments. VA has also expanding telehealth "hubs"—medical centers that easily hire providers to deliver telehealth to another part of the country where a provider shortage exists. As of the end of 2017, VA has nine fully operational hubs in Primary Care and 11 in Mental Health. Additionally, some Veterans Integrated Service Networks (VISNs) have been setting up their own hubs.

VA is also working to implement VA Video Connect, a simplified mobile and web-based application connecting Veterans with providers using encrypted video. It allows Veterans to see and talk to their health care team from anywhere using their smart phone, iPad or desktop computer, making appointments more convenient and reducing travel and wait times. VA is in the process of implementing this across VA.

2. Inefficient clinic practices, lack of adequate training, and complicated legacy software led to high rate of scheduling errors.

Clinic Practice Management: Beginning in early 2016, VA implemented a Clinic Practice Management program at each VA Health Care System based upon private sector and DOD best practices to optimize administrative activities. This program monitors data and oversees timeliness and accuracy of Veteran appointments. Each VA system has at least one Group Practice Manager as well as a Clinic Practice Management team. A user-friendly Clinic Practice Management dashboard allows the Group Practice Managers as well as facility leadership to monitor clinic activities. This dashboard includes scheduling performance data down to each individual scheduler.

Scheduler Training: VA recognized its scheduler training in the past was ineffective. To reduce scheduling errors, VA enhanced its training and identification of scheduling error warning signs. In December 2016, VA commenced system-wide mandatory face-to-face scheduler training, including hands-on supervised practice scheduling sessions. All newly hired schedulers must successfully complete this training. Over 30,000 schedulers have completed the training.

Scheduling Directive: Revisions and clarifications on national guidelines were included in VHA Directive 1230, Outpatient Scheduling Processes and Procedures, published on July 15, 2016. VA completed over 70,000 episodes of directive-related training for over 50,000 staff who schedule appointments. Using Lean methodology, VA is also in the process of simplifying the scheduling process, which was initiated based upon input from front-line staff including schedulers. This is expected to result in a simplified update to scheduling and consult directives.

VistA Scheduling Enhancement: Using 1980's technology, VA's current scheduling system is inefficient, results in scheduling errors, and creates barriers to optimize clinician productivity. Until the time a comprehensive resource-based scheduling system can be deployed VA is implementing VistA Scheduling Enhancement (VSE) as an interim solution. This improved user interface makes it easier to view available appointment times and reduces entry errors. The VistA Scheduling Enhancement has been implemented in 97% of facilities within VA.

3. Lack of national oversight and local monitoring systems meant that red flags were not responded to in time.

New National Establishments: The Office of Veteran Access to Care, a national level program office, was created in 2016. The office provides oversight and direction for policy and operations for optimization of Veteran access to health care. This office is led by an executive-level Assistant Deputy Under Secretary for Health for Access to Care who directly reports to the Deputy Under Secretary for Health for Operations and Management, and also has a platform for interaction and feedback with the Secretary, Deputy Secretary, Under Secretary for Health and Principal Deputy Under Secretary for Health.

VA established a Health Improvement Center to track trends in quality, safety, access, and Veteran experience across multiple indicators. Sites that display anomalies or unfavorable trends are contacted and, where it is determined sub-par performance exists, the new Office of Reporting, Analytics, Performance Improvement, and Deployment, within the VHA Office of Organizational Excellence, mobilizes a team of experts to visit the site and provide on-site training and consultation, with follow-up to assure that progress is made.

Scheduling Triggers and Audits: Using advanced statistical techniques, Scheduling Triggers were implemented as an early warning sign to alert leadership about inconsistencies with scheduling procedures and timeliness of care. Additionally, a mandatory standardized Supervisory Audit Tool was implemented June 1, 2017 to ensure every scheduler is audited at least twice annually. Audit results lead to direct feedback and coaching of individual schedulers, and is used by Facility, VISN and National leadership to ensure compliance, and assist with identifying opportunities for improvement.

4. Additional Improvements to improve access.

Timely Care: VA has made it a priority to focus on ensuring that the urgent care needs of Veterans are met in a timely manner. VA held two stand downs in November 2015 and February 2016 to reduce backlogs and ensure Veterans with urgent needs received timely care. Additionally VA worked to deliver same-day services for Primary Care and Mental Health. As of December 31, 2016, same-day services were achieved at all VA medical centers and as of November 2017, same day services is now available at the more than 1000 outpatient clinics across VA.

VA also standardized processes to ensure new referrals to specialists are screened for urgent needs. In FY 2014, the average time it took to complete the most urgent

referrals to a specialist was 31.3 days. As of December 2017, the average time was 2.6 days. In support of the focus on urgent consults, VA instituted a weekly national consult management call whereby scheduling experts provide technical assistance to the field to ensure the timeliness of scheduling. The calls commenced in 2015 and have become a driving force supporting timely scheduling and completion of urgent consults.

To ensure the timely follow-up care for Veterans with urgent needs, in December 2016 VA implemented a process for providers to indicate priority level for follow-up appointments to ensure that Veterans' timely follow-up needs are met. Providers flag these time-sensitive appointments in the return to clinic order to signal the scheduler to arrange for the follow up appointment no later than the provider recommended date. Since implementation through the end of FY 2017, 128,000 time-sensitive appointments were completed across VA and of those about 90 percent have been completed by the provider recommended date. Over the first 3.5 months of FY 2018, almost 80,000 such appointments have been completed and of those, 94.8% have been completed by the provider recommended date.

Veteran Control: VA is working to empower Veterans to schedule the care they need. The Veterans Appointment Request App enables Veterans to schedule or cancel Primary Care appointments, and has been deployed to 1 14 sites since January 2017. VA also instituted Direct Scheduling allowing Veterans to request routine audiology, optometry, and nutrition appointments without having to obtain a referral from a Primary Care Provider. This not only decreased the wait time for services, it freed up primary care capacity. VA is working to expand Direct Scheduling options to podiatry, prosthetics, wheelchair, screening mammography, smoking cessation, and weight management appointments as well.

Access and Quality in VA Healthcare website: In April, VA launched the "Access and Quality in VA Healthcare" website at www.accesstocare.va.gov to promote transparency. Through this tool, Veterans, their families, and caregivers can view data related to:

- Patient wait times at VA facilities in their area;
- Veterans experiences scheduling primary and specialty care;
- Available options for same day services; and,
- Quality of healthcare delivered at every medical center.

Question 5. The fiscal year 2018 budget request estimates a reduction in medical care collections for fiscal year 2017 and fiscal year 2018. Please explain in detail what factors contributed to this estimated decrease in collections.

Response. There are several key factors that contribute to the stable/declining collections estimate for 2017 and 2018:

1. *Tiered Medication Copayments:* Effective February 27, 2017, VA amended its regulations governing copayments for certain Veterans for medication required on an outpatient basis to treat non-service-connected conditions. Prior to this change, the medication copayment was $8 per fill for Veterans in Priority Groups 2—6 with an annual out of pocket cost cap of $960. For Veterans in Priority Groups 7 & 8, the medication copayment was $9 per fill and there was no out of pocket cost cap. Under current policy, per fill copayments are $5 for Tier 1 medications, $8 for Tier 2 medications, and $11 for Tier 3 medications; with an annual out of pocket cost cap of $700 applicable to Priority Groups 2—8. Under the revised regulations, the average copayment per prescription is less than in the past. Thus, VA estimates collections for these pharmacy copayments will be lower in 2017 and into the future.

2. *Third Party Collection or Recovery:* Changes in the healthcare landscape have caused payers to adjust rates and/or reimbursement methodologies to minimize expenditures. 38 CFR 17.101 permits health plan contracts to pay billed charges or the amount they would pay for care or services furnished by providers in the same geographic area. Historically, many health plan contracts paid VA 100 percent of billed charges or above market rates. During the last six months of 2016, five large payers reduced reimbursement rates, or requested a decrease to align VA with what they are paying other providers in their respective markets. Additionally, VA has been tracking six payers identified as being at "high risk" for reducing payments based upon high reimbursement rates. These payers may request reductions in reimbursement rates with 30 to 120 days' notice.

Additional factors: VA's Third Party reasonable charges are projected to decrease in CY 2017 by an average of 3 percent, which translates to a negative impact on collections; in particular for payers reimbursing on a percent of charge basis. Pursuant to 38 CFR 17.101, outpatient charges are calculated at the 80th percentile of various data sources such as Fair Health, MarketScan and Medpar for the Centers for Medicare & Medicaid Services (CMS)/Medicare data. In 2017, VA experienced a decrease in outpatient charges as a result of decreased charges in the Fair Health

data as well as decreased charges for Durable Medical Equipment (DME) in the CMS data.

EDUCATION

Question 6. One of VA's priorities is to improve timeliness of service, and VA has made it a goal to fully automate claims for veterans' education benefits and consolidate outdated enrollment certification systems. This would produce faster decisions, reduce labor and administrative costs, and improve accuracy of claims. Is the decision to postpone this development due to a lack of IT resources or are there other practical considerations for waiting?

Response. VA is prioritizing the retirement and replacement (when warranted) of its legacy information technology systems due to the increased cost, risks with maintaining these systems, and the need to modernize our business processes to improve service delivery. For example, the Benefits Delivery Network (BDN) is the claims processing, payment, tracking, and disposition system used for education programs but consists of antiquated mainframe systems and is in need of replacement. VA is currently working on a solution to address its enterprise IT challenges, and is prioritizing accordingly to ensure that replacement systems meet the needs of all users and Veterans. Once these systems are replaced VA can redirect its focus on newer systems. For example, enhancing the Long Term Solution to provide functionality such as automated certificates of eligibility for original claims; electronically generated letters; expanded automation of supplemental claims; issuance of advance payments; monthly certification of attendance; and improved business analytics for reporting purposes.

APPEALS

Question 7. At the hearing, Secretary Shulkin testified that VA would need an additional $800 million in order to address the 470,000 legacy appeals.

a. Please provide copies of the modeling data and assumptions used in reaching that conclusion.

Response. VA is committed to addressing the pending inventory of legacy appeals. Since the Secretary's testimony, several enhancements to VA's appeals process have influenced the assumptions VA uses to inform resource decisions. Following enactment of the Veterans Appeals Improvement and Modernization Act on August 23, 2017 VA immediately began implementation. By February 2019, all requests for review of VA decisions will be processed under the new, multi-lane process. VA is also continuing work to address the pending inventory of legacy appeals through an approach that focuses resources on legacy appeals processing while also allowing Veterans to enter the new appeals system.

VA established a new program on November 1, 2017, the Rapid Appeals Modernization Program (RAMP), to provide those Veterans who are waiting on the legacy appeals process, an opportunity for early participation in the new system. The administration of RAMP allows VA the opportunity to quickly resolve legacy appeals and to test certain facets of the new appeals system. VA will refine the new system based upon actual data prior to full implementation. VBA will direct appeals resources to maintain RAMP claims processing within prescribed timeliness goals as well as continue to process legacy appeals.

