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THE FISCAL YEAR 2019 BUDGET FOR VETERANS' PROGRAMS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED FIFTEENTH CONGRESS

SECOND SESSION

MARCH 21, 2018

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THE FISCAL YEAR 2019 BUDGET FOR VETERANS' PROGRAMS

WEDNESDAY, MARCH 21, 2018

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

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

Present: Senators Isakson, Moran, Boozman, Heller, Cassidy, Rounds, 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 thank our Ranking Member for being here. Hopefully, the other Members that are coming will be here shortly.

Particularly, I want to thank the Secretary for being here today. We have had a busy month and a half at the VA. I want to thank everybody on the Committee and everybody at the VA for their cooperation as we work toward trying to get in the omnibus, which I do not think we did, but to solve a lot of problems, which I think we did solve, which will be solved shortly after we come back, I hope, because we need to continue to give support to the VA as an agency that we have in the past.

Mr. Secretary, we are glad you are here, and we stand ready to help you in any way that we can.

In keeping with what I said, I am going to introduce you in just a second. I'd like you to introduce your partners in crime who are with you, then make your statement. After which we will do questions. After that, Mr. Fuentes will testify on behalf of the *IBVSOs*, as is our custom, and then we will take questions for Mr. Fuentes and company. So, if that is suitable to everybody—is Mr. Fuentes here. I saw him somewhere. Is he here yet? [Pause.]

Not yet. OK. Well, I hope I am not going too fast, but——

Secretary Shulkin, will you introduce your cohorts and then make your statement please.

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

Secretary SHULKIN. I would be glad to, Chairman Isakson and Senator Moran. First of all, it did not surprise me you did not cancel the hearing today, because I know nothing is going to stop you when it comes to helping veterans, and today is an important hearing. Veterans come first, absolutely.

Let me just introduce my team. As you can see I need a lot of help to understand this budget. To my left is our Assistant Secretary for Finance, our Chief Financial Officer, Jon Rychalski. Matt Sullivan is our Chief Financial Officer for the National Cemetery Administration. Richard Chandler is our Deputy Assistant Secretary for Information Technology, Resource Management. Jamie Manker is our Acting Principal Deputy Under Secretary for Benefits, Veterans Benefits Administration, and Mark Yow is our Deputy Under Secretary for Finance, our CFO for the Veterans Health Administration. Hopefully they will be of help in answering some of the questions that you may have today.

The budget that President Trump has presented for 2019 and the 2020 advanced appropriation is a strong budget and it reflects the President's commitment to veterans and their families. It provides the resources necessary for VA to continue to modernize and to respond to the changing needs of veterans, including investing in foundational services, greater access to care, effective management practices, and modernizing our infrastructure and legacy systems.

The President's 2019 budget requests $198.6 billion for the Department, $88.9 billion in discretionary funding, and $109.7 billion in mandatory funding. The discretionary budget represents an increase of $6.8 billion, or 8.3 percent over the 2018 request. This reflects an additional $2.4 billion in discretionary funding that is now available because of the recent budget cap compromise that was reached.

VA thanks the Congress for this additional funding made through the 2019 budget cap deal. These additional resources enable VA to address our outstanding infrastructure needs while funding veterans' health care, including the care veterans receive under our community care partners under the new CARE legislative proposal. Our capital request is $3.4 billion, or a 20 percent increase over 2018, and ensures we can fix our highest priority infrastructure needs.

By requesting all these necessary resources for our Community Care Program in our discretionary budget, we hope to prevent the need to request further funding increases and lapses in veterans'

care because the funds may be in the wrong checkbook, something I am sure we will talk about later today.

The budget includes $8.6 billion for veterans' mental health services, an increase of $468 million, or a 5.8 percent increase above the current level. This increase will enable about 162,000 more outpatient mental health visits, and it also directs $190 million for suicide prevention outreach. It provides emergency mental health services to members who were administratively discharged in other-than-honorable category.

Further, the budget enables us to effectively implement the President's January 9 Executive Order that supports transitioning military members with mental health services during that first critical year as veterans.

We have also targeted women's health, one of our fastest-growing populations in VA, by adding $29 million more to the fiscal year 2019 budget, an increase of 6 percent over 2018. The budget provides $1.1 billion in major construction, as well as $707 million in minor construction.

I am proud that the 2019 request for infrastructure is the largest in the last 5 years. That will allow us to address VA's modernization, renovation, and aging infrastructure concerns.

In information technology, the budget allows us to innovate operationally and includes an increase of $129 million above the budget from 2018 to enhance the veteran experience.

Another major project made possible by this budget is the financial management business transformation, our financial management system, that, as you know, is a very old system, and this will allow us to have an off-the-shelf modern system.

The budget also supports our new Electronic Health Record Modernization program to significantly enhance the coordination of care for veterans who receive care not only from VA but also the Department of Defense and our community partners. The budget includes $1.2 billion to advance the single accurate lifetime electronic health record. It also makes important investments in benefits. For example, we are going to hire an additional 605 personnel for the Appeals Management Office, an increase of 40 percent, to implement reforms, and an additional 225 people in the fiduciary field examination role to ensure protection for the most vulnerable veterans.

The budget also reflects our efforts to reform business practices intended to do what is right for our veterans and allows us to continue our transformation of VA.

But our responsibilities do not end with simply asking for more resources to support veterans. Along with that request for resources comes the obligation to promote fiscal responsibility. It is my belief that by focusing on the well-being and enhanced functioning of veterans, conducting administrative reviews of disability compensation payment rates, and extending application of the Stop Fraud, Waste, and Abuse initiative to benefits, we will make benefits more equitable for all veterans and wisely use taxpayer resources.

Advances in treatment and medical technologies have significantly reduced the impact of certain disabilities in the lives of many veterans, and our goal is to get veterans better, decrease

their need for compensation, and to do that we have to modernize the rating system.

I want to thank this Committee for their efforts to build an improved integrated network for veterans, community providers, and VA employees. We call these reforms the Veterans Coordinated Access and Rewarding Experiences, or Veterans CARE. CARE is meant to simplify eligibility requirements, streamline clinical and administrative processes, build a high-performing network, and implement new care coordination support for veterans. It is a full spectrum of care for veterans that capitalizes on foundational services and delivers on world-class services.

As Secretary of VA, my job is to build a modern, adaptable, sustainable VA for a changing world. More importantly, my job is to ensure the VA's care, benefits, systems, and policies are stronger in the future. The President's budget supports our mission at VA. In the coming years, these priorities will help VA maintain our commitment to our Nation's veterans.

Mr. Chairman, I look forward to working with you and the entire Committee on doing what is right for veterans, and I look forward to any 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 COMMITTEE. Thank you for the opportunity to testify today in support of the President's Fiscal Year (FY) 2019 Budget, including the FY 2020 Advance Appropriation (AA) request. I am accompanied today by Jon Rychalski, Assistant Secretary for Management and Chief Financial Officer; Mark Yow, Chief Financial Officer for the Veterans Health Administration (VHA); James Manker, Acting Principal Deputy Under Secretary for Benefits; Matthew Sullivan, Deputy Under Secretary for Finance and Planning for the National Cemetery Administration (NCA), and Richard Chandler, Deputy Assistant Secretary for Resource Management, Office of Information and Technology. I also want to thank Congress for making 2017 a legislative success for Veterans. With the unwavering support and leadership of our VA committees, Congress supported and passed groundbreaking legislation on Department of Veterans Affairs (VA) accountability, appeals reform, the Forever GI Bill, Veterans Choice improvements, personnel improvements, and extended Choice funding twice. We have important work left to do, but I am confident we are moving in the right direction. The 2019 budget request fulfills the President's strong commitment to all of our Nation's Veterans by providing the resources necessary to improve the care and support our Veterans have earned through sacrifice and service to our country.

FISCAL YEAR (FY) 2019 BUDGET REQUEST

The President's FY 2019 Budget requests $198.6 billion for VA—$88.9 billion in discretionary funding (including medical care collections), of which $76.5 billion is requested as the FY 2019 AA for Medical Care including collections. The $76.5 billion is comprised of $74.1 billion previously requested (including collections), and an annual appropriation adjustment of $500 million for Medical Services for community care and $1.9 billion for the Veterans Choice Fund. In total, the discretionary request is an increase of $6.8 billion, or 8.3 percent, over the President's FY 2018 Budget request. It will sustain the progress we have made and provide additional resources to improve patient access and timeliness of medical care services for the approximately 9 million enrolled Veterans eligible for VA health care, while improving benefits delivery for our Veterans and their beneficiaries. The President's FY 2019 budget also requests $109.7 billion in mandatory funding, of which $107.7 billion was previously requested, for programs such as disability compensation and pensions.

For the FY 2020 AA, the budget requests $79.1 billion in discretionary funding including collections for Medical Care and $121.3 billion in mandatory advance ap-

propriations for Compensation and Pensions, Readjustment Benefits, and Veterans Insurance and Indemnities benefits programs in the Veterans Benefits Administration (VBA).

This is a strong budget request that fulfills the President's commitment to Veterans by ensuring the Nation's Veterans receive high-quality health care and timely access to benefits and services while concurrently improving efficiency and fiscal responsibility. I urge Congress to support and fully fund our FY 2019 and FY 2020 AA budget requests—these resources are critical to enabling the Department to meet the increasing needs of our Veterans and successfully execute my top five priorities: 1) Focus Resources; 2) Modernize VA Systems and Services; 3) Improve Timeliness; 4) Suicide Prevention; and 5) Provide Greater Choice.

I want to emphasize that the FY 2019 Budget is not a "business as usual" VA Budget. We have critically assessed and prioritized our needs and aggressively pursued internal offsets, modernization reforms, and other efficiencies to provide Veterans the quality care they have earned while serving as a responsible fiscal steward. I greatly appreciate Congress' ongoing support for VA, as demonstrated by consistent support for our legislative priorities and consistently generous enacted appropriations. On behalf of the entire VA and the many Veterans we serve, I thank you for your unflagging commitment to our mission. I take very seriously my obligation to you, the American taxpayer and the Veterans who served our country so well. That commitment is represented in this budget request in which I have worked to bend the cost curve through targeted spending and significant reforms in an attempt to ensure that the VA remains sustainable for years to come.

Priority 1: Focus Resources

The FY 2019 Budget includes $ 76.5 billion for Medical Care, including collections, $4.2 billion above the FY 2018 Budget and $79.1 billion for the FY 2020 AA. I am committed to ensuring Veterans get high quality, timely and convenient access to care *that is affordable* for future generations. As a result, I am implementing reforms that will prioritize our foundational services while redirecting to the private sector those services that they can do more effectively and efficiently. These foundational services are those that are most related to service-connected disabilities and unique to the skills and mission of VHA.

Foundational Services include these mission-driven services, such as:

- Primary Care, including Women's Health;
- Urgent Care;
- Mental Health Care;
- Geriatrics and Extended Care;
- Rehabilitation (e.g., Spinal cord, brain injury/polytrauma, prosthesis/orthoses, blind rehab);
- Post Deployment Health Care; and
- War-Related Illness and Injury Study Centers functions.

VA facility and Veterans Integrated Service Network (VISN) leaders are being asked to assess additional, community options for other health services that are important to Veterans, yet may be as effectively or more conveniently delivered by community providers. Local VA leaders have been advised to consider accessibility of VA facilities and convenience factors (like weekend hours), as they develop recommendations for access to community providers for Veterans in their service areas. Let me be clear, however, that this is not the onset of privatizing VA.

While the focus on foundational services will be a significant change to the way VA provides health care, VA will continue to ensure that the full array of statutory VA health care services are made available to all enrolled Veterans. VA will also continue to offer services that are essential components of Veteran care and assistance, such as assistance for homeless Veterans, Veterans Resource Centers, the Veterans Crisis Line/Suicide Prevention, Mental Health Intensive Case Management, treatment for Military Sexual Trauma, and substance abuse programs.

Investing in foundational services within the Department is not limited to health care. For over a decade, 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 FY 2019 Budget enables the continuation of this unprecedented success with a request for $315.8 million for NCA in FY 2019, an increase of $9.6 million (3 percent) over the FY 2018 request. This request will support the 1,941 Full-Time Equivalent (FTE) employees needed to meet NCA's increasing workload and expansion of services. In FY 2019, NCA will inter over 134,000 Veterans and eligible family members and care for over 3.8 million gravesites. NCA will continue to memorialize Veterans by providing 364,850 headstones and markers, distributing 677,500 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 FY 2019 request includes $117.2 million in major construction funds for three gravesite expansion projects. Upon completion of these expansion projects, and the opening of new cemeteries, nearly 95 percent of the total Veteran—about 20 million Veterans—will have access to a burial option in a national or grant-funded state Veterans' cemetery within 75 miles of their home.