VA will also utilize the legal authority for Veterans who receive Statements of the Case or Supplemental Statements of the Case after the effective date of the legislative change to elect to participate in the new system and transition from the old process.

Once the new system is implemented, VA intends to allocate resources in an efficient manner that will establish timely processing, and utilize all remaining appeals resources to address legacy appeals. The Board will focus its resources on its core mission and will work to maximize efficiencies in appeals processing, to include technological and process improvements. This will enable the Board to also meet timeliness goals in the new system and devote all remaining resources to processing legacy appeals.

The rate at which the legacy appeals inventory can be resolved is dependent on a number of factors, including the rate of election into the new framework process of claimants with appeals pending in the legacy system. As VA gathers data, and creates a forecasting model based upon actual Veteran behavior and employee productivity, this will inform resource needs and help establish achievable goals and milestones for reducing the number of pending legacy appeals, including the expected number of appeals, remands, and hearing requests at VBA and the Board.

b. Please explain what steps VA has taken or will take to identify or secure any resources necessary to address the backlog of legacy appeals.

Response. VA remains committed to reducing the pending inventory of legacy appeals as quickly and efficiently as possible. In January 2017, the Veterans Benefits Administration (VBA) realigned its appeals policy and oversight of its national appeals operations under a single office, the Appeals Management Office (AMO). This realignment allows VBA to focus on internal people, process and technology appeals initiatives, and implementation of the appeals reform legislation. Under this realignment, VBA's appeals productivity through May 31, 2017, has increased by 32 percent over FY 2016 production during the same period.

Question 8. According to the fiscal year 2018 budget request, the Board of Veterans' Appeals (Board) had 660 employees in fiscal year 2016, expects 886 employees in fiscal year 2017, and requests 1,050 employees for fiscal year 2018. The budget request also reflects that the Board issued 52,000 decisions in fiscal year 2016, expects to issue nearly 66,000 decisions in fiscal year 2017, and expects to issue over 80,000 decisions in fiscal year 2018.

a. As of March 2017 (half way through the fiscal year), the Board had issued about 19,000 decisions. Is the Board still expecting to issue over 66,000 decisions in fiscal year 2017? If not, please outline the factors that have contributed to not meeting that target and how many decisions the Board now expects to issue during fiscal year 2017.

Response. The Board is committed to its mission to hold hearings and decide appeals for Veterans and their families. Unfortunately, due to a variety of reasons, the Board did not meet its FY 2017 goal. There were a number of contributing factors, to include, hiring falling short of goals; the impact of revised attorney performance standards; time spent training and mentoring new attorneys; time attorneys spend on FMLA/leave and on official time; outdated technology; complexity of cases; and Veterans Benefits Management System user difficulties. As of June 25, 2017, the Board issued 32,598 decisions. compared to the 37,490 that it had issued during the same time period in the prior fiscal year. As more Board attorneys complete training and become fully productive, the Board projects increased productivity in the remaining weeks of FY 2017. We anticipate that the Board will decide at least 50,000 appeals by the end of FY 2017.

b. In a June 8, 2016, memorandum to stakeholders about appeals reform, VA noted as a risk factor that "staffing ramp at the Board is steep and challenging." What challenges has the Board faced since 2016 in hiring additional employees; what steps is the Board taking to address those challenges; and what impact has that hiring had on overall productivity at the Board?

Response. In FY 2017, Congress provided an additional $45.7 million to the Board to facilitate hiring additional personnel. To support the Board's aggressive hiring in FY 2017, the Center of Excellence Pilot Program for hiring legal professionals was established with VA's Office of Human Resources and Administration (HRA). The Board made great progress in hiring early in FY 2017, consistent with the budget, but was slowed by the hiring freeze. On March 13, 2017, the Secretary approved exemptions for eight occupations directly involved in appeals processing. Since that time, the Board resumed its aggressive hiring plan and, as of June 29, 2017, the Board had 882 FTEs employees on board, compared to 667 FTEs at the start of FY 2017. Additionally, the Board is in the process of filling approximately 100 additional attorney positions, as well as other key vacancies. As more Board attorneys completed training and became fully productive, the Board projected an increased productivity in the remaining weeks of FY 2017. At the end of FY 2017, the Board issued 52,661 appeals decisions.

c. Would the Board expect to encounter similar difficulties in hiring an additional 164 employees during fiscal year 2018? If so, please outline what steps would be taken to mitigate those risks.

Response. The Board does not anticipate difficulties in hiring additional employees during FY 2018. The Board has worked successfully with the Center of Excellence to on board over 200 new attorneys in FY 2017 to date. Based on this proven ability to hire and on board a large number of new employees, the Board does not anticipate difficulties in hiring additional employees in FY 2018. We plan to continue to work closely with HRA to accomplish our hiring objective.

d. When would the Board expect to realize an overall increase in productivity as a result of employees hired during fiscal years 2017 and 2018?

Response. The Board has a 6-month period during which new attorneys receive training and develop the necessary skills to effectively produce quality decisions in a timely manner. Therefore, new Board attorneys are not fully productive until after they have completed their 6-month training period. The Board anticipates that we will see incremental increases in productivity as new employees complete this training period. We would project all employees to be fully productive 6 months after we

complete our FY 2018 hiring plan. Notably, while Board attorneys are on production after 6 months, most cannot handle and are not given the most challenging cases until their 2-year point.

e. What steps—other than hiring new employees—is the Board taking to improve overall productivity; what is the cost of each such initiative; and what impact is each such initiative expected to have on productivity?

Response. The Board is committed to improving productivity. The Board is modernizing appeals processing technology to optimize efficiency to best serve Veterans and their families, and to ensure the seamless transfer of appeals between jurisdictions by leveraging industry best practices and Human Centered Design principles. The Board is fortunate to have Digital Service at VA (DSVA) leading the technical approach to this effort. Specifically, DSVA is developing several attorney-specific tools, including a document review tool for claims file review; a Decision Builder; and eFolder Express, providing a one-click download of the eFolder. These tools are intended to assist decision-writing attorneys in reviewing the record and drafting decisions more efficiently. The Board revised its attorney performance standards in October 2016. After using these standards for one quarter and evaluating their effectiveness in enabling the Board to meet its mission, the standards were revised again, effective January 15, 2017. The Board continually monitors performance, and during FY 2017 was in negotiations with the union about revising the attorney performance standards, to best position the Board to meet its goal of deciding appeals. As a result, new standards went into effect at the start of FY 2018. There are no anticipated additional costs to the Board for the technological changes being developed by DSVA, because their development work is ongoing and all funding for these changes is covered by the existing Appeals Modernization budget.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JON TESTER TO HON. DAVID J. SHULKIN, M.D., SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 9. Does this budget allow for VA to accommodate those Veterans who are currently not enrolled in VA care but who may lose their other health insurance if Obamacare is repealed?

Response. Any impacts on Veterans or VA would depend on the specific changes to the Affordable Care Act enacted by Congress.

Question 10. I am concerned that the President has not accurately projected in-house demand for health care services. Can you explain the utilization and reliance projections for FYs 18 and 19? Please also provide data showing budget projections and actual utilization and reliance statistics for FY 2013, 14, 15, 16, and 17 (as available).

Response. The following information on utilization and reliance is from the 2017 VA Enrollee Health Care Projection Model (EHCPM), which supported VA's 2018 Budget. The table below shows historical and projected annual change in utilization for ambulatory and inpatient services as modeled using the EHCPM. It separately shows data for Veterans eligible for the Choice Program based on the 40-mile distance criterion.

- Utilization in VA facilities and of community care increased significantly from FY 2013 to FY 2014, in part due to VA capacity issues that led to passage of the Veterans Access, Choice, and Accountability Act of 2014 (Choice Act).
- Choice Act funding helped VA sustain growth in community care from FY 2013 to FY 2014 and continue growth into 2015.
- From FY 2015 to FY 2016, utilization of community care increased significantly for Choice Program eligible Veterans based on residence. Utilization by eligible Veterans based on other criteria also increased but to a lesser extent.
- The historical and projected decline in total inpatient days is due to a number of factors, including transition of inpatient care to ambulatory facilities (a general trend in health care across the Nation), VA's efforts to reduce avoidable in VA's management of inpatient care, and changes in the enrollee demographic mix.

Annual Growth for Ambulatory Work RVUs[2]

FY[1]	All Care			40-Mile Only[3]			Non-40-Mile Only		
	Community Care	VA Facility	Total	Community Care	VA Facility	Total	Community Care	VA Facility	Total
2010									
2011	0.0%	3.2%	2.9%						
2012	2.7%	4.6%	4.4%						
2013	6.2%	2.8%	3.2%						
2014	21.7%	6.2%	7.8%						
2015	3.2%	5.5%	5.2%						
2016	9.5%	3.0%	3.7%	34.9%	11.4%	16.1%	5.6%	2.3%	2.7%
2017	14.8%	3.6%	5.0%	67.1%	3.3%	18.2%	4.6%	3.6%	3.7%
2018	14.3%	3.8%	5.2%	45.3%	3.6%	17.3%	4.6%	3.8%	3.9%
2019	13.7%	3.7%	5.2%	35.0%	3.6%	16.4%	4.5%	3.7%	3.8%

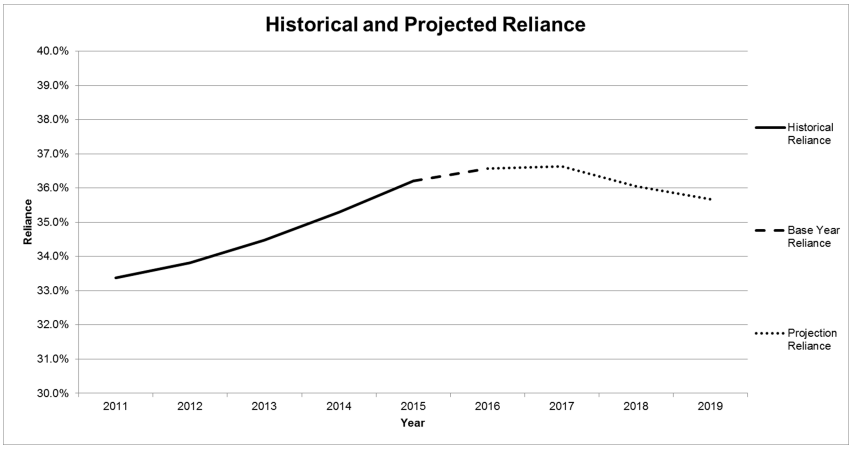
Annual Growth for Inpatient Days

FY[1]	All Care			40-Mile Only[3]			Non-40-Mile Only		
	Community Care	VA Facility	Total	Community Care	VA Facility	Total	Community Care	VA Facility	Total
2010									
2011	14.6%	-1.7%	-0.4%						
2012	10.9%	-3.3%	-2.0%						
2013	2.5%	-1.3%	-0.9%						
2014	6.8%	1.0%	1.6%						
2015	12.0%	-2.0%	-0.4%						
2016	15.9%	-5.4%	-2.6%	32.3%	11.6%	15.9%	14.3%	-6.3%	-3.7%
2017	7.4%	-0.3%	0.9%	64.8%	-1.3%	14.5%	1.1%	-0.2%	0.0%
2018	6.4%	-1.1%	0.1%	42.1%	-1.6%	13.4%	0.0%	-1.1%	-0.9%
2019	6.5%	-1.8%	-0.3%	32.1%	-1.8%	12.8%	0.0%	-1.8%	-1.5%

1) Projections for FY 2017 through FY 2019 reflect the assumptions supporting the FY 2018 budget
2) Based on 2015 Essential RBRVS. Excludes Mental Health to remove impact of CPT definition changes
3) Projections based on expenditure split

The graph below shows historical and projected average reliance across all services (excluding LTSS). Reliance refers to the portion of an enrollee's total health care he/she is expected to receive through VA rather than other health care sources.