In order to provide Veterans and taxpayers the greatest value for each dollar, the Budget also proposes certain changes to the way in which we spend those resources. For example, our FY 2019 request proposes to merge the Medical Community Care appropriation with the Medical Services appropriation, as was the practice prior to FY 2017. The separate appropriation for Community Care has restricted our Medical Center Directors as they manage their budgets and make decisions about whether the care can be provided in their facility or must be purchased from community providers. This is a dynamic situation, as our staff must adjust to hiring and departures, emergencies such as the recent hurricanes, and other unanticipated changes in the health care environment throughout the year. This change will maximize our ability to focus even more resources on the services Veterans most need.

To further ensure that our entire budget request is focused serving Veterans, VA has implemented an initiative to detect and prevent fraud, waste, and abuse (STOP FWA). In support of this initiative, VA (1) established the VA Prevention of Fraud, Waste, and Abuse Advisory Committee, which will provide VA insight into best practices utilized in the private and public sector; (2) is partnering with Centers for Medicare & Medicaid Services (CMS) to replicate their investigation process and utilize their data to identify medical providers with performance issues; and (3) is working with the Department of the Treasury to perform a deep dive to move VA's Community Care Program closer to the industry best practices.

In 2019, VA will take steps to achieve mandatory savings of approximately $30 billion over the next 10 years, beginning in FY 2021. Due to advancements in treatment and medical technologies, there has been a decrease in the impacts of certain disabilities on the lives of many Veterans.

Priority 2: Modernizing VA Systems and Services

Focusing resources will only take us so far—we need to modernize our VA systems and services, so the Department can continue to provide high quality, efficient care and services, and keep up with the latest technology and standards of care. Key modernization reform proposals included in the FY 2019 Budget Request are Electronic Health Record Modernization (EHRM), Financial Management Business Transformation, modernizing our legacy systems, and infrastructure improvements.

Electronic Health Record Modernization

The Budget invests $1.2 billion in EHRM. The health and safety of our Veterans is one of our highest national priorities. On June 5, 2017, I announced my decision to adopt the same electronic health record (EHR) system as the Department of Defense (DOD). This transformation is about improving VA services and significantly enhancing the coordination of care for Veterans who receive medical care not only from VA, but DOD and our community partners. We have a tremendous opportunity for the future with EHRM to build transparency with Veterans and their care providers, expand the use of data, and increase our ability to communicate and collaborate with DOD and community care providers. In addition to improving patient care, a single, seamless EHR system will result in a more efficient use of VA resources, particularly as it relates to health care providers. Given the magnitude of this transformation and the significant long-term costs and complex contracting needs, we are requesting a single separate account for this effort.

This new EHR system will enable VA to keep pace with the improvements in health information technology and cyber security which the current system, VistA, is unable to do. Moreover, the acquisition of the same solution as DOD, along with the added support of joint interagency governance and support from national EHR leadership including VA partners in industry, government, academic affiliates, and integrated health care organizations, will enable VA to meaningfully advance the goal of providing a single longitudinal patient record that will capture all of a Servicemember's active duty and Veteran health care experiences. It will enable seamless care between the Departments without the current manual and electronic exchange and reconciliation of data between two separate systems. To that end, I have insisted on high levels of interoperability and data accessibility with our commercial health partners in addition to the interoperability with DOD. Collectively, this will result in better service to our Veterans because transitioning Servicemembers will

have their medical records at VA. VA is committed to providing the best possible care to Veterans, while also remaining committed to supporting Veterans' choices to seek care from private providers via our continued investment in the Community Care program.

Legacy Systems Modernization

The FY 2019 Budget continues VA's investment in technology to improve the lives of Veterans. The planned Information Technology (IT) investments prioritize the development of replacements for specific mission critical legacy systems, as well as operations and maintenance of all VA IT infrastructure essential to deliver medical care and benefits to Veterans. The request includes $381 million for development to replace specific mission critical legacy systems, such as the Benefits Delivery Network and the Burial Operations Support System. Investments in IT will also support efforts and initiatives that are directly Veteran-facing, such as mental health applications to support suicide prevention, modifications of multiple programs to accommodate special requirements of the community care program, Veteran self-service applications (Navigator concept), education claims processing integration consolidation, and benefit claim appeals modernization. The Budget also invests $398 million for information security to protect Veterans' information.

The FY 2019 Budget request would increase the Department's ability to apply agile program management to the dynamics of modern IT development requirements. To do this, the Department proposes increasing 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.

Financial Management Business Transformation

Another critical system that will touch the delivery of all health and benefits is our new financial management system, which is under development. The FY 2019 budget requests $72.8 million in IT funds and $48.8 million in fair share reimbursable funding from the Administrations for business process re-engineering to support Financial Management Business Transformation across the Department. These resources support the continued modernization of our financial management system by transforming the Department from numerous stovepipe legacy systems to a proven, flexible, shared service business transaction environment. Even though the U.S. Department of Agriculture (USDA) is not moving forward as VA's Federal Shared Service Provider, VA continues to work with USDA to ensure a smooth transition. VA's Office of Finance continues to manage the program and the implementation is on schedule and within budget.

Infrastructure Improvements and Streamlining

In FY 2019, VA will focus on improving its infrastructure while we transform our health care system to an integrated network to serve Veterans. This budget requests $1.1 billion in Major Construction funding, as well as $706.9 million in Minor Construction for priority infrastructure projects. This funding supports projects including the St. Louis, Missouri, Jefferson Barracks Medical Facility Improvements and Cemetery Expansion project; the Canandaigua, New York, Construction and Renovation project; the Dallas, Texas, Spinal Cord Injury project; and national cemetery expansions in Rittman, Ohio; Mims, Florida; and Holly, Michigan. VA is also requesting $964 million to fund more than 2,100 medical leases in FY 2019 and $672.1 million for activation of new medical facilities.

VA appreciates the support of Congress and is grateful for the passage of the VA Choice and Quality Employment Act of 2017 (Public Law (P.L.), 115–46), which included authorization for 28 major medical leases, some of which had been pending authorization for approximately 3 years. The leases will establish new points of care, expand sites of care, replace expiring leases, and expand VA's research capabilities. In FY 2019, VA is seeking Congressional authorization of four new outpatient clinic leases to expand services currently offered at existing clinics. The requested leases would be located in the vicinities of Lawrence, Indiana; Plano, Texas; Baton Rouge, Louisiana; and Beaumont, Texas.

The FY 2019 Budget includes a new initiative to address VA's highest priority facilities in need of seismic repairs and upgrades. VA's major construction request includes $400 million that will be dedicated to correct critical seismic issues that currently threaten the safety of Veterans and VA staff at VA facilities. The seismic program would fund newly identified unfunded, existing, and partially-funded seismic projects within VA's major, minor, and non-recurring maintenance programs.

VA's FY 2019 Budget includes proposed legislative requests, consistent with the Veteran Coordinated Access & Rewarding Experiences Act draft bill that VA submitted last fall, which, 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 joint facility projects with DOD and other Federal agencies; and 3) expanding VA's enhanced use lease authority to give VA more opportunities to engage the private sector and local governments to repurpose underutilized VA property.

To maximize resources for Veterans, VA repurposed or disposed of 131 of 430 vacant or mostly vacant buildings since June 2017. VA is on track to meet the goal that I set in June 2017 for VA to initiate disposal or reuse actions for all 430 buildings by June 2019.

The Department is also a participant in the White House Infrastructure Initiative, which is exploring additional ways to modernize VA's real property assets, and support our continued delivery of quality care and services to our Nation's Veterans. The proposed Infrastructure Initiative includes flexibilities for VA to leverage existing assets to continue its efforts to reduce the number of vacant buildings in its inventory; tools to leverage VA assets for the construction of needed new facilities to serve Veterans; and an increase to VA's existing medical facility leasing threshold, which would streamline our leasing process so VA can more quickly and efficiently deliver facilities to provide care and services to Veterans.

Accountability and Effective Management Practices

Another critical system VA is significantly improving 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 some employees have tarnished the reputation of VA while so many have dedicated their lives to serving our Nation's Veterans. We will not tolerate employees who deviate from VA's I-CARE (Integrity, Commitment, Advocacy, Respect, and Excellence) values and underlying responsibility to provide the best level of care and services to them. Last May, VA established the Office of Accountability and Whistleblower Protection. Between June 1, 2017, and December 31, 2017, VA removed more than 900 staff (not including probationary terminations) and placed more than 250 staff on suspensions of 14 days or greater. We thank Congress for passing the Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017 (P.L. 115–41), so that new accountability rules for VA are now the law of the land.

We are also focused on improving our unduly burdensome internal hiring practices. In the face of a national shortage of health care providers, VHA faces competition with the commercial sector for scarce resources. Over the past year, we reduced the time it took to hire Medical Center Directors by 40 percent and obtained approval from the Office of Personnel Management for critical position pay authority for many of our senior health care leaders. But there is much work left to do. I will need Congress' help with legislation to reform recruitment and compensation practices allowing VA to stay competitive with the private sector and other employers.

Priority 3: Improve Timeliness

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 access to same-day services for primary care and mental health care at the more than 1,000 all VA clinics across our system. I am also committed to ensuring that any Veteran who requires urgent care will receive timely care.

In 2017, 81.5 percent of nearly 6 million outpatient appointments for new patients were completed within 30 days of the day the Veteran first requested the appointment ("create date"), whereas 97.3 percent of nearly 50.2 million established appointments were completed within 30 days of the date requested by the patient ("patient-indicated date"). VHA has reduced the Electronic Wait List from 56,271 entries to 20,829 entries, a 63.0 percent reduction between June 2014 and December 2017. The Electronic Wait List reflects the total number of all patients for whom appointments cannot be scheduled in 90 days or less. During FY 2018 and FY 2019, VA will continue to focus its efforts to reduce wait times for new patient appointments, with a particular emphasis on primary care, mental health, and medical and surgical specialties.

In FY 2019, 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 FY 2019 Budget requests a total of $76.5 billion in funding for Veterans' medical care in discretionary budget authority, including collections. The FY 2019 request will support nearly 315,688 medical care FTE, an increase of over 5,792 above the 2018 level.

VA is implementing a VISN-level Gap Coverage plan that will enable facilities to request gap coverage providers in areas that are struggling with staffing shortages. It is a seamless electronic request that allows VISNs to focus resources where they are most needed according to supply and demand. Telehealth will be the principal form of coverage in this initiative, which is budget neutral.

NCA has begun phase one expansion of the weekend burial pilot program, which provides Veterans and family members with increased access to burials at select national cemeteries. During phase one, NCA will offer cremation-only weekend burials at six cemeteries. The FY 2019 Budget will support phase two of the pilot by expanding the weekend program to an additional five cemeteries.

Accelerating Processing of Disability Claims

Since 2013, VA has made remarkable progress toward reducing the backlog of disability compensation claims pending over 125 days. VBA's FY 2019 budget request of $2.9 billion would allow VBA to maintain the improvements made in claims processing over the past several years. This budget prioritizes more timely review of 1.3 million rating claims and 187,000 higher level reviews to decrease the amount of time Veterans wait for a resolution. It also prioritizes fiduciary care for vulnerable beneficiaries to ensure protection for VA's most vulnerable veterans who are unable to manage their VA benefits. This budget supports the disability compensation benefits program for 4.5 million Veterans and 600,000 survivors.

To continue improving disability compensation claims processing, VBA has implemented an initiative called Decision Ready Claims (DRC). The DRC initiative offers Veterans, Servicemembers, and survivors faster supplemental claims decisions through a partnership with Veterans Service Organizations (VSO) and other accredited representatives to assist applicants with ensuring all supporting evidence is included with the claim at the time of submission, enabling the claim to be decided within 30 days of submission to VA. In FY 2019, VBA plans to complete 25 percent, or nearly 300,000 disability compensation claims, under the more timely DRC initiative.