- The projected reliance reflects the impact of all known factors that affect enrollee reliance on VA health care, including economy, demographic changes in the enrolled Veteran population, and the anticipated impact of recent VA initiatives and changes in legislation and policy.
- The FY 2018 Budget request assumes that reliance by Veterans eligible for the Choice Program based on distance is assumed to increase by 10 percent per year until it reaches 50 percent by approximately 2021. (We assume all of these Veterans will elect to receive care in the community).
- Changes in the enrollee demographic mix results in slightly lower reliance in 2018 and 2019. New enrollees tend to be healthier and less reliant on VA than the enrollees who are dying.



Question 11. What projection methods are you using to anticipate costs of deciding not to appeal the court's decision in Staab?

Response. To implement the Staab decision, VA published Interim Final Rule-AQ08 on January 9, 2018 to establish a payment methodology that will apply to claims where partial payment was made by the Veterans' health insurance plan. The regulation incorporates the statutory limitation that VA unable to provide reimbursement for any copayment, coinsurance, deductible, or other similar payment a Veteran is responsible for under a health plan contract. VA's current cost estimates for implementing the decision are based on this methodology and projected claim volume for outpatient and inpatient emergency treatment, including transportation.

Question 12. GAO continues to list VA health care on its high-risk list. Explain how this budget addresses concerns raised by GAO.

Response. VA continues to work diligently to mitigate the Government Accountability Office (GAO) High Risk concerns. VA is also addressing GAO High Risk List issues through Modernization efforts. VA leveraged FY 2017 resources to exercise an option year of an existing federally Funded Research Development Center (FFRDC) to aid in designing and implementing a strategy to mitigate the risks outlined by GAO. Under consideration for VHA will be the possibility of funding further support effort with the FFRDC for GAO High Risk List work. In May 2017, a Root Cause Analysis (RCA) presented to GAO was met with positive response. VA also met with GAO on Jan 11, 2018 regarding the root causes for the five risk area; this also was met with a positive response. VA is currently updating action plans for the five high risk areas based on the enterprise RCA and anticipates FY 2018 resources will support these efforts. There are no existing discretionary line items in the FY 2018/FY 2019 budget to specifically address the five individual high risk areas. Requests for additional budgetary consideration will be driven by the corrective action plans. A VHA Office of Internal Audit and Risk Assessment, designed to conduct independent and objective risk-based audits to enhance oversight and accountability, has been funded and has achieved initial operating capability.

Question 13. The President's Budget Request includes $751 million for HEP C drugs. How many veterans have you treated? How many have you identified that still need treatment? What are you efforts to reach those who need treatment but may not be taking advantage of treatment at VA? What resources are you expending to provide education to veterans to avoid the spread of HEP C?

Response. The President's Budget Request includes $751 million for hepatitis C virus (HVC drugs. Since January 2014 through December 31, 2017, VA treated over 100,000 Veterans with new direct-acting antivirals, with cure rates between 90–95 percent. As of the end of December2017, there were approximately 40,000Veterans in VA care who needed hepatitis C treatment. Attempts have been made to contact most, if not all, of these patients by phone, letter, or direct provider contact, and many have refused treatment or were unable to be engaged in treatment. VA providers are continuing to reach out to these patients to ensure all who are interested and able receive treatment. VA estimates approximately 15,000–20,000 of patients who need HCV treatment may be difficult to engage in care and treat due to treatment refusal, inability contact and, treatment-limiting medical, mental health, or substance use co-morbidities

VA's outreach efforts include:

1. Field-based VISN Hepatitis Innovation Teams deploying system redesign/LEAN at the majority of facilities to address gaps in HCV testing and treatment, including outreach to at-risk populations
2. National and local clinical informatics tools are in place across VA's health care system for tracking all patients diagnosed with HCV
3. VA encourages all Veterans who think they may have hepatitis C to get tested, and if eligible for VA care, to come in to VA for treatment. VA has an ongoing HCV testing and treatment ad campaign in 18 high prevalence cities in the US: www.hepatitis.va.gov/campaign-test-treat-cure.asp VA encourages all Veterans who think they may have hepatitis C to get tested, and if eligible for VA care, to come in to VA for treatment. VA has an ongoing HCV testing and treatment ad campaign in 18 high prevalence cities in the US: www.hepatitis.va.gov/campaign-test-treat-cure.asp

Resources for HCV prevention education include:

1. Prevention information, including transmission risk and what to do if you test negative or positive for HCV, are included in the resources on the Veteran Portal of VA's hepatitis website: www.hepatitis.va.gov
2. More direct HCV prevention patient education materials are available at: https://www.hepatitis.va.gov/products/patient/hcv-prevention-factsheet.asp.
3. Treatment as Prevention (TasP) is a successful intervention for the prevention of HIV transmission, which has shown that people with HIV who have an undetectable viral load (e.g., are successfully on antiviral treatment) have an incred-

ibly low, if any, possibility of transmitting the virus to another person. This is also true for HCV treatment as an intervention for HCV prevention, particularly given cure rates of over 90–95 percent among Veterans treated in VA in care.

While not explicitly focused on prevention, VA's national hepatitis awareness campaign messaging on hepatitis C testing includes transmission risk information: www.hepatitis.va.gov/campaign-test-treat-cure.asp.

Question 14. According to the OIG's 2016 report on staffing shortages, Physician Assistants are one of the top five occupations in greatest need. What are you doing to fill PA positions and others identified as having the greatest need?

Response. Several strategies have been employed to address the PA occupation shortage and to enhance recruitment and retention. The policy governing PA practice is currently under review to identify and eliminate barriers to PA practice in order to promote greater patient access, as well as making VHA a more attractive practice environment. Critical access disciplines such as primary care and mental health have been targeted for increased training and PA utilization. For example, the PA Post-Graduate Patient Aligned Care Team (PACT) Primary Care Residency has been successful in providing advanced training in the PACT Patient Centered Medical Home model of care and incorporating graduates into VA's clinical workforce. The recent expansion of PA postgraduate residencies in Mental Health has been highly successful in attracting trainees, and has added to VA's mental health clinicians. Establishment of additional PA residency programs in other critical specialties is currently under consideration. Nationwide, the PA profession has experienced a robust growth in demand with a resultant increase in salaries. The American Academy of Physician Assistants 2016 Salary Survey, confirmed by the Department of Labor, Bureau of Labor Statistics, reports the average annual starting pay for PAs is over $100,000. In contrast, current starting salary under the U.S. Locality Pay Schedule is $49,765.

Local facilities prioritize hard to recruit and retain occupations based on local workforce needs. Medical Center Directors are authorized to approve special salary rates for PAs when recruitment or retention of occupations or individuals with specialized skills is difficult. VA is also considering using the Secretary's existing authority to include PAs as a covered occupation in the Locality Pay System to transition PAs to a market based pay system.

Facility leadership also determines which occupations are eligible for consideration of other existing recruitment tools such as the Education Debt Reduction Program and the Employee Incentive Scholarship Program.

Question 15. Over the last few years, VA has taken action to create qualification standards to enable the recruitment of Licensed Professional Mental Health Counselors as well a Marriage and Family Therapists. The number of licensed professional mental health counselors employed by the VA declined from 72 in FY 2015 to 64 in FY 2016 and the number of marriage and family therapists increased from only 15 in FY 2015 to 24 in FY 2016. This data suggest that VA's efforts to expand hiring of these occupations is not succeeding. What new initiatives is VA undertaking to hire more counselors and MFTs? What aspects of the President's Budget support this effort?

Response. The addition of Licensed Professional Mental Health Counselors (LPMHCs) and Marriage and Family Therapists (MFTs) to the VA mental health workforce has expanded VA facilities' staffing options. The number of LPMHCs employed by VA increased from 189 at the end of FY 2015 to 284 as of December 2017, similarly, the number of MFTs increased from 122 to131 over the same period. This data suggest VA's efforts to expand hiring of LPMHCs is working, however, is still experiencing challenges hiring MFTs.

As VA's demand for mental health professionals grows, we expect that VA will continue to successfully recruit LPMHCs and MFTs i. Because LPMHCs and MFTs are relatively newer professions within VA, and decisions to hire into these occupations are made at a local level, the pace of hiring may vary from site to site.

To promote the MFT and LPMHC professions throughout the country, VA's Mental Health Offices also created a marketing plan to target stakeholders including: Mental Health hiring officials, Human Resources staff and VISN and Medical Center leadership. The marketing plan focused on the benefits of hiring LPMHCs and MFTs, including their contribution to inter-professional mental health teams and their cost effectiveness.

Question 16. The VA requested separate occupational series from OPM for LPMHCs and MFTs in 2011. Considering VA's hiring challenges for other mental health providers and the Secretary's focus on veteran suicide, will VA reprioritize the creation of occupational series for LPMHCs and MFTs? If not, please explain how the lack of the series does not inhibit hiring efforts.

Response. Beginning September 28, 2010, VA facilities were authorized to hire LPMHCs and MFTs as specialty mental health providers after Congress recognized these as occupational categories of mental health specialists in the Veterans Benefits, Health Care, and Information Technology Act of 2006. VA has an approved occupational series and title codes for this occupation under Hybrid Title 38.

Although a standalone occupational series for this occupation does not exist, this has not complicated hiring within VA. VA has developed and established a specific qualification standard and would continue to use this standard even if OPM developed a standalone series; therefore, the creation by OPM would not have a bearing on VA's recruitment or retention. Qualified candidates have successfully searched, applied for, and been hired for VHA positions announced for this occupation as established under Hybrid Title 38 with the official title of Marriage Family Therapist or Licensed Professional Mental Health Counselor within the GS–0101 Series.