Decisions on Appeals

In August 2017, the President signed into law the Veterans Appeals Improvement and Modernization Act of 2017 (P.L. 115–55), which represents the most significant statutory change to affect VA claims and appeals in decades and provides much-needed reform. VA is in the process of implementing the new claims and appeals system by promulgating regulations, establishing procedures, hiring and training personnel, and developing IT systems. By February 2019, all requests for review of VA decisions will be processed under the new law, which will provide a more efficient claims and appeals process for Veterans, with opportunities for early resolution of disagreements with VA decisions.

The FY 2019 request of $174.8 million for the Board of Veterans' Appeals (the Board) is $19.2 million above the FY 2018 Budget and will sustain the 1,025 FTE who will adjudicate and process legacy appeals while implementing the Appeals Improvement and Modernization Act. The Board is currently on pace to produce over 81,000 decisions, a historic level of production.

In addition, VBA is also undertaking a similar, multi-pronged approach to modernize its appeals process through legislative reform, increased resources, technology, process improvements, and increased efficiencies. The requested $74 million for appeals processing increases VBA's appeals FTEs by 605, more than 40 percent above 2018.

This increase comes after VBA realigned its administrative appeals program under the Appeals Management Office (AMO) in January 2017, as part of an effort to streamline and improve performance in legacy appeals processing. The improved focus and accountability resulting from this realignment helped increase VBA appeals production by 24 percent, decrease its appeals inventory by 10 percent, and increase its appeals resolutions by 10 percent, resolving over 124,000 appeals during FY 2017.

In FY 2019, the Appeals Modernization project will achieve the benefit of using Caseflow Certification, which is a commercially developed system that will help reduce errors and delays caused by disjointed manual processing, and improve the Veteran experience by enabling transparency of appeals processing and ultimately facilitating the delivery of more timely appeals decisions.

Priority 4: Suicide Prevention

Suicide prevention is VA's highest clinical priority, and Veteran suicide is a national health crisis. On average, 20 Veterans die by suicide every day—this is unacceptable. The integration of Mental Health program offices and their alignment with the suicide prevention team and the Veterans Crisis Line is being implemented to

further enhance VA's ability to effectively meet the needs of the most vulnerable Veterans. The FY 2019 Budget Request increases resources to standardize suicide screening and risk assessments and expands options for safe and effective treatment for Veterans struggling with Post Traumatic Stress Disorder and suicide.

The FY 2019 Budget requests $8.6 billion for Veterans' mental health services, an increase of 5.8 percent above the 2018 current estimate. It also includes $190 million for suicide prevention outreach. VA recognizes that Veterans are at an increased risk for suicide, and we have 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 Ending 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, starting far earlier in the trajectory that leads to a Veteran taking his or her own life. VA cannot do this alone; 70 percent of Veterans who die by suicide are not actively engaged in VA health care. Veteran suicide is a national issue and can only be ended through a nationwide community-level approach that begins to solve the upstream risks Veterans face, such as loss of belonging, meaningful employment, and engagement with family, friends, and community.

Executive Order to Improve Mental Health Resources

On January 9, 2018, President Trump signed an Executive Order (13822) titled, "Supporting Our Veterans During Their Transition From Uniformed Service to Civilian Life." This Executive Order directs DOD, VA, and the Department of Homeland Security to develop a Joint Action Plan that describes concrete actions to provide access to mental health treatment and suicide prevention resources for transitioning uniformed Servicemembers in the year following their discharge, separation, or retirement.

VA encourages all transitioning Servicemembers and Veterans to contact their local VA medical facility or Vet Center to learn about what VHA mental health care services may be available.

REACH VET Initiative

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) program. This program finishes its first year of full implementation in February 2018 and has identified more than 30,000 at risk Veterans to date. REACH VET uses a new predictive model 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, so that VHA providers can review and enhance care and talk to these Veterans about their needs. REACH VET was expanded to provide risk information about suicide and opioids, as well as clinical decision support to Veterans Crisis Line responders and is being further expanded to provide this important risk information to frontline VHA providers. REACH VET is limited to Veterans engaged in our health care system and is risk-focused, so while it is critically important to those Veterans it touches, it is not enough to bring down Veteran suicide rates. We will continue to take bold action aimed at ending all Veteran suicide, not just for those engaged with our system.

Other than Honorable Initiative

We know that 14 of the 20 Veterans who, on average, died by suicide each day in 2014 did not, for various reasons, receive care within VA in 2013 or 2014. Our goal is to more effectively promote and provide care and assistance to such individuals to the maximum extent authorized by law. To that end, beginning on July 5, 2017, VA promoted access to care for emergent mental health care to the more than 500,000 former Servicemembers who separated from active duty with other than honorable (OTH) administrative discharges. This initiative specifically focuses on providing 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. As part of this initiative, former Servicemembers with OTH administrative discharges who present to VA seeking emergency mental health care for a condition related to military service would be eligible for evaluation and treatment for their mental health condition. Such individuals may access the VA 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 assessment, medication management/pharmacotherapy, lab work, case management, psycho-education, and psychotherapy. As of December 30, 2017, VHA had received 3,241 re-

quests for health care services under this program. In addition, in FY 2017, Readjustment Counseling Services through Vet Centers provided services to 1,130 Veterans with "Other than Honorable" administrative discharges and provided 9,889 readjustment counseling visits.

Priority 5: Greater Choice for Veterans

Veterans deserve greater access, choice, and control over their health care. VA is committed to ensuring Veterans can make decisions that work best for themselves and their families. Our current system of providing care for Veterans outside of VA requires that Veterans and community providers navigate a complex and confusing bureaucracy. VA is committed to building an improved, integrated network for Veterans, community providers, and VA employees; we call these reforms Veteran Coordinated Access & Rewarding Experiences, or Veteran CARE.

Veteran CARE would clarify and simplify eligibility requirements, build a high performing network, streamline clinical and administrative processes, and implement new care coordination support for Veterans. Veteran CARE would improve Veterans' experience and access to health care, building on the best features of existing community care programs. This new program would complement and support VA's internal capacity for the direct delivery of care with an emphasis on foundations services. The CARE reforms would provide VA with new tools to compete with the private sector on quality and accessibility.

Demand for community care remains high. The Veterans Choice Program comprised approximately 62 percent of all VA community care completed appointments in FY 2017. We thank Congress for the combined $4.2 billion provided in Calendar Year 2017 to continue the Choice Program while discussions continue regarding the future of VA community care. Based on historical trends, current Choice funding may last until the end of May 2018, depending on program utilization. VA has partnered with Veterans, community providers, VSOs, and other stakeholders to understand their needs and incorporate crucial input into the concept for a consolidated VA community care program. Currently, VA is working 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. The time to act is now, and we need your help.

In FY 2019, the Budget reflects $14.2 billion in total obligations to support community care for Veterans. This includes an additional $2.4 billion in discretionary funding that is now available as a result of the recently enacted legislation to raise discretionary spending caps. Of this amount, $1.9 billion replaces the mandatory funding that was originally requested in FY 2018 to be carried over into FY 2019. This funding will be used to continue the Choice Program for a portion of FY 2019 until VA is able to fully implement the Veteran CARE program. The remaining $500 million will support VA's traditional community care program in FY 2019. The Administration would also support using discretionary funding provided in FY 2018 in the cap deal to ensure that the Choice Program can continue to operate for the remainder of FY 2018.

Finally, the Budget transitions VA to recording community care obligations on the date of payment, rather than the date of authorization. This change in the timing of obligations results in a one-time adjustment of $1.8 billion, which would support a total 2019 program level of $14.2 billion for community care needs.

FOREVER GI BILL

In addition to expanding choice in health care, the Harry W. Colmery Veterans Educational Assistance Act of 2017 or the Forever GI Bill contains 34 new provisions, the vast majority of which will enhance or expand education benefits for Veterans, Servicemembers, Families and Survivors. Most notably, this new law removes the 15-year time limitation for Veterans who transitioned out of the military after January 1, 2013, to use their Post-9/11 GI Bill benefits. This law also restores benefits to Veterans who were impacted by school closures since 2015, expands benefits for certain Reservists, surviving dependents, Purple Heart recipients, and provides many other improvements. Thirteen of the 34 provisions were effective on the date of enactment, while the remaining provisions have future effective dates ranging from January 1, 2018, to August 1, 2022.

CLOSING

Thank you for the opportunity to appear before you today to address our FY 2019 budget and FY 2020 AA budget requests. These resources will honor the President's commitment to Veterans by continuing to enable the high quality care and benefits our Veterans have earned. They will support my efforts to achieve my top priorities

while ensuring that VA is a source of pride for Veterans, beneficiaries, employees, and taxpayers. I ask for your steadfast support in funding our full FY 2019 and FY 2020 AA budget requests and continued partnership in making bold changes to improve our ability to serve Veterans. I look forward to your questions.

Chairman ISAKSON. Thank you very much, Mr. Secretary. I want to ask one question, then we will go straight to the other Members; that question is, in the event the appropriators do not appropriate, or we fall short on the money we are going to need before the fiscal year is over to meet the demands of care in the community and the other things we have done, are you making plans for what other resources we are going to use to meet those demands?

Secretary SHULKIN. Yes. As you know, Mr. Chairman, we have faced this situation before. As of March 16 we have $1.1 billion left in the Choice fund that is unobligated. At a run rate of about $370 million a month, we will get to probably the first week in June before we start running out of money in the Choice Program. At that point we will rely upon our traditional community care funds, which is approximately $800 million a month.

We will put in place a prioritization system to make sure the veterans that need the care the most are going to get that care in the community as well as in VA. It is not ideal. As you know, all of us share the goal of making sure that veterans are getting the care they want. We prefer that we find a funding mechanism for Choice to get us through the rest of the fiscal year.

Chairman ISAKSON. Yes. I think it is important that we prioritize so we meet the needs of the vets and deliver the services they are expecting from us.

Secretary SHULKIN. Absolutely.

Chairman ISAKSON. Senator Tester.

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

Senator TESTER. Thank you, Chairman. As we have said, I want to thank you for being here today, and Mr. Secretary and your staff, thank you for the meeting yesterday morning.

The budget proposes to spend about $1 billion more on community care this year than last year, and either you or Mr. Rychalski can talk about this $14.2 billion, fiscal year 2019, $13.02 billion in fiscal year 2018. Is that correct?

Secretary SHULKIN. Yes.

Senator TESTER. OK. Overall request for medical care is $76.54 billion, is lower than this year's estimate, which is $77.4, almost a billion dollars less. Is that correct?

Secretary SHULKIN. I am going to refer this to Mark Yow. Mark has a way of explaining this that I think will make sense to you.

Mr. YOW. Senator, as we talked about last year, when you look at only the appropriation you are only getting part of the picture.

Senator TESTER. Yes.

Mr. YOW. There are some other moving parts here—carryover, obligated balances to bring forward. We also have a reduced requirement for hepatitis C this year, about $600 million less than we had last year. So, it is difficult to compare just the appropriation alone and see the difference.

When we look at total obligations, we believe our medical services appropriation is going to increase slightly less than 1 percent this year compared to last year, when we look at all funding sources.

Senator TESTER. The figures that I gave you are from the budget book. What you are saying is that there are carryover dollars that are going to make up the difference?

Mr. YOW. There are a number of funding sources that are available. We have an obligated balance from the prior year——

Senator TESTER. I know, but just tell me. You all tell me that—because your budget is $1 billion less——

Mr. YOW. Yes, sir.

Senator TESTER [continuing]. And I just want——

Mr. YOW. When I look at medical services——

Senator TESTER. Yes.

Mr. YOW. The President's budget requested that VA combine medical services and medical community care together in the budget going forward. When I back out the component that would be medical community care, the residual amount of funding for medical services actually increases by almost 1 percent compared to last year.

Senator TESTER. Is it true that we—the recent budget deal provided an additional $4 billion for existing facilities? You do not need to answer it. It is true. The information that we got from the VA, Secretary Shulkin, from your staff, is that you are going to spend half of that on Choice funding.

Secretary SHULKIN. Yes. That right now is the proposal, which is to spend about half on infrastructure and half on Choice.

Senator TESTER. All right. We have had this conversation almost every time we have been in here, which is that you said multiple times you are not in favor of privatization. We have heard from every VSO except one that they do not want to see privatization. Yet, boy, I see privatization written all over this budget. And I have got to tell you, I never served so this is not about me.

Secretary SHULKIN. Yes.

Senator TESTER. We have created a lot of veterans that are dependent on the VA, and I can tell you, from my perspective, if we privatize this beast the veterans will be up in arms, and should be up in arms. I just want to make sure—the budget is about priorities and I do not see the VA being the priority. I see community care being the priority in this budget. Tell me I am wrong and tell me why.

Secretary SHULKIN. I do think that this is a budget that balances the priorities. There is, as I mentioned in my opening statement, more investment in infrastructure in VA's fiscal year 2019 budget than there has been in the last 5 years. We are desperately trying to hire where we have vacancies and to make sure that we fill these vacancies and improve the way that the services are delivered in VA, but we are not willing to let our veterans wait for care.

Senator TESTER. I got it.

Secretary SHULKIN. Therefore, we are using the community where we need to——

Senator TESTER. I got it.

Secretary SHULKIN [continuing]. And I think over the last couple of years we have made good progress by balancing working with the private sector and trying to strengthen the VA.

Senator TESTER. Yes. Well, I will just tell you, and I cannot speak for everybody sitting around this table, but in Montana they are doing their damndest to privatize the VA. They are using telehealth and pushing people out the door, for basic appointments; not for dealing with mental health and all the stuff we have talked about on this Committee, which is very valuable. They are using it for primary appointments because they have got no docs.

Then, I look at this budget much closer and I would have absolutely brought this up with you yesterday if I had had the numbers I have today.

Secretary SHULKIN. Yes.

Senator TESTER. Let me go to a different area. About 8 months ago you stood with me in Montana—and thank you for being there—and announced VA would be issuing new regulations to help rural communities build State nursing homes for veterans——

Secretary SHULKIN. Yes.

Senator TESTER [continuing]. In a more timely fashion. When will those be released?

Secretary SHULKIN. Well, I absolutely am committed to redoing the regulations to help rural facilities get greater funding. We do need to rewrite those regulations.

Senator TESTER. Yes.

Secretary SHULKIN. We are in the process of doing that right now. They will be rewritten and implemented in 2019, calendar year 2019.

Senator TESTER. That is a ways off. We are in 2018 now.

Secretary SHULKIN. Yes, it takes us, unfortunately 6 to 9 months to complete the rulemaking process.

Senator TESTER. OK. As you know by now, the recently released omnibus had some pretty major money in it for construction of State veterans homes.

Secretary SHULKIN. Yes.

Senator TESTER. I fought hard to make sure this was the case. We need your fiscal year 2018 construction grant priority list. It is yet to be published by the Department, and I would love to see that list. When do you think we can see that list?

Secretary SHULKIN. I think we do have that list available. We would be glad to share that with you.

Senator TESTER. I am going to be really parochial right now.

Secretary SHULKIN. Yes.

Senator TESTER. Is Butte on that list?

Secretary SHULKIN. Butte would be 57th on that list. If we do not——

Senator TESTER. Where is the funding——

Secretary SHULKIN. Current funding levels will not get to 57. It usually gets us to project 13 or 14 on the State Veterans Home Construction Grant Priority List.

Senator TESTER. Even with the omnibus money?

Secretary SHULKIN. Oh. I thought you were talking about State veterans homes.

Senator TESTER. Yes, I am.

Secretary SHULKIN. Yes. Yes. Well, as you know, we have, in 2019, $156 million for that. This year, about $80 or $90 million. So that is why I agree with you, that the rural States were never going to be funded, and I know that was your intention to help the rural States. That is why I have created this new reg that will prioritize a certain amount of funding for rural States.

Senator TESTER. OK. That was not the answer I wanted to hear but I am out of time. Thank you.

Chairman ISAKSON. Just to make sure I understand, Mr. Yow, would you answer a question for me?

Mr. YOW. Sure.

Chairman ISAKSON. When Senator Tester asked the question he asked about funding, and made a comment it looked like you were having a lot of money roll—take a lot of money and you roll it over from the previous year to pay for it next year? Are you all now accruing your expenses at the time they are ordered, not when they are actually provided? Meaning you are accruing more expenses than you actually are realizing? Is that the reason you have more money to roll forward?

Mr. YOW. That is part of it, sir. Yes, sir. You also remember last year, before we got the Choice funds, we had set aside some funds that we were going to ask to transfer into community care. When we eventually got the additional Choice funds, those funds were returned but they were not able to be executed by the field in the time that we had left last year when that was all resolved in August. So, that was about $800 million or so of that.

Chairman ISAKSON. Thank you very much.

Mr. YOW. Yes, sir.

Chairman ISAKSON. Mr. Moran.

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

Senator MORAN. Mr. Chairman, thank you very much. The fiscal year 2018 appropriation bill in the omnibus plusses up State veterans' homes by $100 million or more. It is a significant increase, so I hope it is helpful.

Mr. Secretary, the original Choice bill—we will have a chance to have a conversation in our appropriations process——

Secretary SHULKIN. Yes.

Senator MORAN [continuing]. But I have two questions I am going to try to get in, in the short time that I have. The Choice bill that was passed in 2014, that legislation included a clause that allowed veterans to receive care through Choice based upon, quote, "unusual and excessive burden."

Secretary SHULKIN. Yes.

Senator MORAN. We had a conversation during your confirmation hearing on this topic because we were then told that there were six criteria by which that was limited. It had to meet one of those six criteria to be considered excessive. And you were kind enough—I quote you—"I can give you good news on that. Those were meant to be examples, those six."

Secretary SHULKIN. Right.

Senator MORAN. "I think the field took them literally, that these were the only five conditions."—I am not sure how we got to five.

"So we have now gone out nationally and clarified that, to give the flexibility that you need."

I responded, even with your commitment in hand and on the record, I am reminded that, quote, "In many instances in which the VA assures us they have solved the problem, you get out to Kansas and nobody knows of the change."

Just recently, March 6, one of my veteran staff workers attended a VA Eastern Kansas town hall meeting where the community care supervisor for the region and the medical center director explained the Choice Program and how eligibility works to veterans in the audience. They explained the 40-mile, 30-day criteria. Then they proceeded to discuss a whole new set of criteria that we had never heard of called medical hardship, which is to be used when a veteran has health conditions that prevent them from being able to travel.

Then they talked about the unusual excessive burden. They told the veterans in attendance that that was limited to only six conditions, and that at each month those six conditions changed, based upon guidance sent out by the VA.

So, we have gone from six conditions that are examples to six conditions that are for real, and six conditions that change on a monthly basis. Where are we on excessive burden?

Secretary SHULKIN. Well, I think your interpretation, that you and I discussed at the time of confirmation, is the right one, which is that we want there to be the flexibility that when a veteran has an unusual and excessive burden that they be able to access the Choice Program, and we want that to be. You cannot describe every situation that is going to happen, so we do not want that to be limited to a list. We want there to be clinical and administrative judgment in that. If the field is still not getting that message, we will make sure that we go out and clarify that again.

But we did. Dr. Yehia, at the time that we met with you, went out and spoke to all of our network directors shortly after our conversation, to make sure they understood that.

So, I am disappointed that people are still using rigid lists when they should be using the best judgment for the veteran.

Senator MORAN. I would add a couple of things. One, the idea that the six items change on a monthly basis is even more concerning.

Secretary SHULKIN. Right.

Senator MORAN. That is a whole new aspect that we have never talked about, and this issue, incidentally, is one that Senator Tester pushed to be included in the Choice Reauthorization Bill that we are still attempting to get passed.

Secretary SHULKIN. Right.

Senator MORAN. So, this issue does not go away, even after we pass legislation. I want to make certain that, in the case of the new bill, it is a discussion between the VA physician and a patient, a veteran, in which this can be utilized, and I need to make certain that we are not back to the six criteria as the only way that that excessive burden can be utilized.

Secretary SHULKIN. I am fully supportive of your approach here.

Senator MORAN. Thank you.

Maybe this is a question for Assistant Secretary Rychalski. I want to hear, in your time that you have been there, how are we doing on the ability to estimate the dollars needed? We have had this problem, particularly with Choice, but it is not simply limited to Choice, in which the burn rate is apparently impossible or very difficult to know what it is.

And I heard the Secretary indicate where he is. I heard what Mr. Yow said. Have you got procedures in place that we now are more able to rely on? Again, I will admit that you have only been there a few months.

Mr. RYCHALSKI. Right.

Senator MORAN. Do we have the system in place in which we can rely upon the estimates of the VA to know when those dollars are going to be required, and that we avoid what the Secretary talked about, limitations, changing criteria on who is eligible to Choice by prioritization?

Mr. RYCHALSKI. I would say, in my experience, the short answer is no, we do not have the procedures in place, but I think we are working in that direction. And, I would liken this to my experience with the military health system in the early days of TRICARE, where we had substantial fluctuations. I think the key here is on one hand we need some experience under our belt to get a sense of patient demand, cyclical fluctuations, and contracting issues.

I think the VA, before I asked them, asked for authorities that will help tremendously. By that I mean we talked about the timing of obligation that frees up funding, consolidating the Community Care Programs into one, making it discretionary. All of those things, from a practical standpoint, provide flexibility to manage the highs and lows, and then as time passes and the program stabilizes, what we found in the military health system is you get a better sense of how much money is needed and when that money is needed.

Another thing that we are looking at, that we used to use in the Military Health System, is the actual cash disbursements, which tells you how much cash you need on hand. It is not the obligation. It is actually paying the check.

So, there are a number of things in the works, and I think over the next, you know, 6, 12, 18 months, we will have a much better predictive capability. I know VA is working very hard on it. But, it is just sort of deja vu for me, from what I experienced with the Military Health System some years ago. I think they are on the right track, though, based on my experience and the things that I would recommend, that worked for the Military Health System.

Senator MORAN. It is one of my concerns that we do not necessarily take into account things that are already—have not yet been expended but are obligated.

Mr. RYCHALSKI. Right.

Senator MORAN. Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Moran.

Senator Murray.

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

Senator MURRAY. Thank you very much. Mr. Chairman and Ranking Member Tester. I especially want to thank both of you for

your dedication to passing the caregivers legislation and getting it out of this Committee. I am committed to getting this done, as I know you are, and I really appreciate it. We have talked a lot about how important this program is. It makes a difference for veterans and their families. We heard, in the last few weeks, from the VSOs, that it is a critical priority for them. So, thank you.

Mr. Secretary, I just have to say to you I am disappointed again to see the Department is requesting significant cuts to this program compared to previous projections. I am going to continue to do my part here to make sure those funds are there for those families that need them.

With that, Mr. Secretary, I want to follow up on Senator Tester, because I am concerned the Department is proposing to combine the medical services and the medical community care accounts. I, too, share significant concerns that this is going to lead to diverting funds from the VA health system that desperately needs it in order to send our veterans out to private markets.

So, let me ask you, what specific restrictions and reporting requirements does the Department recommend to provide transparency, first of all, and make sure that the VA system itself is not raided?

Secretary SHULKIN. Well, we have talked about that. We very much appreciate your oversight role in this and we understand very much the sentiments of the Committee, and I share those sentiments. So, we are going to be committed to transparency in how we spend the money, in terms of individual decisions about what money gets invested in the VA, what money goes out into the community. We would propose doing that on a monthly basis and being able to share that with you.

Senator MURRAY. But a proposal—are there strict requirements on transparency that we will see?

Secretary SHULKIN. Sharing with you the allocation of where the money is actually being spent.

Senator MURRAY. And what specific restrictions can we see so that we know that it will not be misspent?

Secretary SHULKIN. Well, it is not a matter, necessarily, I think, not of misspending but it is a matter of—that this is not a——

Secretary MURRAY. Respending.

Secretary SHULKIN. Right. Right. So, if you have some suggestions about how you would like to see us do that, our commitment is to being transparent about this. This is not—while I understand the concern, this is not an attempt to raid money from the VA to privatize. This is an attempt to make the best decisions.

Secretary MURRAY. Well, all of us would feel better——

Secretary SHULKIN. Yes.

Secretary MURRAY [continuing]. If we saw specific recommendations and restrictions, that are written in from the Department that it gives us that assurance.

Secretary SHULKIN. OK. Well, Mr. Rychalski has a suggestion.

Mr. RYCHALSKI. Right. Just a couple of suggestions. One would be, as a practical matter, as a management tactic, it is better for us if we have the consolidation. It is less about, in my mind, privatization as much as it is to promote efficiency in our ability to manage the program.

So, I have a couple of observations. One is we are also proposing that all the funds become discretionary, which I think gives you more control over the discretionary resources. The other thing I would say is that we can provide a spending plan, we can provide monthly reporting, we can provide reporting in advance of, things like that. We will have the same level of visibility.