Question 17. Please provide information on the number of social workers and psychologists hired by the VA in FY 2015, FY 2016, and FY 2017 to date, as well as the number of social workers and psychologists participating in Office of Academic Affiliation internships in FY 2015, FY 2016, and FY 2017 to date.

Response. Please see table below for data through May 31, 2017. (Note: VHA's data pull for mental health occupations includes psychologists and social workers. However, social workers include all hires, even though they may not work in mental health specifically).

Occupation	FY 2015	FY 2016	FY 2017 thru May	Total
Psychology	670	680	204	1,554
Psychiatrist	351	348	169	868
Licensed Prof Mental Health Counselor	72	64	43	179
Marriage Family Therapist	15	24	7	46
Peer Support	121	68	23	212
Total Mental Health Hires	1,229	1,184	446	2,859
Registered Nurse	7,700	6,531	4,101	18,332
Social Work	1,887	1,173	783	3,843

RN and Social Work hires are provided separately since all RNs and Social Workers are not assigned to a mental health area.

Question 18. One of the Department's goals is to change the culture of VA to be more welcoming to women. What in the President's Budget Request supports that goal?

Response. Women Veterans currently comprise 9.6 percent of the Veteran population and that is expected to increase to 10.5 percent by 2020. We are committed to providing increased access to gender-specific health care (genitourinary care; female cancer screening; osteoporosis; pregnancy and childbirth; care in a women's clinic) in a safe and welcoming environment. The 2018 President's Budget shows an increase of $33.5M for women's gender-specific care from $471.2M in 2017 to $504.7M in 2018.

VA provides health care services to women Veterans, including primary care, gynecology care, maternity care, specialty care, and mental health services. VA has also focused on improving its facilities to meet the needs of women Veterans.

In order to review facility accommodations for women Veterans VHA has adopted Environment of Care (EoC) standards. These are incorporated into a tablet-based survey that is conducted regularly. The facility Women Veterans Program Manager is a member of the EoC team. EoC data is shared with each facility and VISN monthly, and is the responsibility of the VISN Capital Asset Manager.

When a need arises to enhance facilities, the VISN follows the Strategic Capital Improvement Process (SCIP). The VHA Office of Women's Health Services participates in this process and provides input on specific facility needs for women Veterans. Currently, there are 21 projects in process (either in design, solicitation/bid, or construction) specific to women Veterans' health.

VA has enhanced the provision of care to women Veterans through Designated Women's Health Primary Care Providers (WH-PCP). By the end of FY 2016, VA had trained over 3,000 WH-PCPs, and has at least one at all of VA's health care systems. In addition, 90 percent of community based outpatient clinics (CBOCs) had a WH-PCP in place. VA is training additional providers to ensure every woman Veteran has the opportunity to receive primary care from a WH-PCP.

VA is proud of its high quality health care 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 health care. Quality measures show

that women Veterans are more likely to receive breast cancer and cervical cancer screening than women receiving their care in the private sector. VA also tracks quality by gender and, unlike other health care systems, has been able to reduce and eliminate gender disparities in important aspects of health screening, prevention, and chronic disease management.

Question 19. Does this budget support the new initiative to cover Veterans with other-than-honorable discharges, and how much do you anticipate that it will cost? Considering that you are unable to provide these veterans with beneficiary travel compensation and access to non-VA care, how will you provide services under this initiative to veterans who do not live near a VA facility?

Response. Effective July 5, 2017, VA began implementing an initiative to expand urgent mental health care to former Servicemembers with other than honorable (OTH) administrative discharges who believe their mental health condition is related to military service. This marks the first time VA has implemented an initiative specifically focused on expanding these services to former Servicemembers with OTH administrative discharges who are in mental health distress and may be at risk for suicide or other adverse behavior. Under this initiative, former Servicemembers with an OTH administrative discharge may receive care for their mental health emergency for an initial period of up to 90 days, which can include inpatient, residential, or outpatient care. If after 90 days, the former Servicemember still requires emergency mental health services, he/she may receive another 90 day episode of care within the VA or be transitioned to services. Each VISN has developed their own protocol for requesting an additional 90-day episode of care, which must be approved by the VISN CMO.

This initiative is focused on reducing suicide among those who served their Nation. VA will work to maximize existing capacity in support of this initiative. Because this initiative began after the budget request was submitted, VA did not include an estimate in the FY 2018 Budget. However, VA currently estimates the cost of this initiative to be $200 million in FY 2018 and is funding it within existing resource levels.

Question 20. As the mental health-diagnosed veteran population continues to age and veterans develop age-related diseases such as dementia, please describe the Department's efforts to develop long-term care options for these veterans. How is the Department monitoring changes in state-operated facilities that house this population of veterans? Please provide the Department's projections for changes in state-operated bed numbers over the next 10 or 20 years and how it plans to make up any gaps.

Response. The growth in the aging Veteran population with multiple medical, mental, and neurocognitive disorder comorbidities is expanding the need for additional services for these patients. The "Complex Patient" Care Implementation Task Force ("Task Force"), launched in August 2016, is focused on providing safe and effective care for this growing group of Veterans, and to follow up on recommendations made by the Inpatient Care for Veterans with Complex Cognitive, Mental Health and Medical Needs Task Force ("Care of Veterans with Complex Needs Report").

The Task Force was created in response to multiple, repeated requests from field leadership and also the Congressionally-mandated Federal Advisory Committee for Geriatrics and Gerontology. The Task Force has created a definition for Veterans with complex problems and conducted a national needs assessment of all 138 facilities with inpatient settings. Through the effort, several innovative inpatient promising practices for this patient population have been identified.

Additional efforts include building Community Living Center (CLC) capacity to care for aging Veterans with serious mental illness (SMI), and/or neurocognitive disorders, including integration of mental health professionals on all CLC teams, a range of dementia training programs, including STAR-VA, and development of a SMI toolkit. Additional efforts include National Investment Center for Seniors Housing & Care programs that support long-term care in the home and integration of mental health professionals in Home Based Primary Care, and Community Residential Care (CRC) and Medical Foster Homes. Relatedly, there are ongoing efforts to support family caregivers to care for Veterans with SMI and/or neurocognitive disorders (e.g., REACH-VA and other caregiver support programs) to support long-term care in the home.

State operated beds or nursing home care of any type is generally not preferred by Veterans. Appropriate use of home and community based services provided by VHA can reduce the need for such nursing home beds in the future. Available data suggest the projected need for additional nursing home care for Veterans over the next 15 years can be met in Medicare and Medicaid-certified community nursing

homes; however, VA is having difficulty accessing many community nursing homes because of Federal Contract requirements. Community nursing homes frequently cite complexity of the Federal contracting process as an issue along with the requirement to comply with the Service Contract Act. VA is working on identifying best practices for managing these Veterans to honor their preferences for care whenever possible in home and community based settings.

VHA Geriatrics and Extended Care is conducting a study of Long Term Services and Supports to understand Veteran needs for these services through 2030, and how they differ by rural and urban status. Moreover, the study is expected to provide policy options for addressing gaps in projected future needs.

Question 21. Data provided to the Committee in April 2017 indicated that the Asheville, North Carolina and Salem, Virginia Medical Centers in VISN 6 were unable to hire psychiatrists, psychologists, social workers, and nurse practitioners due "to budget constraints." Please provide an update on their hiring abilities, as well as a list of any other mental health positions at any VA facility that are under a similar hold.

Response. There are no mental health vacancies on hold due to budgetary constraints. The budget supports hiring actions for clinical positions vacated over the course of the FY. All Mental Health Service clinical vacancies are in an auto-fill status to expedite the recruitment process.

Question 22. You have spoken about adding thousands of new mental health providers. Can you please update us on these efforts as well as the retention of existing employees?

Response. VHA is making steady progress toward reaching the Secretary's goal of a net increase of 1,000 Mental Health Providers by December 31, 2018. We have increased our net onboard of psychiatrists, psychologists, and mental health counselors by 258 as of November 30, 2017, and we are embarking upon a national recruitment and marketing campaign to attract the best mental health providers to meet our goal.

VHA utilizes the Education Debt Reduction Program (EDRP) to repay education loans for healthcare professionals, including mental health, in critical positions where recruitment and retention is difficult. The EDRP, authorized by the Veterans Programs Enhancement Act of 1998, and implemented in 2002, as amended, allows participants to receive education debt reduction payments up to $120,000 for up to 5 years.

EDRP is one of VHA's most effective tools for filling critical positions, however, it is a limited resource. Local medical centers are responsible for identifying and prioritizing positions that are the most critical for recruitment and retention based on local needs and funding. Since the implementation of the new maximum award amount authorized under Public Law 113–146, VHA has awarded nearly 2,500 new EDRP awards. Occupations identified in the FY 2015 Office of Inspector General Mission Critical Occupation Report (physicians, registered nurses, psychologists, physical therapists and physician assistants) account for nearly 79 percent of all new awards in FY 2015–2016. Physicians and registered nurses (including advance practice nurses) receive the most EDRP awards, at 37 percent and 23 percent, respectively.

VA also utilizes other programs to recruit and retain highly qualified employees to mental health and other specialties. For example, the Student Loan Repayment Program (SLRP) improves recruitment and retention by offering assistance which enables VA to provide up to a lifetime total of $60,000 with a maximum of $10,000 per year in payments to the lending institution. Full-time VA employees may also be eligible for loan forgiveness through the Public Service Loan Forgiveness (PSLF) program. Only the entity that holds a loan may forgive outstanding loan balances, therefore the authority for the PSLF resides with the Department of Education.

Question 23. What lasting impacts did the hiring freeze have on your ability to recruit high quality staff?

Response. Minimal impact. Four days after the Presidential Memorandum VA provided exemptions for its most critical positions; more specifically, patient care positions, safety positions in activation of leases and construction projects, and those supporting burial benefits. Since then, the Secretary has allowed the Administrations to fill positions they deem necessary to meet mission requirements. The prioritization of filling vacancies is determined by the requesting organization, in coordination with the servicing human resources office.

Question 24. VA has articulated on multiple occasions that the flip side of accountability is the importance of recruiting high quality staff. It's my understanding that much of that work with candidates is done through HR. So you can imagine that it seems somewhat counterintuitive that you have not ended the hiring freeze

for H.R. professionals, and now you have flat funded them for 2018. How do these factors align?

Response. VA is undertaking a comprehensive Department-wide analysis at how to provide all internal support services, to include Human Resources (HR), in the most efficient manner. We are determined to provide a single enterprise-wide efficient and effective approach to HR. In light of this process, we are being deliberative in hiring H.R. professionals. At this time, frontline (i.e., those supporting a medical center) H.R. offices are able to hire against vacant H.R. positions.

Once we fully understand our H.R. approach for the future, we'll be in a better position to align budget requirements.