Senator MURRAY. If you use the word "will" instead of "can."

Mr. RYCHALSKI. We absolutely will.

Secretary SHULKIN. Yes.

Mr. RYCHALSKI [continuing]. To your preferences; we can do all of those things.

Senator MURRAY. OK.

Secretary SHULKIN. We will do all those things.

Senator MURRAY. OK. In my home State of Washington, we have a very serious need for more resources and better oversight, in addition to significant construction and maintenance needs, clinics that need to be relocated. The latest count of veterans experiencing homelessness is increasing——

Secretary SHULKIN. Yes.

Senator MURRAY [continuing]. And increasingly troubling, the Walla-Walla hospital, which is critical to veterans in that part of my State, just received a one-star quality rating. You have promised that the Department will take steps to address both the needs of homeless veterans and make the needed improvements at Walla-Walla. I want to ask what specific resources and personnel the VA is sending to address that.

Secretary SHULKIN. Yes. Well, first of all, we are very concerned about the uptick in homeless veterans. The two largest areas that saw the increase geographically were Seattle and Los Angeles. In both cases, affordable housing is the limitation. We have worked with HUD to make sure that more vouchers are available and that we are pushing the limit on how much we can raise the value of those vouchers to be able to get housing. But, there is a shortage of affordable housing in Seattle, which I am sure you are aware of because it is a very popular place to live and to, you know, be part of that community.

We continue to look for ways to address, particularly in Seattle and Los Angeles, new approaches, and we are working——

Senator MURRAY. Can you get me the specifics on that——

Secretary SHULKIN. Yes.

Senator MURRAY [continuing]. And answer the question on Walla-Walla?

Secretary SHULKIN. Yes. Yes. In Walla-Walla, a one-star facility, we have identified specific management accountability strategies to work with one-star hospitals now, and we are requiring action plans that show how the hospitals will achieve improvements; they are on a very defined time limit to show results. We are providing extra resources and teams to low performing VA health care facilities to help them improve.

Senator MURRAY. OK. Will you get back to my office, specifically the resources and personnel you are going to have to address that. I just have a few seconds, but I was really concerned to see your budget asks for a large decrease in the Office of Inspector General. I know how important that role is. I know you, yourself, were the

subject of investigation. I have really grave concerns about under-resourcing an office that really plays a vital role in our oversight of the VA, on behalf of our Nation's veterans. And I want to know why this budget does not provide the OIG with the full funding that they need?

Secretary SHULKIN. Yes. Listen, we are supportive of the role of the Office of Inspector General (OIG) as well. In fact, this budget actually does provide them with the required resources. Jon, will you explain why it looks like it does not?

Mr. RYCHALSKI. If you look at our budget request from 2018 to 2019, it actually goes up over 7 percent, so the Inspector General's Office, in fact, is receiving an increase. They had some carryover money from a previous year, so they hired above their budget level, and they sort of established that level as the new baseline, which is not technically correct. I mean——

Senator MURRAY. Yes. My understanding is you are losing about 30 staff in the OIG office.

Mr. RYCHALSKI. I am not familiar with that circumstance, I would have to verify that.

Secretary SHULKIN. Let us get back to you. That is not our understanding. Our understanding is that OIG over-hired and that they do have the staffing they need.

Senator MURRAY. Well, your budget asks for a decrease, including the carryover funding, so we have a misconception of reading there.

Secretary SHULKIN. OK.

Mr. RYCHALSKI. Well, I think, historically, for 2 years OIG under-executed their budget. I would be curious to talk with OIG to find out if they have executed their full budget, or are over their budget, and have to eliminate positions.

Senator MURRAY. Thank you.

Secretary SHULKIN. Thank you.

[The information requested during the hearing follows:]

U.S. DEPARTMENT OF VETERANS AFFAIRS,
OFFICE OF INSPECTOR GENERAL,
Washington, DC, April 3, 2018.

Hon. PATTY MURRAY,
Committee on Veterans' Affairs
U.S. Senate, Washington, DC.

DEAR SENATOR MURRAY: Your question regarding the VA Office of Inspector General's (OIG) budget for fiscal year (FY) 2019 was referred to the OIG for a response. We appreciate your interest and are grateful for your support.

The budget request for the OIG FY 2019 of $172 million will not be sufficient for the OIG to fully meet its mission of effective oversight of the programs and operations of VA. While that amount would represent an increase over the OIG's funding of $164 million for FY 2018, it falls short of even the OIG's actual FY 2018 operating budget of $179.9 million (which includes $15.9 million of carryover due to a late hiring cycle that was out of synch with the budget cycle).

There will not be a carryover of that size for FY 2019 as those funds will have been expended primarily on new hires to conduct our oversight work. In addition, we are now funding our Office of Contract Review approximately $5 million that was previously paid by VA through a reimbursable agreement, and there are other increased costs in FY 2019. Consequently, a FY 2019 appropriation of $172 million would likely require a decrease of about 28 OIG staff. This would inevitably result in a curtailment of some of our oversight activities at a time when VA is experiencing growth, including large and complex projects such as VA's new electronic health records initiative, improving VA's financial systems, enhancing and consolidating VA's IT systems, and expansion of community care programs. The OIG will

need additional funds to not only conduct oversight of these costly programs, but also to expand our investigations of other high-risk VA programs, such as construction, procurement, education benefits, and the delivery of timely and quality healthcare. The VA OIG's staffing is among the smallest ratio of oversight staff to agency staff across the Inspector General community. Moreover, the OIG budget represents less than .1 percent of VA's overall budget, which again is less than a significant number of OIGs at other cabinet level agencies. A FY 2019 appropriation of $172 million will undermine progress achieved to "right size" the OIG oversight capacity to match the growth and demands of VA's new initiatives.

We will provide a copy of this letter to Chairman Isakson and request that it be made part of the hearing record.

Again, thank you for interest and support of the OIG.

Sincerely,

MICHAEL J. MISSAL,
Inspector General.

Chairman ISAKSON. Thank you, Senator Murray. Just pause for 1 second. We welcome you, Mr. Rychalski. We are glad to have you on board. This is, I think, your first meeting since you have come on board. We are glad to have you.

Mr. RYCHALSKI. Thank you. It is a pleasure to be here.

Chairman ISAKSON. Mr. Yow, I am sorry this is your last meeting, I think. You are retiring. Is that not correct?

Mr. YOW. Lord willing, yes, sir. [Laughter.]

I sure hope so.

Chairman ISAKSON. We may come draft you, so stay close. You have done a great job for the VA and we appreciate it very, very much.

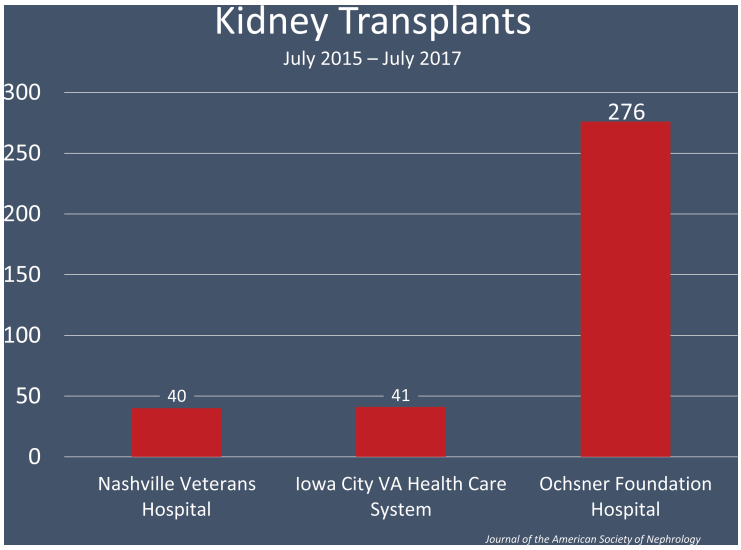
Senator Cassidy.

HON. BILL CASSIDY, U.S. SENATOR FROM LOUISIANA

Senator CASSIDY. Hey, Dr. Shulkin, again. Thank you for all your good work. I am strongly supportive of that which you are attempting to do.

I am going to speak now as a physician who has worked in the transplant field; we had this conversation a little bit a day or so ago. I am concerned regarding the access by veterans to transplantation services, as well as, frankly, the quality of transplant service that they are having access to. The importance, just for those who may not be familiar with transplant services, if you get transplanted you have a higher quality-of-life, you are more likely to live longer, and it costs the taxpayer less money.

There are problems, though. Let me just use the example of kidney transplantation. If you are transplanted at a VA facility, you have a lower rate of survival relative to being transplanted outside the VA. The VA transplant system, I am sure related to this, have a lower volume. Will you give me my first chart please?

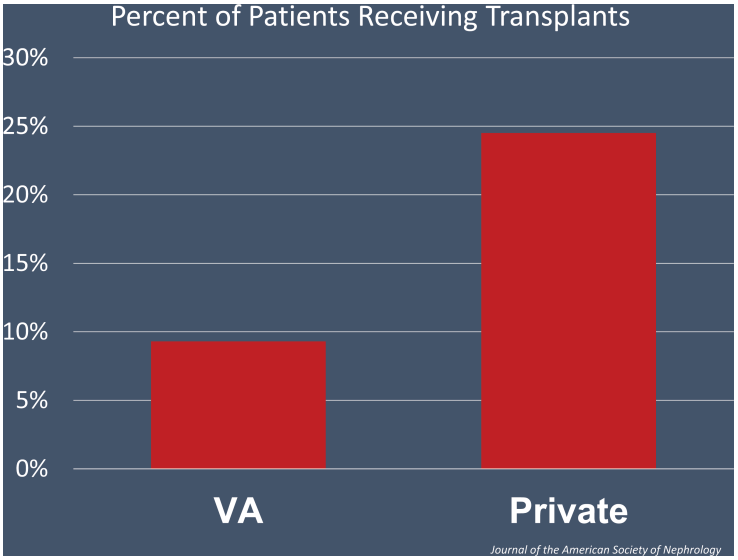


Senator CASSIDY. I mention volume because, as we both know, the higher the volume the more likely someone survives. This is over a 2-year period. Here is where the VA, where somebody from New Orleans would be referred to for transplant. Over 2 years these have 40, whereas Ochsner, which is in the city, has 276. More volume, better outcomes, clearly established.

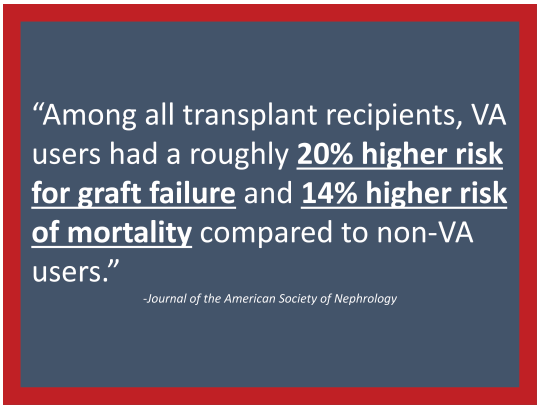
Second, aside from worse outcomes, or as an example, worse outcomes, there is a 20 percent higher rate of organ graft failure if you get it within the VA, as opposed to the non-VA.

Now the VA has submitted testimony.

I am sorry. I should also mention that VA patients have a longer wait time, with a lower rate of referral. Can you show chart two, please? So, if this is somebody with private insurance, this is the rate of referral, and of somebody within the VA, that is their rate of referral. There is also a problem relative to vets not getting referred for transplantation. I will note that the studies say that if the veteran has private insurance along with VA coverage, they have a rate of referral that looks like this, not like that.



Senator CASSIDY. Then, I think that is where I come up with my third chart—I have messed up my assistant—and that is the one which shows that if you do get transplanted with the VA, you have a higher risk of the transplanted organ failing.



We just have got problems. Now, we have submitted an amendment that would allow the veteran to get transplanted, with referral, at a center closer to their home, where they could get, say, if they are in New Orleans, a better-quality transplant. The VA has submitted testimony, not yet heard, but opposing my amendment, allowing veterans to seek care at a higher-volume, higher-quality facility. We have actually requested a briefing from the VA, on February 7, as to why they would oppose this, and, frankly, we have not heard back from the VA. We have asked them and we have still not heard back. We are pinging, pinging, and not hearing back.

So, we have got a problem. When you first—I think the first meeting I heard you speak at, as the deputy secretary, you said the VA should be about the veteran, not about the bureaucracy. Frankly, we are not allowing veterans to stay close to home and have a higher-quality, more-likely-to-live experience. How do we defend that if the veteran is a priority? Your thoughts.

Secretary SHULKIN. First of all, Senator Cassidy, I greatly respect not only your expertise, but exactly the position that you are taking, which is our job to do the best thing for the veteran. And if your data is correct, you and I are going to be working together on this thing.

Senator CASSIDY. Now this is all peer reviewed from the academic literature, and I have the whole stack here in my notebook.

Secretary SHULKIN. What I would like to do is exchange information, as you may have some information that I do not have. The information that I have, which is—and I brought the same thing for you—is a thorough review of the literature that has taken a look at information that shows that there really are no outcome differences between VA and non-VA patient in terms of survival.

Senator CASSIDY. The only subgroup that was true for was African Americans, but if you take all-comers, not just African Americans——

Secretary SHULKIN. Yes.

Senator CASSIDY [continuing]. There was a statistically significant difference.

Secretary SHULKIN. OK. Well, again, we are probably looking at some different studies. I think we can quickly get to the right data analysis. The studies that I have do show the concerns that you expressed about a delay in access to organs, wait times; so that is a concern.

I would be glad to work with you. We want to get to the right answer. We want veterans to get the highest quality care; no doubt about that.

Senator CASSIDY. Now we had asked for a briefing from VA Transplant Services 6 weeks ago and still have not heard back. Is that correct?

Secretary SHULKIN. Well, this is the first I have heard of it, but I can assure you we are going to get that for you; and if I need to come to that directly, I will. We do have—I have from them their fiscal year, quarter 1, 2018 transplant report with all their volumes and outcomes. So, I think together we can get to the best solution here.

Senator CASSIDY. Sounds great.

Secretary SHULKIN. Thank you.

Senator CASSIDY. I thank you. I yield back.

Chairman ISAKSON. Thank you, Dr. Cassidy.

Senator Sanders.

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

Senator SANDERS. Thank you, Mr. Chairman. Thank you, Secretary Shulkin and others for being with us today.

Just three issues that I wanted to touch on. It is no great secret that there is a war going on within the administration and within the Congress about the future of the VA. The veterans' organiza-

tions are very strong, and Senator Tester made this point, that what they want to see is a VA strengthened, not weakened, not dismembered. Yet, we have very powerful political forces in this country, Koch brothers and others, who really want to privatize the VA, and they have some support in the U.S. Congress.

Let me be as clear as I can be. I will do everything that I can to stand with the veterans' organizations and millions of veterans who want to improve the VA and not privatize it.

My experience in Vermont is not dissimilar to Senator Tester's in Montana, that Choice is causing a whole lot of problems for our veterans, through bureaucracy, inadequate payments, so forth and so on. So, I intend to do everything I can to oppose the privatization of the VA, and hope that you will work with us on that, because that is what the veterans want, not a political debate. I think maybe we might want to support the veterans for whom the VA is supposed to be working. All right? That is issue number 1.

Number 2, you have got 35,000 unfilled positions. How do we provide quality care in a timely manner to veterans if you have so many vacancies? And I understand it is a national issue.

Secretary SHULKIN. Yes.

Senator SANDERS. We do not have enough doctors in this country. We do not have enough nurses in this country, which is pathetic unto itself. But, what is the VA doing right now to make sure that we are filling those vacancies in a timely manner?

Secretary SHULKIN. Well, last year we made progress. We had a net gain of about 8,700 employees. This year our budget calls for a net gain of about 5,792 staff. So, what we are trying to do is to streamline our hiring processes. OPM just gave us 15 more categories that we can do direct hiring in, which improves the process. We are doing more hiring fairs. We are working hard to improve——

Senator SANDERS. OK. So, filling those vacancies——

Secretary SHULKIN. Filling the vacancies is——

Senator SANDERS [continuing]. Is a major priority.

Secretary SHULKIN [continuing]. Is a priority.

Senator SANDERS. All right. Second issue. Included in the Bipartisan Budget Act of 2018 is the commitment that $2 billion in fiscal year 2018 and $2 billion in fiscal year 2019 will be used to, quote, "rebuild and improve VA hospitals and clinics," end of quote.

Secretary SHULKIN. Yes.

Senator SANDERS. Instead, the Administration—I gather, you guys—are proposing to use more than half of that $4 billion negotiated for VA infrastructure to fund the existing Choice Program. If we put money into infrastructure to rebuild crumbling buildings in the VA, why are you taking money out of that and putting that into the Choice Program?

Secretary SHULKIN. Well, as you know, we share your concern that the VA infrastructure has been undercapitalized. We estimate it is a $50 billion capital——

Senator SANDERS. That is why we put $4 billion into it.

Secretary SHULKIN. I get it. I get it. That is why the 2019 budget includes more money for major/minor construction than for 5 years, and the——

Senator SANDERS. I know. I was part of that 5-year program.

Secretary SHULKIN. OK. Absolutely. So, our concern is that, as the Chairman indicated in his opening remarks, that we do not today have enough funding—we know this—to get through the Choice and the Community Care programs. We have tried to make a reasoned decision about the best way to use resources. So, ultimately this is up to you.

Senator SANDERS. All right. It is up to us.

Secretary SHULKIN. It is.

Senator SANDERS. I mean, you can come here and we can argue about funding for Choice. That is a good debate. But we put $4 billion into infrastructure and I intend to do everything I can to see that money goes into infrastructure.

Furthermore, as I understand it, this year VA is requesting to combine medical community care and medical services accounts——

Secretary SHULKIN. Yes.

Senator SANDERS [continuing]. And you have further requested to divert discretionary funding intended for other VA purposes to provide additional funding to the Choice Program.

Look, if we want to argue about the Choice Program—you have needs. Come and ask for the Choice Programs. But I resent taking money meant to go into the VA going into the Choice Program.

All right. The last point that I want to make is—I am being parochial, as well.

Secretary SHULKIN. Yes.

Senator SANDERS. You and I have chatted. We are all parochial. We all have our own State needs and that is what it is about.

Secretary SHULKIN. Yes.

Senator SANDERS. Vermont is the only major medical center in the country not to have a dental clinic. You and I have chatted about that.

Secretary SHULKIN. Yes.

Senator SANDERS. Can you give me some assurances that we will end that unfortunate distinction?

Secretary SHULKIN. I received your letter and right now I am working with the dental office to try to address it. I certainly would like to. I cannot tell you that I have a solution for you, but I am going to get one for you in 2 weeks.

Senator SANDERS. I hope you can find us a solution.

Secretary SHULKIN. Yes.

Senator SANDERS. We like to be unique but not in that sense.

Secretary SHULKIN. Yes. Got it.

Senator SANDERS. We also have a situation, as I mentioned to you, that the Burlington Lakeside Clinic—the problem is too many veterans are coming in. They like the quality care that they are getting, yet we do not have the staff to accommodate them, and we want to expand that. Can you give me some assurances that that will happen?

Secretary SHULKIN. I do not have that detail for you yet, Senator. I just do not.

Senator SANDERS. Then let us talk about it.

All right. Let me just conclude on this thing. We all know that you are under a lot of political pressure. We read about that once or twice in the papers. And there are differences of opinion regard-

ing Choice. Let us have that debate. But let us not take money that we have fought for, to go into the VA, and see that taken into the Choice Program. Some of my friends want money for the Choice Program. Come up and argue with the veterans' organizations and tell them why you want it. But when we put money into the VA, we expect it to stay in the VA. Thank you.

Chairman ISAKSON. Senator Rounds.

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

Senator ROUNDS. Thank you, Mr. Chairman, and I appreciate Senator Sanders' concern with regard to the funding and where it goes, where it should be spent. I also have to say, Mr. Chairman, I have appreciated the ability to work with you and everything you have done to try to find consensus on this Committee with regarding to some of the similar issues that Senator Sanders has raised, in particular, the issue of Choice.

I was not here when Choice was created, but I understand the reason why it was created. Correct me if I am wrong, but it appears to me Choice was designed to help veterans be able to access services that were taking more than 30 days to get at VA facility, and for veterans who live more than 40 miles away from a VA facility. I am not sure whether or not either one of those two circumstances have improved to the point where we have either fewer people that live closer than 40 miles to a VA facility, and I am not sure yet that we have seen clear evidence that people are waiting less than 30 days to get an appointment. If they have, and if we have that eliminated, then clearly Choice should be costing us less money, not more.

On the other hand, it seems to me that if the cost of Choice is greater than what we are estimating, it is because veterans are deciding, on a case-by-case basis, that they are better served by moving into a community-based location, as opposed to a VA facility, not that they may not prefer, in many cases, to use the VA services directly.

In my State of South Dakota, if you talk to folks in the Sioux Falls area, they think the Sioux Falls facility is doing a great thing. They are very disturbed with the fact that Hot Springs right now is not receiving the appropriate attention it should as an existing VA facility.

My question to you, sir, if you take a look at Choice right now, and the fact that the people who have been providing services to those veterans are having a terrible time getting paid, and in many cases it is not a matter of not providing the services but it is a matter of a bureaucracy, which is having a very tough time agreeing to make the appropriate payments. Is the reason why Choice is discouraging to some people because they are not happy with that physician who provided the services or the facility that provided the services, or is it because those same physicians have not been getting paid by the VA because of a bureaucracy which simply does not have the tools available to make the decision in a timely manner?

Secretary SHULKIN. Yes. Senator, I think you described all the problems correctly, which is that the Choice Program, well intentioned, was set up to be administratively complex. It was difficult

for veterans to understand how to access it. It has been difficult to administer it. It is why we are proposing to take away seven different ways to pay for the same thing and to put it into a single set of rules and policies so that people can understand it, make it easier to use, and easier to pay the providers.

As you know, coming from a provider background, I strongly believe people deserve to get paid when they deliver a service, and we have failed many of our providers in terms of that. We are making very good progress in correcting some of that now.

So, we want to make this easier for veterans to access private sector services when they need it, when it is the best thing for them, and we want them to be able to access VA services when they choose and when it is easier and better for them to access it. That is what we are trying to build.

Senator ROUNDS. I think you started working on the Community Care Program.

Secretary SHULKIN. Yes.

Senator ROUNDS. And, you really want the Community Care Program to work, but would not it be fair to say that some of those same physicians, who you are going to be trying to contract with, right now are having a very difficult time being paid for past services already rendered? Are you going to have a tough time getting them convinced that the VA is going to be able to have a system in place to pay them appropriately? What are you doing about it?

Secretary SHULKIN. Well, I acknowledge that we have been slow and unfair to many of the providers, so we have developed rapid response teams to deal with those that we owe the most money to and those that are in high-priority areas, particularly rural areas. We are trying to re-establish some of the trust that has been lost. It is a priority for us.

Senator ROUNDS. I think you are on the right track when you are trying to contract in advance with different organizations to provide those services for those veterans. I hope we can come to a consensus, among all of us on this Committee, that it still allows that veteran the ability to make the decision about where they want to receive their service and let them financially make the decision that we adhere to.

I do not want to sit here in Washington, DC, and tell them what a great job the VA is doing when back home they are walking with their feet and going someplace else simply because of the availability of the services closer to home, or perhaps, in some cases, because, truly, as Senator Cassidy has suggested, they feel that there may be better services at an outside facility.

I want the VA to feel—I want the VA to be able to promote themselves as being a center of excellence for a lot of the services that veterans cannot get anyplace else.

Secretary SHULKIN. Yes.

Senator ROUNDS. I most certainly hope that we are on the same track——

Secretary SHULKIN. Yes.

Senator ROUNDS [continuing]. In making sure that this is focused on the veteran and not on the VA.

Secretary SHULKIN. You know, Senator, I think what you are describing is something that I hope all of us can believe in. How could

you argue against wanting veterans to have choice and the best type of care?

I think what you are hearing from some other Members of the Committee are that VA, for decades, has been put in an inferior position, by being undercapitalized, by having bureaucratic rules on how to hire. So, if we can make this a more modern system to allow VA to be able to have the type of services we want, and the private sector to be available to veterans, I think that is the best system possible, because then the veteran has the choice.

So, I think while it is difficult, and maybe I make nobody happy with this answer, we are trying to balance an investment in VA to make it a stronger system at the same time that we are trying to make sure that we are not keeping veterans in a system that is not working for them.