Question 25. Can you explain the differences between the services provided by VA human resources and VHA human resources, and tell us why we need to fund both? They seem duplicative in many ways. Would there be cost savings for the Department if the two were consolidated?

Response. In accordance with OMB Memorandum M–17–22, VA is undertaking a comprehensive Department-wide review of its support services, including HR.

The mission of VA's HRA is to develop and implement enterprise human capital management strategies, policies, and practices. Program offices comprising HRA focus on policy and programs such as Human Resources Management, Diversity and Inclusion, Labor-Management Relations, Equal Employment Opportunity complaints, and Senior Executive Management. HRA is closely reviewing where potential efficiencies may exist.

In addition, each Administration, to include VHA, operates on-the-ground H.R. offices that provide daily operational and advisory functions for managers, supervisors, and employees. These include, but are not limited to, classification, recruitment, on-boarding, personnel actions processing, employee development, benefits, separation management, employee relations, performance management, etc.

Question 26. Can you explain why the H.R. office is flat funded from last year, but the FTE level is effectively cut in half? Where is the funding going, and where will the staff go?

Response. HRA's FY 2018 budget request reflects no increase in the level of Budget Authority from 2017. Most of HRA funding is generated by reimbursable authority funding from other VA entities. Among the largest reimbursable services is the handling of EEO complaints by the Office of Resolution Management (ORM). The reduction in staff reflected in FY 2018 is based on the plan that 296 ORM staff positions will be re-aligned to the Office of Accountability and Whistleblower Protection. After further review by the Department, it was determined that ORM FTEs should remain in the organizational structure of HRA.

Question 27. I note that FTE for Acquisitions and Construction management is increasing by over 60 people in your budget request for this year. I expected to see a cut, frankly. Major construction is taking a "strategic pause," and the construction that is happening is being managed by the Army Corps of Engineers. What cuts have been made to reflect the Corps' role, and why do you need additional staff in that office?

Response. For the major construction staff request, the current estimated FTE number for FY 2017 is 139 and for FY 2018 the estimate is 197. The original estimate for FY 2017 was 177. The combination of project slippages and the hiring freeze have reduced the number needed and VA's ability to hire staff still required for its major construction projects.

VA will have 26 ongoing projects valued at $4.15B in FY 2017/FY 2018 and six new projects (primarily national cemeteries) totaling $0.24B. It will also be overseeing the execution by the Army Corps of Engineers (USACE) of 13 projects valued at $6.474B. There are four other projects in planning valued at over $2B that requires contracting officer support.

It should be noted that the partnership between VA and USACE includes VA responsibilities to coordinate with USACE during construction and provide the interface with the medical center, as well as the on-site knowledge of VA technical requirements. VA believes Resident Engineer and Contracting Officer positions were not sufficiently staffed in the past. VA's 2018 Budget reflects staffing to appropriate levels by following the model established by the Defense Health Agency in providing support and guidance to the USACE construction management team, and ensuring that the project meets the VA programmatic requirements.

It should be noted that the appropriation language was changed in FY 2017 to allow major construction staff funding to include support for contracting officers working directly on major construction projects to ensure alignment with the program they are supporting. The inclusion of contracting officers accounts for 35 of

the 197 FTEs in FY 2018 with 162 resident engineers comprising the remainder of the FTEs.

Since FY 2016, significant cuts have been made to the General Administration funding that provides support to Major Construction via project/program managers, planners, architect/engineers and other support personnel.

Question 28. Your Budget rescoped and resized several major medical lease projects as well as eliminated two leases that had previously been proposed for authorization. Please provide specific information regarding any services that have been eliminated or reduced from these clinics. Please provide specific information that explains the underlying analysis VA used to determine these services or spaces were no longer needed. If the Department determined that the community would be able to take on this extra demand, please provide information that explains how the Department determined that capacity exists in the community.

Response. Prior to the finalization of the FY 2018 Budget, VHA reviewed 28 Major Lease initiatives. Out of these, 9 included reduction of Specialty Care services and associated square feet because it was determined such services were more readily available through community providers and/or at the parent VA Medical Center. VHA utilizes the VA Health Systems Planning Application, Veterans Choice Locator and other available databases, to project demand and match that to capacity, both in house and through community providers. This process helps ensure appropriate and sufficient services are available. In no cases were services removed because they were no longer required, and in all cases services will be available to Veterans.

Question 29. Does this request take into account the partnerships you have with other agencies, such as HUD? Did you know, for example, that the HUD budget for supporting HUD-VASH vouchers decreased by 8%? Will the Administration be able to serve the same number of Veterans?

Response. VHA has been in communication with the Department of Housing and Urban Development (HUD). If HUD does not receive additional funding for HUD-VASH in FY 2018, it would not impact the availability of existing FY 2008-FY 2017 awards, which mean VHA must continue to provide case management for recipients of nearly 90,000 existing vouchers, as required by statute. If HUD does not receive new funding in FY 2018, VHA will not need to add staff to support new vouchers, but will need continued funding to support existing vouchers.

Question 30. Does VA have the resources in this budget to provide the wrap-around services that are so critically important to doing more than just addressing a crisis situation? (VHA)

Response. The FY 2018 budget request supports an additional 5,500 HUD-VASH vouchers from the FY 2017 HUD budget. HUD-VASH staff provides clinical case management and supportive services primarily in the community or the home, and which vary based on the needs of the Veteran. There are five basic levels of case management—intensive, stabilization, maintenance, preparation for discharge, and graduation/discharge. Each level has varied levels of engagement with Veterans in HUD-VASH.

Question 31. Granted great progress has been made in the last five years on ending homelessness among veterans, but given that there are still 40,000 homeless Veteran nationwide, why has VA decided to put less emphasis on this core VA mission?

Response. VA remains steadfast in its commitment to ensuring Veterans are able to obtain permanent, sustainable housing and have access to high quality health care and other supportive services.

Question 32. Do you agree that consistent resources need to be dedicated to VA counter-homelessness programs in order to get as close to zero homeless veterans nationwide as we can?

Response. Yes.

Question 33. I was concerned by a recent military times article indicating VA has shifted its goals on veteran homelessness from zero to what you referred to as functional zero, and I quote here "12,000 to 15,000 that despite being offered options for housing and getting them off the street, there are a number of reasons why people may not choose to do that." The 2016 PIT count included just over 13,000 unsheltered veterans, and your homeless programs are operating at the same pace, as I believe they should. Can you explain how you arrived at this specific range as your goal for unsheltered veteran homelessness, and can I get your commitment to reducing veteran homelessness, especially unsheltered homelessness, as much as possible and to ensuring that all of the administration's programs are collaborating effectively with each other, and community partners, to make veteran homelessness rare, brief, and nonrecurring?

Response. VA remains fully committed to ending and preventing Veteran homelessness, and continues to operate with the urgency to ensure it is rare, brief and non-recurring, especially for unsheltered Veterans.

Question 34. Your own studies demonstrate the importance of research opportunities to recruiting and retaining clinical staff. In addition to VA's own research cuts, other agencies are cutting their contributions to VA research also. Do you have an estimate of the impact that this overall Trump budget will have on your hiring efforts?

Response. At this time, VA does not have the ability to predict a detrimental impact on hiring, although, many clinicians view the ability to conduct research as advantageous to a well-rounded clinical experience.

Question 35. What percentage of the work on appeals currently sits with the VBA in the appeals management center? Is there a reason that addressing the existing appeals with additional staff was not a priority?

Response. As stated above, in January 2017, VBA realigned its appeals policy and oversight of its national appeals operations under AMO. The realignment promotes increased accountability of appeals performance and establishes a clear division of labor between claims and appeals work, with dedicated appeals FTE. This realignment allows VBA to prioritize appeals by focusing on internal people, process and technology, and implementation of appeals reform legislation if enacted. Under this realignment, specific guidance has been disseminated instructing field offices that appeals staff must maintain authorized staffing levels.

In 2015 and 2016, Congress provided funding for additional staff that included a total of 300 FTE employees for appeals processing at VBA. VBA's appeals productivity through May 31, 2017, has increased by 32 percent over FY 2016 production during the same period. As of June 30, 2017, the Appeals Resource Center, the centralized processing resource for appeals remanded from the Board of Veterans' Appeals, had 35.8 percent of the remand workload in VBA and 3.3 percent of the total appeals workload.

VA continues to assess the current and future allocation of FTE employees to work appeals to ensure that the pending legacy appeals inventory is addressed in a timely and efficient manner. Whether VA will need additional resources for appeals since the August 23, 2017, enactment of appeals reform legislation is contingent upon resource allocation decisions made by the Department and the Administration during the annual budget process and cannot be predicted at this time.

Question 36. Fiduciaries are some of the most vulnerable of the Veteran population and it is currently taking more than TRIPLE the time it should in order for a field examination to happen so that a fiduciary can be appointed. How is your budget, which flat funds this program, helpful in addressing this problem?

Response. In 2017, VBA allocated an additional 51 FTEs to meet the program's oversight responsibilities in order to avoid delays in the initial appointment of fiduciaries, and the FY 2018 President's Budget codifies those additional FTEs. As of May 2017, VBA has reduced the average days to complete initial appointments to 151.1 days—down from 287 days in FY 2016—and we are making progress toward the goal of 82 average days to complete initial appointments by FY 2018 and 76 days by FY 2022.

Question 37. If VA does not plan to hire additional FTE for the VR&E program how does VA intend to assist veterans in critically understaffed regions?

Response. Staffing requirements for the Vocational Rehabilitation and Employment (VR&E) program are influenced by many factors. Currently, we are supplementing our Vocational Rehabilitation Counselors (VRCs) workload with the expanded use of and augmentation of tasks through National service contracts for the execution of certain VRC tasks, such as vocational assessments. We recently developed and deployed targets for these contracts by Region/District based on workload density to better serve Veterans and VRCs. Additionally, VBA is continually looking at VR&E system and process improvements to reduce administrative burden on VRCs. Current efforts include working to deploy a new case management system (in development), and examining ways to centralize VR&E administrative tasks like invoice processing.

Question 38. In the past two years, ITT and Corinthian College both closed and left tens of thousands of veterans in an unacceptable and precarious position. We've also seen other predatory behavior by for-profit schools looking to take advantage of Veterans and their beneficiaries. Are you confident that the levels of staffing supported by this budget, and the amount of oversight that staff is able to do, will prevent these practices in the future? We want to identify these schools before we have a situation where a school is shut down, rather than after. Moreover, we want to ensure that VA has the resources to communicate with veterans far ahead of any

school closure in order to facilitate the transfer of the GI Bill beneficiary to an alternate school for the completion of their degree.

Response. Based on the staffing levels requested for FY 2018, VA will facilitate proper oversight of GI Bill benefits. Since the closure of these schools, the Department has focused on improving the quality of the oversight process, increased communication and information sharing activities with other Federal agencies with oversight of post-secondary educational institutions, and has increased outreach activities and assistance to beneficiaries enrolled in "at risk" schools.

Question 39. Will the staffing levels for these Education programs support continued rates of original and supplemental claim completion within a reasonable amount of time?

Response. VBA has approximately 800 FTEs processing claims with a current Fiscal Year-to-Date timeliness for original claims at 22.8 days and supplemental claims at 8.0 days. At the beginning of FY 2017, VBA redirected 75 Atlanta Regional Processing Office employees from processing education claims to processing compensation claims. This increased the workload at the three remaining Regional Processing Offices. Also, during the fall peak enrollment period from August 2017 to October 2017, VBA received an increase in education claims. This year, VBA received a 24 percent increase in claims for FY 2017 compared to FY 2016. Last, other factors (i.e., legislative changes and system changes) may impact future processing times. VBA did not meet its Fiscal Year To Date goal for original claims with an average days to complete (ADC) of 24.66 days; however, VBA did achieve the goal for supplemental claims with an ADC of 8.6 days. In addition, VBA continues to utilize overtime and a national brokering strategy to balance the workload and reduce the time it takes to process a claim.

Question 40. Can you give us a timeline for the plan to modernize VA's infrastructure you're developing and hoping to pilot?

Response. VA is committed to developing high performing healthcare networks that consider current and future Veteran demand for medical care, and responsive services by integrating VA-provided healthcare, community care, and telehealth services. VA is partnering with private sector healthcare experts to conduct objective assessments, based on a piloted methodology, to develop local health system optimization plans. A contract was awarded in September that will enable VA to recommend health system optimization plans in all 96 VA healthcare markets. Our current target is to complete this by the 3rd quarter of FY 2019.

Question 41. Your budget includes a proposal that would allow VA to more easily transfer funding for infrastructure between agencies. How does that authority play into the modernization plan you're developing?

Response. The proposed legislation would allow VA to pursue joint projects with other Federal agencies, including DOD. Joint facility projects between VA and other Federal agencies (i.e., medical facilities not specifically under the jurisdiction of the Secretary) currently require specific statutory authorization. The proposed legislation would: (1) enhance VA's ability to coordinate with DOD and other Federal agencies; (2) improve access, quality, and cost effectiveness of direct health care provided to Veterans, Servicemembers, and their beneficiaries; (3) permit joint capital asset planning and capital investments to design, construct, and utilize shared medical facilities; (4) provide VA authority to procure the use of joint medical facilities for itself and other Federal agencies like DOD, and transfer funds between agencies for such initiatives.

Question 42. Please explain what legislative barriers exist that prevent the Department from disposing of the roughly 1,100 facilities that are described as underutilized and vacant buildings.

Response. To clarify, at this time VA is only pursuing disposal or reuse of 430 vacant buildings. The underutilized buildings will be reviewed, as VA works to determine where additional efficiencies can be identified and reinvested in Veterans' services, and will be considered when VA completes the market area optimization assessments and plans.

Occasionally, there are impediments that delay disposal or reuse stemming from environmental factors and/or the historic nature of a building. Impediments do not specifically prevent disposal/reuse, but can significantly slow the process. The National Historic Preservation Act (specifically, Section 106 consultation requirements) as well as the National Environmental Policy Act provide statutory requirements which VA must adhere to when pursuing this process.

Additionally, other authorities would provide greater reuse flexibility of unneeded assets, and help improve services for Veterans. For example, VA's FY 2018 Budget request proposed to expand VA's enhanced use lease authority beyond the scope of supportive housing. This authority would provide more opportunities for VA to suc-

cessfully repurpose underutilized and vacant properties nationwide, for uses that are consistent with VA's mission and operations.

Question 43. We understand that VHA is conducting a series of market-based analyses examining VA capacity and private sector capacity nationally. What role is OALC playing in these analyses?

Response. VA's Office of Construction & Facilities Management (CFM) is working closely with VHA to conduct market-based assessments nationwide. Previous VA Integrated Planning efforts did not comprehensively assess the optimal balance of services for VA to provide in its facilities, versus those that can be provided in the community. The market-based Service Delivery Planning will focus on community care providing additional services other than foundational and essential services (e.g. Primary Care, Mental Health and associated Rehabilitation). CFM will manage the planning process in partnership with VHA, once a contract has been awarded.

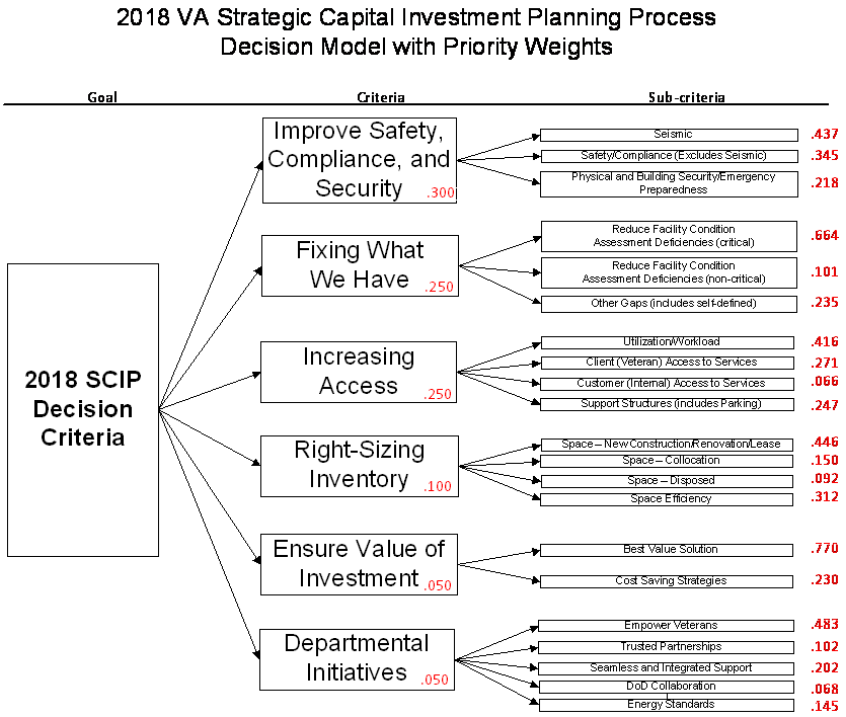
Question 44. Please explain what factors go into determine SCIP ratings. What weights does each category and subcategory receive? How often does the Department update those needs?

Response. The Strategic Capital Investment Planning (SCIP) process is reviewed each year to consider changes in medical delivery, technology, Departmental and Congressional mandates, and local or regional projections. Changes, related to VA's Construction and Lease program, inform updates to the criteria and weights. The SCIP Board is comprised of nine senior management members from the three Administrations and the offices of six Assistant Secretaries. The Board works on a Departmental level with each member applying their specialized knowledge to discussions. The SCIP Panel, which is comprised of one staff member representing each Board member, supports the Board.

Decision criteria and sub-criteria priority weights are developed using a multi-attribute decision methodology—the analytic hierarchy process (AHP). This methodology facilitates the development of criteria and sub-criteria weights, by allowing multiple evaluators to consider a number of diverse criteria when setting weights. Within the AHP, priority weights are set using the Pairwise Comparison method, which asks each Board member to rate the importance of criteria, one pair at a time, reducing the likelihood of inconsistent ratings. The results of the Pairwise Comparison exercise are the criteria weights. Priority weights for each group of sub-criteria are developed that same way.

The Board presents a recommendation to the SCIP process, including criteria and priority weights, through a formal executive review process. That process is developed through senior management, with approval of the Secretary to ensure consistency with the Department's strategic goals.

Below is the SCIP 2018 Decision model and criteria and sub-criteria weighting.



Question 45. The Department projects a large drop in the resources needed to support facility activations, dropping from an estimated $862 million in FY 2018 to $744 million in FY 2019. Please provide a list of facilities that are projected for activation in FY 2018 and FY 2019. Additionally, the request explains that VA has taken steps to better synchronize resources. Please provide further details of these steps.

Response. Attached is the activations report that has been submitted to Congress. VA's Office of Construction & Facilities Management and VHA are working to improve communication of updated project schedules for Major Construction and Major Lease projects, to help ensure improved activation project scheduling. Additionally, VA Facility Activation Project Management teams have been established to coordinate and synchronize resources.

Question 46. We understand that VA has never before utilized a public interest exception to a full and open procurement. In fact, the exception has only been used in national security situations. The last time Congress was assured by VA that a contract was guaranteed and solid, VA lost badly in court and we were forced to provide an emergency appropriation to complete construction of the Denver VA Medical Center. What guarantee can you give the Committee that this procurement method will be the best value for taxpayers and veterans?

Response. VA is taking the necessary precautions to ensure that the scope of this effort is well-defined, feasible, and will further the public interest of providing seamless care for our Veterans.

Question 47. Your budget requests funding for a further review of the EHR decision through an IPT. Is this request still valid? Can you explain what new information this team will be looking at that wasn't previously available? Or are these resources that can be shifted?

Response. The June 5, 2017, announcement of the Determinations and Findings (D&F) by Secretary Shulkin supporting direct negotiations by the VA with Cerner Corporation alleviated the requirement for such an IPT. These costs and efforts are being supported by the present PMO budget requirements. In addition, VA has extensive testing, change management and data migration strategies to be fielded dur-

ing the Initial Operating Capability phase and will leverage lessons learned from DOD.

Question 48. Your budget projects essentially flat staffing for OIT in FY 2018. It is our understanding that part of the *MyVA* project was looking at the OIT staffing levels present at VHA, VBA, and NCA facilities in order to provide proper IT support at those facilities. Can you update the Committee on the development of these staffing models?

Response. OI&T is working on the draft for a Comprehensive Staffing Model that will perform an analysis of existing workforce, project needs and examine how to address identified gaps. As part of the Secretary's initiative to increase efficiency, OI&T is currently reviewing existing workforce structuring and identifying positions that can be realigned to direct customer facing support. Starting in FY 2018, OI&T will work with VA customers to balance between service level requirements and industry best practices for IT staffing.

Question 49. What resources are allocated in the Budget Request for the development of the Digital Health Platform?

Response. The Digital Health Platform concept has transformed to be more inclusive, creating a gateway and interfaces for benefit, memorial, and corporate systems as well. The systems requiring interfaces and the resources of this Digital Veteran Platform will fund its development.

Question 50. What VistA enhancement projects will this Budget Request support in FY 2018? In what ways has this roster of projects changed as a result of the decision to procure Cerner's EHR?

Response. The FY 2018 budget includes a request for development funding for the following VistA related activities as summarized below.