Senator ROUNDS. Not at the cost of a veteran.

Secretary SHULKIN. Right.

Senator ROUNDS. Thank you.

Secretary SHULKIN. Yes.

Senator ROUNDS. Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Rounds. I am going to continue the—we have not even called the vote, right, so I am going to keep going as long as I can. The next up in the batter's box, a baseball fan himself, Senator Brown.

HON. SHERROD BROWN, U.S. SENATOR FROM OHIO

Senator BROWN. Thank you, Mr. Chairman. Mr. Secretary, welcome, and to all of you. Thanks for serving us and serving veterans. Before these hearings typically I call around to veterans hospitals, Vet Centers in Ohio and Cleveland, Columbus, Cincinnati, and Chillicothe and talk to directors. I talk to veteran service organizations, as Senator Sanders said, VSOs and commanders around my State, and we hear from national commanders in hearings. Ohio is one of the, I believe, two dozen States that has Veteran Service Commissions in each of our 88 counties, and I talk to a number of them.

I echo the concerns that Senators Tester, Murray, and Sanders said. None of them—almost none of them likes the idea of this move toward privatization. I understand the pressure you are under, the accelerated pressure you are under. We hope that you continue to understand that veterans in this country do not want to see a rush toward privatization, political antics notwithstanding, political challenges here notwithstanding.

First, thank you for the $29 million—I will be local, as Bernie said a minute ago—$29 million commitment to the Ohio Western Reserve Cemetery. Thank you for that.

I want to talk to you about housing and about homelessness, as Senator Murray did. Through better policy, increased Federal funding we made progress. HUD's January 2017, however, point in time count showed 40,000 veterans still homeless. It has increased nationally. My question, sir, were you consulted before HUD decided to not ask for the additional HUD-VASH vouchers to meet this need in 2019 fiscal year? Did you push back? Do you believe the rest of VA's homelessness programs are enough to address the growing need?

Secretary SHULKIN. Yes. My understanding of what HUD has done is they have committed to keeping the same amount of vouchers in the system, not decreasing them, that they rotate. When somebody stops using a HUD voucher they have committed to keeping those active. So, it is actually the same number of vouchers that have been out there. Secretary Carson and I——

Senator BROWN. But you did not ask Carson to come up with additional vouchers.

Secretary SHULKIN. No. No, but Secretary Carson and I have talked about what we need to do to begin to start making additional progress, and certainly additional HUD-VASH vouchers would be helpful, from my point of view, but he has a lot of things that he is balancing in his own system. I wanted to make sure that there was not any decrement in commitment from HUD, and they have committed to the program, because it has been a very successful program.

Senator BROWN. Well, one of the things he is balancing is—and I am going to ask him about this in Banking Committee tomorrow—is a whole lot of family involvement, expenditure of money that does not go to housing. When I was just at the Neighborhood Housing Services in Cleveland this week. One out of four homes, families in Cuyahoga County, Ohio's second-largest right-on-the-edge counties, one out of four live in housing where more than half their income goes to housing. While this is not a HUD hearing, I understand, but what has happened——

Secretary SHULKIN. No, right.

Senator BROWN [continuing]. With HUD in budget cuts and blaming it on the budget deficit after tax cuts and then, you know, you, representing veterans, have to pay for part of that. I mean, I know that there is a better budget for veterans——

Secretary SHULKIN. Right.

Senator BROWN [continuing]. Than there is housing, but it certainly washes on you. I am hopeful you will use your cabinet meetings and discussions with Secretary Carson——

Secretary SHULKIN. Yes.

Senator BROWN [continuing]. To push for more vouchers. OK. Thank you for that.

I want to talk about that day you and I were sitting next to each other on the runway for 3 hours in an airplane, which I will always smile about. We discussed a lot of things. We had a lot of time. One of them was Agent Orange presumptive eligibility——

Secretary SHULKIN. Yes.

Senator BROWN [continuing]. Categories, and I hear—I think we all hear often from veterans affected by toxic exposure. I have about five questions that I—it is too—we do not have enough time to go through all of them.

Secretary SHULKIN. Yes.

Senator BROWN. Let me just read the four questions. Let me read the questions. We will get them to you and I hope you can give us a good, specific answer in writing.

First, when will you make a determination regarding Agency Orange presumptive conditions, including bladder cancer, hypothyroidism, and Parkinson's-like symptoms? I know the VA has done

a good job at adding to those names, those illnesses, but they are obviously a continued challenge.

Second, what steps has VA taken to follow congressional intent and provide benefits for Blue Water Navy veterans? Third, my understanding is a diagnosis for constrictive bronchiolitis is somewhat invasive. How do you make sure that veterans are being tested for that?

Last, how does—and you could answer this one now—how does the fiscal year budget keep faith with our servicemembers and veterans who have been placed in harm's way and exposed to toxic chemicals? As we add more of those and more of them come forward, how does our budget deal with that?

Secretary SHULKIN. OK. I will try to do this very briefly. The issue of the Agent Orange presumptions is a very important topic. We have been studying this for a long time. As you know, we recently got the *National Academy of Medicine* study back, which reflects data updated through 2014. I have transmitted my recommendations to the Office of Management and Budget. I did that by November 1. We are in the process right now of going through this data. In fact, we met with them on Monday. They have asked for some additional data, to be able to work through the process and be able to get financial estimates for this. We are committed to working with OMB to get this resolved in the very near future.

The Blue Water Navy, I have already said, I think our veterans have waited too long for this. I very much respect your position on this. I would like to try to find a way where we can resolve that issue for them, rather than make them continue to wait. I do not believe that there will be scientific data that will direct us in this, to give us a clear answer, like we do have on Agent Orange presumptives. The Blue Water Navy, those epidemiologic studies just are not available, from everything I can see. So, we are going to have to sit down and do what we think is right for these veterans.

The bronchiolitis, I am going to have to get back to you further on the diagnostic conditions on that. I know how to diagnose bronchiolitis, but I suspect your question involves more in terms of a military exposure.

And we continue—wherever we find scientific data, on your last question, where there is an association between an environmental exposure and service, wherever there is data, that is our job then to honor that commitment to our veterans, and we continue to do that. That is why we are studying burn pits and Gulf War veterans, and we continue to update our Vietnam veteran epidemiologic studies and continue to add as we find those scientific associations are there.

Senator BROWN. Thank you, Mr. Chairman. I think I speak for many on this Committee to hope that a year from now we see Secretary Shulkin sitting in that chair.

Chairman ISAKSON. Well, I pretty openly stated that on many occasions in the last 2 weeks. He has done a great job and veterans have a champion working for them every day as we work through the problems we run into in swamps from time to time.

I am going to go to Senator Boozman and then to Senator Manchin, and we will be finished with the Members, if everybody will take it within their time.

Senator Boozman.

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

Senator BOOZMAN. Thank you, Mr. Chairman, and thank you, Mr. Secretary, for being here. We do appreciate your hard work and your team's hard work.

In your testimony you stated that suicide prevention is the VA's highest clinical priority.

Secretary SHULKIN. Yes.

Senator BOOZMAN. You are requesting $8.6 billion for veteran mental health services, a 5.8 percent increase over last year. We are all aware of the staggering statistics, that no matter how much we seem to invest we simply still are talking about the 20 veterans that are committing suicide every day——

Secretary SHULKIN. Yes.

Senator BOOZMAN [continuing]. Which is a problem. We also know that only six of those are part of the VA system. In last year's budget, mental health funding supported treatment to nearly 1.7 million veterans and allowed you to hire 1,103 mental health providers and 31 peer support specialists. Again, those are of great benefit to veterans within the VA system, but it leaves out the largest group, these veterans that are committing suicide that are not part of the system, which are so difficult.

You talked about this in your testimony; you talked about the VA cannot do this alone.

Secretary SHULKIN. Yes.

Senator BOOZMAN. Seventy percent of veterans who die by suicide are not actively engaged in VA health care. You talked about President Trump's Executive order——

Secretary SHULKIN. Yes.

Senator BOOZMAN [continuing]. Directing DOD, VA, DHS to develop a joint action plan to establish concrete actions, again, to address this problem. So, $190 million more for veteran suicide prevention outreach, that is a great thing.

I guess the question is, what type of outreach—what are we going to do with that? What type—how is this funding going to affect the veterans that are——

Secretary SHULKIN. Yes.

Senator BOOZMAN [continuing]. Outside of the reach of the VA?

Secretary SHULKIN. I think the best model that we are trying to replicate is what we did in homelessness, which is that we need the entire community's involvement in this. A week ago we had a mayor's challenge of eight cities who stood up and said we are going to bring a team to Washington from those eight cities, and commit ourselves to suicide prevention training with the Federal Government, SAMHSA, as well as VA and others in Federal Government. So, we are reaching out to communities.

We have a social media outreach called #BeThere or BeThereForVeterans.com. Tom Hanks is our national spokesperson where we are trying to get the words out to communities, churches, not-for-profit groups, where there are veterans in need, to reach

out to them and find them resources to help. We have 130 community veteran experience boards, where we bring together groups in the community to focus on suicide as well as other issues for veterans.

So, this model of reaching out for help that the VA cannot do it alone I think is very powerful. I think it will have an impact on the 14 veterans a day that are not getting their care in VA. Of course, we want anybody who needs help to reach out to us through our Veterans Crisis Line or to come in to any of our facilities.

Senator BOOZMAN. You mentioned the hashtag VA. Are you developing any other things to make it easier for a veteran to connect, either with the VA or outside?

Secretary SHULKIN. Yes. Yes, we do. We are adding to our app store, you know, apps where people can connect. We now do texting through our Veterans Crisis Line. Of course, adding another 200 responders to the Veterans Crisis Line and the fact that we now answer the phone on a regular basis I think adds to that capability. Every one of our VA facilities has signed a Suicide Prevention Pledge, which commits the leadership team to doing more in terms of outreach.

Look, this is a tough problem, and we need other people's ideas. We are working with technology companies about innovative ways to do this. But, we are open to other ideas because we just have to do more.

Senator BOOZMAN. Good. Well, we appreciate you elevating it to the level that you have, deservedly so, and I look forward to working with you.

Secretary SHULKIN. Thank you.

Senator BOOZMAN. I yield back, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Boozman, and I want to publicly apologize to Mr. Fuentes, who was to testify in the second panel for the VSOs, but we are going to run out of time after Senator Manchin has his time, says his piece.

So, I am, without objection, submitting the testimony of Mr. Fuentes for the record. Then, Senator Tester and I will meet him at an appropriate time in the next 2 weeks to personally go over the testimony with him together. Right, Jon?

Senator Tester. Yes.

Independent Budget Representatives

STATEMENT OF CARLOS FUENTES, NATIONAL LEGISLATIVE DIRECTOR, VETERANS OF FOREIGN WARS OF THE UNITED STATES; ACCOMPANIED BY SARAH DEAN, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; AND LeROY ACOSTA, ASSISTANT NATIONAL SERVICE DIRECTOR, DISABLED AMERICAN VETERANS

[The prepared statement of Mr. Fuentes follows:]

JOINT STATEMENT OF THE CO-AUTHORS OF *THE INDEPENDENT BUDGET*:

DISABLED AMERICAN VETERANS

PARALYZED VETERANS OF AMERICA

VETERANS OF FOREIGN WARS

CHAIRMAN ISAKSON, RANKING MEMBER TESTER, AND MEMBERS OF THE COMMITTEE, On behalf of the co-authors of *The Independent Budget* (*IB*)—DAV (Disabled American Veterans), Paralyzed Veterans of America (PVA), and Veterans of Foreign Wars (VFW)—we are pleased to present the views of the *IB* organizations regarding the funding requirements for the Department of Veterans Affairs (VA) for fiscal year (FY) 2019, including advance appropriations for FY 2020.

The *IB*'s recommendations include funding for all discretionary programs for FY 2019 as well as advance appropriations recommendations for medical care accounts for FY 2020. The full budget report recently released by the *IB* addressing all aspects of discretionary funding for the VA can be downloaded at www.independentbudget.org. However, the current FY 2018 funding for VA medical care programs is particularly concerning because previous VA Secretary Robert McDonald admitted last year that the VA's FY 2018 advance appropriation request was not sufficient and would need significant additional resources provided this year.