Dollars in Thousands:

NMOC (Medical MyHeV) $15,000

- MHV Infrastructure and Interface Enhancements Phase 2 $10,000
- MHV Veteran-Facing Enhancements Phase 2 $5,000

VistA Module Enhancement $9,000

- Fileman 24 DME $5,000
- VistA Data Access (VDA) Phase 2 $4,000

Access to Care (Medical Core) $2,495

- Veteran Self-Scheduling Appointment System Faster Care for Veterans Act $2,495

Health Provider Systems $2,400

- CPRS Enhancements Phase 2 $2,400
- Registries $1,410
- Veterans Integrated Registries Platform (VIRP) $1,410

Based on the Secretary's June 5, 2017, announcement regarding VA's path forward for VA's EHRM, proposed health development and sustainment investments are being reviewed to ensure they are in full alignment with the Secretary's decision. Many projects will continue until VA systems can be transitioned to the new EHR system. To minimize the impact to Veterans and the providers who use VistA to document care, the decommissioning of VistA and other legacy systems will be done along a structured timeline that ensures there are no compromises to Veteran patient privacy and continuity of care.

The EHRM decision that the Secretary announced on June 5, 2017, comprises a large and complex replacement of VA's EHR which would take place over a multi-year period. While VA is conducting an ongoing review to ensure all current projects included in VistA Evolution and beyond are aligned to the Secretary's June 5 decision, it is clear that many projects will continue for a period of time because VA will need to continue to maintain its existing system until VA systems can be transitioned in an organized way to the new EHR system. Again, VA will be reviewing all relevant ongoing or planned projects to ensure they are aligned with the Secretary's June 5 decision.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. BILL CASSIDY TO HON. DAVID J. SHULKIN, M.D., SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 51. The VA's several affiliations with academic medical institutions provide a significant opportunity to incorporate the input of the person who is actually treating the veteran. This process would eliminate many of the mistakes being

made when it comes to more complex and advanced technology in the med-surg items and device space. Processes and procedures driven from the top down cannot overcome a lack of informed decisionmaking from the beginning.

What is the VA doing to better incorporate physician and clinical practitioner feedback into their procurement process, especially with regards to the Next Generation—Med- Surg Prime Vendor (NG-MSPV) program?

Response. VA has embraced Clinically Driven Sourcing (CDS) to better incorporate physician and clinical feedback. Under the CDS concept clinicians identify, review and select products to be made available for their use under national, regional, or local contracts. Next-Generation Medical/Surgical Prime Vendor (NG-MSPV) provides a good example of this concept. Before products are made available through the NG-MSPV they are reviewed by a multi-disciplinary integrated team that includes clinicians familiar with the products that are candidates for inclusion in the NG-MSPV formulary. The clinician's role on the team is to select the products that meet their needs.

Question 52. a. Last year, the VA established a new pre-authorization requirement for the procurement of certain medical products, with the stated goal of getting a contracting officer involved prior to a surgical case to ensure the government pays fair pricing for the products used.

Response. In April 2016, VA started the pre-authorization process by establishing a not-to-exceed order, and then a post-procedure consult with VA contracting to finalize the purchase order (PO). In that process, pre-authorization consults are performed by VA clinicians/staff to identify implant components and pricing, which are then used by contracting staff to establish a price and product ceiling on the order (the "not-to-exceed" level). Following a procedure, vendors and VA staff confirm what products were implanted in the patient (units, cost, quantities, serial numbers, contract number, etc.), which is then submitted to VA contracting (the post-procedure consult).

As understood, if a post-procedure consult is not submitted to contracting within 24 hours of the procedure, it is considered an "unauthorized commitment," and is subject to a ratification process that can significantly delay vendor receipt of a PO. Overall, I have heard numerous reports that this new process has indeed resulted in a significant backlog of payments to manufacturers for devices already implanted in Veterans.

b. What is being done to establish an improved process that includes appropriate procurement safeguards but also ensures appropriate efficiencies in payments to manufacturers providing critical medical technologies to our veterans?

Response. For clarification, a delay in a post-procedure consult does not result in an "unauthorized commitment" and is not subject to ratification; however, it does delay payment. VA is continuing to refine the implant contracting process to include changes to improve submittal timeliness for post-procedure consults, and the requirements for ratification to include expediting the process through completion of payment to the vendor. We are also monitoring payment timeliness, numbers of "unauthorized commitments" and ratification speed to determine if our improvements are effective.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. PATTY MURRAY TO HON. DAVID J. SHULKIN, M.D., SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

MEDICAL AND PROSTHETIC RESEARCH

Question 53. VA's medical and prosthetic research has contributed many vitally important advances in medicine. Yet, medical and prosthetic research is cut five percent in the President's Budget Request. With cuts being made across President Trump's budget to other Federal sources of research funding, such as the draconian cuts to the National Institutes of Health, critical Federal investments in lifesaving medical research will be eliminated. What specific research would be eliminated or curtailed under the Department's request?

Response. At this time we are unable to determine which projects may be impacted. VA's Office of Research and Development will continue to perform robust research in priority areas and those of unique healthcare needs for Veterans such as:

- Suicide prevention
- PTSD
- TBI/Neurotrauma and Neurotechnology
- Chronic Pain and Opiate Abuse
- Spinal Cord Injury
- Precision Medicine and Patient-Centered Care

- Access, Choice and Coordination of Care
- Implementation and Spread of Innovation
- Limb Loss
- Million Veteran Program

Research program areas that would be curtailed includes:

- Disorders of Aging
- Musculoskeletal Disorders
- Neurodegenerative Diseases

Question 54. For years VA has been citing problems with recruitment and retention as a problem within the VHA system. VA studies have shown that 80 percent of VA clinicians cited research programs as a factor in coming to VA, and over 90 percent cited it as a reason for staying at VA. How will these cuts impact VA's ability to remain competitive in recruiting and retaining quality researchers and physicians?

Response. The All Employee Survey data indicates that job satisfaction for physicians is closely linked to academic activities including involvement in research and teaching; however, VA is unable to predict any potential outcomes recruiting and/or retention that may result from any decreases.

HOMELESS VETERANS

Question 55. Since 2009 it has been the goal of VA to end veteran homelessness. Since that time, great progress has been made in addressing veteran homelessness. But this progress has only come from complete VA dedication to that goal and the utilization of an array of Federal resources. Earlier this month, you announced that zero homeless veterans is no longer an agency priority, and President Trump's budget would cut the HUD budget for supporting HUD-VASH vouchers decreased by 88 percent.

- What impact will these decisions have on homeless veterans trying to access VA services?
- What impact will these decisions have on veterans currently utilizing the HUD-VASH program?
- What services will VA offer to veterans that are adversely impacted by any change in homeless veteran services?

Response. If HUD does not receive additional funding for HUD-VASH in FY 2018, it will not impact the availability of existing FY 2008-FY 2017 awards, which means that VHA must continue to provide case management for recipients of nearly 90,000 existing vouchers, as required by statute.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOE MANCHIN III TO HON. DAVID J. SHULKIN, M.D., SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 56. Originally, our understanding was that the VA anticipates that funds for the Choice Program will exhaust in November/December of this year. However, that is not the case. What is the actual date that Choice will run out of money?

Response. In August 2017, the President signed the VA Choice and Quality Employment Act of 2017, which authorized an additional $2.1 billion for the Veterans Choice Program (VCP). These funds represent a short-term, temporary funding solution that will enable Veterans to continue receiving care through VCP while a replacement program is developed.

A number of fluctuating variables influencing program utilization will dictate actual obligation rate. VA will continue to analyze program utilization trends and will refine funding projections as future utilization patterns become better defined and will stay in close communication with our Committees to apprise all members of current status.

Question 57. Your budget asserts that "the number of VR&E participants has steadily increased and is expected to continue to increase over time." In fact, program participation has increased by 15% since 2015. However, in your budget you propose a cut to the program of $13.8 million or 4.2%. If the VA does not plan to hire additional full-time employees for the VR&E program, how does the VA intend to support veterans in critically understaffed regions, like West Virginia?

Response. VA utilizes several mechanisms to allocate resources to support VR&E programs, including the expanded use of and augmentation of tasks through National service contracts, which help to balance the caseloads for Vocational Rehabilitation Counselors (VRCs). We recently developed and deployed targets for the use

of these contracts by Region/District based on workload density, in order to better serve Veterans and VRCs. Additionally, VBA is continually looking at VR&E system and process improvements in order to reduce administrative burden on counselors. Current efforts include working to deploy a new case management system now in development, and examining ways to centralize VR&E administrative tasks like invoice processing.

Question 58. It is my understanding that even though the hiring freeze has been lifted, VA has done a self-imposed hiring freeze.

a. How are you reviewing which positions are exempted?

b. What is your process?

Response. Consistent with OMB Memorandum M–17–22, VA removed hiring restrictions for field positions at VHA's medical facilities (for medical and non-medical positions), and for VBA regional and field offices. NCA had no restrictions and this remains unchanged. Hiring restrictions were also removed for the following Executive level positions: Medical Center Directors; Network Directors; Cemetery Directors; and VBA Regional Office Directors. This allowed the Administrations to fill positions they deemed necessary to meet mission requirements.

For all other positions, VA is following a process that requires thorough review before hiring, and which also requires an approval at the appropriate Under Secretary level. VA Central Office and all other Executive level hiring must be approved by the VA Chief of Staff.

Question 59. In March, you announced that veterans with other-than-honorable or "bad paper" discharges will be allowed to be receive mental health treatment.

a. How do you ensure that access for an honorably discharged veteran is not diminished with this policy?

b. If a veteran shows up at an emergency room today and says he is suicidal how will you treat him differently today than when your plan is in effect?

c. We were told that we would have a comprehensive plan for implementation by June. Where is that plan?

VA Response A-C: Effective July 5, 2017, VA began implementing an initiative to expand the provision of urgent mental health care to former Servicemembers with other than honorable (OTH) administrative discharges who believe their mental health condition is related to military service. This marks the first time VA has implemented an initiative specifically focused on expanding these services to former Servicemembers with OTH administrative discharges who are in mental health distress, or may be at risk for suicide or other adverse behavior.

This initiative is focused on reducing suicide among those who served the Nation.

Under the initiative, which utilizes existing legal authorities, if a former Servicemember with an OTH administrative discharge presents to a VHA Emergency Department and self-identifies as being in mental health distress, a provider will conduct a clinical assessment and determine the appropriate course of action in conjunction with the former Servicemember. Under this initiative, former Servicemembers with an OTH administrative discharge may receive care for a mental health emergency for an initial period of up to 90 days, which can include inpatient, residential, or outpatient care. In addition to presenting at an Emergency Department, individuals make seek help by calling the Veterans Crisis Line or visiting a VA Urgent Care Center or Vet Center.

Regarding the implementation plan, VHA and VBA developed a joint action plan addressing required policy updates, internal and external communications, IT modifications to CPRS, field education and support. The field was notified of the OTH Initiative via memos dated 3/20/17 (Access for Mental Health Services for Other Than Honorable Discharged Servicemembers), 4/19/17 (Validating VA Mental Health Plan to Meet the Needs of Other Than Honorable (OTH) Discharged Servicemembers), and 6/26/17 (Eliminating Veteran Suicide: Emergency Services for Other Than Honorable Discharges). A training PowerPoint presentation was developed in May, 2017 for field staff who register OTH Servicemembers in the electronic health record (EHR). VHA Directive 1601.02A was updated on June 7, 2017 to include information about providing care to this population. A Communications Plan was completed in June, 2017, which included internal and external PowerPoint presentations and Fact Sheet. In addition to external presentations to VSO groups and congressional partners, a series of national webinar calls was completed for VA field education.VA began implementing this initiative on July 5, 2017. In September, 2017, the IT contract was awarded to develop and implement necessary computer upgrades for the EHR, which will allow the field to track the 90-day episode of care.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MAZIE K. HIRONO TO HON. DAVID J. SHULKIN, M.D., SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

VA HEALTH CARE OUTCOMES

Introduction: Despite the bipartisan investments made in the VA each year, there continues to be basic failings that impact the experience of Veterans: issues in accessing benefits, communications with the VA, problems with VA medical care, and others.

Question 60. What will be different next year in how you address just one of those issues—for example, health care access? Under this budget how will access to care be different for veterans next year in how they get it through the VA or outside it? How will the average veteran feel these proposals in their everyday interaction with VA?

Response. VA continues to work to ensure all eligible Veterans have their urgent care needs met in a timely fashion. A year ago, VA implemented same day services at all medical centers and some of its community based outpatient clinics. On January 12, VA announced that 100 percent of its more than 1,000 medical facilities across the country now offer same-day services for urgent primary and mental health-care needs. . VA is also working to ensure new referrals to specialists are screened for urgent needs, and that these Veterans are referred for timely care. Since FY 2014, the average wait time to complete the most urgent consults decreased from 31 days to 2.8 days during December2017. VA is also working to ensure follow-up appointments for time-sensitive issues are managed in a timely fashion. In late 2016, VA also implemented a process to ensure timely follow-up appointments for time-sensitive medical needs. Since then, over 200,000 such appointments have been completed. A year ago 90% of such appointments being no later than the provider recommended appointment date. Over the past 3 months, this number increased to 95%.

Patient Self-referral Direct Scheduling, the ability for Veterans to schedule a routine appointment without a consult from a primary care provider, was implemented in Optometry and Audiology in 2016. In 2017, it was implemented in all nutrition clinics and is nearing full implementation in podiatry, amputee and wheelchair clinics. In 2018, VA will be adding direct scheduling in cancer Care (Veterans new to VA or transferring their care to VA with a known cancer diagnosis), smoking cessation, mammography (when provided at VA), weight management, social work and pharmacy clinics.

Expansion of telehealth services continues to be a priority for improving access to care particularly to parts of the country where there is a shortage of providers. The use of a national hub and spoke model in VA for Telehealth allows virtual medical appointments to occur in sites that may be rural or have difficulty recruiting providers, where otherwise Veterans would not be able to access care as quickly. As of the beginning of this CY, VA has 11 fully operational Mental Health Hubs and 9 fully operational Primary Care Hubs. Additionally, some of our VISNs are setting up their own hubs. Additionally VA is in the process of implementing a tele-urgent care initiative in five VISNs this year. The initiative is designed to enhance first call resolution, properly addressing the Veteran's need the first time they call to prevent the need for a second or follow up call.

VA is also working to implement VA Video Connect, a simplified mobile and web-based application connecting Veterans with providers via encrypted video, is also being implemented. It allows Veterans to see and talk to their health care team from anywhere, making appointments more convenient and reducing travel and wait times. VA is in the process of implementing this across the Department.

VA has also been implementing Veterans Scheduling Enhancement in all of its healthcare facilities. This system eliminates many of the previously occurring scheduling errors and improves the scheduling experience for the Veteran.

In April, VA launched the "Access and Quality in VA Healthcare" website at www.accesstocare.va.gov. The website promotes transparency and enables Veterans, their families, and caregivers to view data related to:

- Patient wait times at VA facilities in their area;
- Veteran experiences scheduling primary and specialty care;
- Available options for same day services; and,
- Quality of healthcare delivered at every medical center.

The contracts through which we purchase care in the community are undergoing significant changes based on lessons learned. New contracts will be significantly different based on experiences with current contractors and their performance (e.g. access, coverage, etc.). VA followed a methodical approach to receive, categorize, analyze and incorporate feedback from all stakeholders.

The new Community Care Network will increase the number of service areas from two to four, divided by state boundaries, thus allowing each new contractor to provide more local flexibility, improved customer service and increased access to care. Responsibilities for care coordination and scheduling of appointments, which were once assigned to the contractor, will return to VA field sites, unless there is the exercise of an optional task. Interactions with Veterans will be maintained by VA staff on a more face-to-face and timely basis.

Question 61. Do the investments outlined in this budget provide any particular support for veterans in rural communities—like Hawaii—where geography and generational differences in the veteran community require different outreach and communications strategies?

Response. The FY 2018 budget supports Veterans residing in rural communities. VHA's Office of Rural Health (ORH), in concert with VHA national program offices, diligently works to create enterprise wide initiatives and create new and innovative programs that are increasing access to care for rural Veterans. Examples include: Tele-Primary Care and Tele-Mental Health Hubs, Clinical Pharmacy Staffing, and Rural Veteran Transportation Services.

Ensuring access to timely and high-quality care is one of VA's highest priorities. VA Research works to identify and evaluate innovative strategies to improve access and quality, especially for rural Veterans.

Question 62. Will the fact that you are not using the exact platform used by DOD lead to interoperability issues at implementation? What conversations have you had with Secretary Mattis about ensuring interoperability with community providers or CHOICE providers?

Response. With the decision to acquire and implement the same Cerner system that DOD is currently implementing will address the interoperability challenges between the VA and DOD. VA is working with the Department of Defense (DOD) and other subject matter experts, both in government and in the private sector, to ensure our new system will be interoperable with that of community partners. The exact mechanics of the interoperability will be addressed to provide seamless care across a common system is critical to providing the best care for Veterans. VA also realizes the importance of interoperability with our community care partners and educational institutions, and is determining how best to meet this need and will update the Committee soon.

Question 63. Secretary Shulkin you have said that "we're still looking at a multi-year process" and reducing the number of homeless veterans nationwide from roughly 40,000 to 10,000 or 15,000 is an "achievable goal." What is this Administration's specific goal to reduce homelessness and how will this budget help achieve that?

Response. VA is committed to ending Veteran homelessness. While significant progress has been made to reduce Veteran homelessness, there are sub-populations of homeless Veterans who are hard to reach and engage (e.g., chronically homeless Veterans, those with serious mental illness, justice involved Veterans, and those ineligible for VHA health care services).

The 2018 President's Budget includes $1.7 billion for VA's Veteran homelessness programs, including case management support for approximately 93,000 existing HUD-VASH vouchers, grant funding for community-based prevention and rapid rehousing services provided through the Supportive Services for Veteran Families program, clinical outreach and treatment services through Health Care for Homeless Veterans, service intensive transitional housing through the Grant and Per Diem Program and prevention services to justice involved Veterans in the Veteran Justice Program; and employment supports in Homeless Veterans Community Employment Services.

STATUS OF MAUI COMMUNITY BASED OUTPATIENT CLINIC REPLACEMENT CONSTRUCTION

Question 64. Secretary Shulkin, it is my understanding that the VA has received a land donation offer for the Maui CBOC replacement from the State of Hawaii and is currently going through review and concurrence in VA's Central office. What is the current status of this review and concurrence process and when can we expect the concurrence process to be completed? The project is very important to veterans on Maui. Can you ensure that this process is completed as quickly as possible?

Response. The donation of a ground lease from the State of Hawaii was approved by the Office of Construction & Facilities Management on June 23, 2017. VA's local contracting office is now able to proceed with the project.

A P P E N D I X

PREPARED STATEMENT OF JOSEPH R. CHENELLY, NATIONAL EXECUTIVE DIRECTOR, AMVETS (AMERICAN VETERANS)

MR. CHAIRMAN ISAKSON, RANKING MEMBER TESTER AND MEMBERS OF THE COMMITTEE: As the largest veterans service organization open to all veterans who served honorably, regardless of when or where they served, it is a pleasure to present our views on the fiscal year 2018 budget for the U.S. Department of Veterans Affairs (VA).

On behalf of AMVETS National Commander Harold Chapman, we are proud to fully support the requests for funding as outlined in *The Independent Budget* (*IB*). It is crucial that the VA Secretary has all the resources needed to successfully, efficiently and responsibly run the many facets of the Department.

One area of great concern that AMVETS wants addressed immediately is the White House's proposed cut to Individual Unemployability (IU) compensation for veterans eligible for Social Security.

AMVETS National Headquarters has received thousands of emails, calls and messages over the past two weeks from veterans decrying the proposal to steal 225,000 Social Security eligible aged veterans the U.S. Department of Veterans Affairs' IU compensation program if they have paid into Social Security at any point during their life.

Individual Unemployability is a VA program for veterans who cannot work because of their service-connected disabilities. These veterans are rated below 100 percent per the VA rating schedule. But each recipient of IU has been through an exhaustive verification process to ensure they are unable to earn wages above Federal poverty guidelines because of their wounds, injuries or illness.

Cutting this earned and needed benefit would "save" $3.2 billion in 2018 and $41 billion over the next decade, which is slated to go toward an expanded VA Choice program, which has yet to be fully developed. We feel if President Trump knew of the serious repercussions, he would have not included this in his budget request.

These veterans earned a lifetime disability benefit for their service to this Nation. They did not ask to become disabled or to become unemployable as a result of their injuries or wounds. Our nation owes it to them to keep its promise, so they may continue to make ends meet.

If veterans lose their IU, it would trigger the loss of:

- Civilian Health & Medical Program of the VA (CHAMPVA)
- Dependency and Indemnity Compensation (DIC)
- Chapter 35 Educational Benefits for the family
- Commissary privileges
- Property tax relief
- VA Dental & Vision Care
- Vehicle exemption fees

We firmly believe that if this measure of the budget passes, that it would put the lives of these veterans at serious risk. VA's most recent report on suicide notes that about 65% of all veterans who died from suicide were aged 50 years or older.

We urge your committee to reject this dangerous part of the President's budget and not include any cuts to IU in your budget. Every day those who would be affected are growing more distressed. They deserve to keep this earned benefit and live their senior years with some peace of mind knowing that the country they served is not deserting them in the time of their greatest need.

AMVETS is grateful for the Committee's hard work to provide oversight and the resources necessary for our Federal Government to keep its promises to veterans, their families and survivors. Any questions or need for additional information may be addressed to AMVETS National Legislative Adviser Ms. Amy Webb.

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