This insufficient level is reflected in the "Continuing Appropriations Act, 2018 and Supplemental Appropriations for Disaster Relief Requirements Act, 2017" as approved and amended by Congress. VA's medical care programs are currently funded at $71.7 billion and in light of the Administration's revised request of $74.7 billion for FY 2018, submitted last year, VA has been forced to operate under a $3 billion shortfall for nearly half this fiscal year despite increased demands on the system.

The *IB* veterans service organizations (*IBVSO*) believe that the FY 2019 VA revised budget request for VA medical programs and construction is similarly insufficient to meet the health care needs of ill and injured veterans, their families and survivors.

The Administration's revised budget request for medical programs includes $74.1 billion in total discretionary spending and $1.9 billion in mandatory spending for FY 2019. Considering the additional $1.9 billion that the Administration requests to replenish the Choice Act funds in addition to the $14.2 billion Congress has already appropriated under emergency designation since 2014,[1] the total projected expenditure from VA for medical programs in FY 2019 is approximately $76 billion. The *IBVSO*s recommend $82.6 billion in total medical care funding for the VA. For FY 2020, the Administration is requesting $79.1 billion for medical care programs and the *IB* recommends $84.5 billion.

The *IBVSO*s share growing concerns about the massive growth in expenditures in community care spending in FY 2019, which includes $8.4 billion in community care, $1.9 billion and any remaining Choice Act funds. We understand the need for leveraging community care to expand access to health care for many veterans, as discussed in the *IB* framework, but we are troubled by the virtually uncontrolled growth in this area of VA health care spending.

Congress and the Administration must be sure to devote critical resources to expand capacity and increase staffing of the VA health care system, particularly for specialized services such as spinal cord injury or disease, blind rehabilitation, polytrauma care, mental health care, and to address the added health care reliance of veterans on the VA attributed by the Department from the Choice Act. The integrated and holistic nature of VA health care cannot simply be punted into the private sector. Simply outsourcing more care to the community without the same accountability of health outcomes, quality of care, and treatment efficacy could yield higher costs to the tax payer and will ultimately undermine the larger health care system on which so many veterans with the most catastrophic disabilities must rely.

The Bipartisan Budget Act of 2018 (BBA) significantly raised the defense and non-defense discretionary spending caps in FY 2018 and FY 2019, and the President

[1] $10 billion under Public Law 113–146 enacted August 7, 2014, $2.1 billion added August 12, 2017 under Public Law 115–46, and December 22, 2017 under Public Law 115–96.

has signed these new caps into law. In light of the BBA, the Administration modified its FY 2019 budget request to account for these new cap levels.

MEDICAL SERVICES

For FY 2019, the *IB* recommends $53.7 billion for Medical Services. This recommendation includes:

Current Services Estimate	$50,794,232,000
Increase in Patient Workload	$1,636,092,000
Additional Medical Care Program Costs	$1,230,951,000
Total FY 2019 Medical Community Care	$53,661,275,000

The *IBVSO*s believe that significant attention must be placed on ensuring adequate resources are provided through the Medical Services account to ensure timely delivery of high quality health care. The budget shortfall this fiscal year is emblematic of the insufficient funding that has plagued, and may continue to plague, the VA health care system going forward. In FY 2018 (and subsequent fiscal years), the problem will be compounded as the VA will be shedding funds from its traditional Medical Services account to push more care into the community. With these thoughts in mind, for FY 2019, the *IB* recommends $53.7 billion for Medical Services.

Additionally, we believe the Administration's advance appropriation request for Medical Services in FY 2020—$48.5 billion—is woefully inadequate to meet even today's demand for VA health care services. The Administration appears to ignore its responsibility to request a budget that meets its requirements particularly for VA medical care. In light of recent history of Congress advance appropriating based on VA's initial advance appropriation request, the request for FY 2020 is an unacceptable proposition. For FY 2020, the *IBVSO*s recommend Congress appropriate $54.7 billion as an advance appropriation for Medical Services.

Our recommendations for Medical Services reflect the estimated impact of uncontrollable inflation on the cost to provide services to veterans currently using the system. We also assume a 1.1 percent increase for pay and benefits across the board for all VA employees in FY 2019, as well as 1.2 percent in the advance appropriation recommendation for FY 2020.

Our medical programs funding recommendation for FY 2019 is adjusted in the baseline for funding within the Medical Services account based on VA's revised request for FY 2018. *The Independent Budget* believes this adjustment is necessary in light of the nearly $3 billion shortfall that the VA health care system is currently experiencing. If the baseline from FY 2018 is not adjusted to better reflect the true demand for services, we believe VA will once again face a shortfall this fiscal year and the next, while forcing veterans who choose VA for care to unnecessarily wait to receive such care.

Additional Medical Care Program Costs:

The Independent Budget report on funding for FY 2017 and FY 2018, delivered to Congress on February 9, 2016, also includes a number of key recommendations targeted at specific medical program funding needs for VA. We believe additional funding is needed to address the array of long-term-care issues facing VA, including the shortfall in institutional capacity; critical resources to address the continually increasing demand for life-saving Hepatitis C treatments; to provide additional centralized prosthetics funding (based on actual expenditures and projections from the VA's Prosthetics and Sensory Aids Service); funding to expand and improve services for women veterans; and new funding necessary to improve the growing Comprehensive Family Caregiver program.

Long-Term Services & Supports

The Independent Budget recommends a modest increase of $82 million for FY 2019. This recommendation reflects a significant demand for veterans in need of Long-Term Services and Supports (LTSS) in 2017 particularly for home- and community-based care, we estimate an increase in the number of veterans using the more costly long-stay and short-stay nursing home care. This increase in funding also reflects a rebalancing of available resources toward home- and community-based care, which will likely yield a commensurate decrease in institutional spending as is being achieved by states with their rebalancing of spending initiatives.

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 2017 to FY 2018 and the expected continued growth in expenditures for FY 2019.

Women Veterans

The Medical Services appropriation should be supplemented with $500 million designated for women's health care programs, in addition to those amounts already included in the FY 2018 baseline. These funds would allow the Veterans Health Administration (VHA) to hire and train an additional 1,000 women's health providers to meet increasing demand for health services based on the significant growth in the number of women veterans coming to VA for care.

Additional funds are needed to expand and repair VA facilities to meet environment of care standards and address identified privacy and safety issues for women patients. The new funds would also aid VHA in continuing its initiative for agency-wide cultural transformation to ensure women veterans are recognized for their military service and made to feel welcome at VA. Finally, additional resources are needed to evaluate and improve mental health and readjustment services for catastrophically injured or ill women veterans and wartime service-disabled women veterans, as well as targeted efforts to address higher suicide rates and homelessness among this population.

Reproductive Services (to Include IVF)

Congress authorized appropriations for the remainder of FY 2018 and FY 2019 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 2019. 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 2019.

Emergency Care

VA has issued regulations to begin paying for veterans who sought emergency care outside of the VA health care system based on the *Richard W. Staab* v. *Robert A. McDonald* ruling by the U.S. Court of Appeals for Veterans Claims.

The requested $298 million increase in funding reflects the amounts VA has estimated it will need to dispose of pending and future claims. VA has indicated it will not retroactively pay benefits for such claims that were finally denied before April 8, 2016, the date of the Staab decision, and will only apply the new interpretation to claims pending on or after April 8, 2016.

Extending Eligibility for Comprehensive Caregiver Supports

Included in this year's *IB* budget recommendation is funding necessary to implement eligibility expansion of VA's comprehensive caregiver support program to severely injured veterans of all eras. Funding level is based on the Congressional Budget Office estimate for preparing the program, including increased staffing and IT needs, and the beginning of the first phase as reflected in our $11 million FY 2019 recommendation.

MEDICAL COMMUNITY CARE

For Medical Community Care, the *IB* recommends $14.8 billion for FY 2019 and $15 billion for FY 2020.

Current Services Estimate	$14,534,613,000
Increase in Patient Workload	$235,009,000
Total FY 2019 Medical Community Care	$14,752,153,000

Our recommended increase includes the growth in current services to include current obligations under the Choice program. The Choice program is a temporary mandatory program funded under emergency designation and is outside the annual budget process that governs discretionary spending. VA received an infusion of $2.1 billion in August 2017 and another $2.1 billion in December 2017 after it notified Congress program resources could be depleted. While increasing access to community care, the Choice program has in turn increased veterans' reliance on VA medical care.

We also believe funding VA programs for community care with a discretionary and mandatory account creates unnecessary waste and inefficiency. *The Independent Budget* has advocated for moving all funding authorities for the Choice program (and other community care programs) into the discretionary accounts of the VA managed under the Medical and Community Care account.

MEDICAL SUPPORT AND COMPLIANCE

For Medical Support and Compliance, *The Independent Budget* recommends $6.8 billion in FY 2019. Our projected increase reflects growth in current services based on the impact of inflation on the FY 2018 appropriated level. Additionally, for FY 2020 *The Independent Budget* recommends $7.4 billion for Medical Support and Compliance. This amount also reflects an increase in current services from the FY 2019 advance appropriation level.

MEDICAL FACILITIES

For Medical Facilities, *The Independent Budget* recommends $7.3 billion for FY 2019, which includes $1.2 billion for Non-Recurring Maintenance (NRM). The NRM program is VA's primary means of addressing its most pressing infrastructure needs as identified by Facility Condition Assessments (FCA). These assessments are performed at each facility every three years, and highlight a building's most pressing and mission critical repair and maintenance needs. VA's request for FY 2019 includes $1.4 billion for NRM funding assumes an investment of $1.9 billion in FY 2018. While the Department has actually spent on average approximately $1 billion yearly for NRM, we are concerned its FY 2019 request includes diverting funds programmed for other purposes—$210.7 million from Medical Support and Compliance and $39.3 million from the Medical Services/Medical Community Care accounts.

For FY 2020, the *IB* recommends approximately $7.5 billion for Medical Facilities. Last year the Administration's recommendation for NRM reflected a projection that would place the long-term viability of the health care system in serious jeopardy. This deficit must be addressed in light of its $627 million request for FY 2020.

MEDICAL AND PROSTHETIC RESEARCH

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

For VA research to maintain current service levels, the Medical and Prosthetic Research appropriation should be increased in FY 2019 to go beyond simply keeping pace with inflation. It must also make up for how long the continuing resolution funding level for FY 2018 has been in effect. Numerous meritorious proposals for new VA research cannot be funded without an infusion of additional funding for this vital program. Research awards decline as a function of budgetary stagnation, so VA may resort to terminating ongoing research projects or not funding new ones, and thereby lose the value of these scientists' work, as well as their clinical presence in VA health care. When denied research funding, many of them simply choose to leave the VA.

Emerging Research Needs

*IBVSO*s believe Congress should expand research on emerging conditions prevalent among newer veterans, as well as continuing VA's inquiries in chronic conditions of aging veterans from previous wartime periods. For example, additional funding will help VA support areas that remain critically underfunded, including:

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

• leverage the only known integrated and comprehensive caregiver support program in the U.S. to help inform policymakers and other health systems looking to support informal caregivers.

Million Veteran Program

The VA Research program is uniquely positioned to advance genomic medicine through the "Million Veteran Program" (MVP), an effort that seeks to collect genetic samples and general health information from one million veterans over the next five years. When completed, the MVP will constitute one of the largest genetic repositories in existence, offering tremendous potential to study the health of veterans. To date, more than 620,000 veterans have enrolled in MVP, far exceeding the enrollment numbers of any single VA study or research program in the past, and it is in fact one of the largest research cohorts of its kind in the world. The VA estimates it currently costs around $75 to sequence each veteran's blood sample.

Accordingly, the *IBVSO*s recommend $65 million to enable VA to begin processing the MVP samples collected. Congress must begin a targeted investment to go beyond basic, surface-level genetic information and perform deeper sequencing to begin reaping the benefits of this program.

CONSTRUCTION PROGRAMS

Major Construction

Each year VA outlines its current and future major construction needs in its annual Strategic Capital Investment Planning (SCIP) process. In its FY 2018 budget submission, VA projected it would take between $55 billion and $67 billion to close all current and projected gaps in access, utilization, and safety including activation costs. Currently, VA has 21 active major construction projects, which have been partially funded or funded through completion.

In its FY 2018 Budget Request, VA requested and Congress intends to appropriate a significant reduction in funding for major construction projects—between $410 million and $512 million. While these funds would allow VA to begin construction on key projects, many other previously funded sites still lack the funding for completion. One of these projects was originally funded in FY 2007, while others were funded more than five years ago but no funds have been spent on the projects to date. Of the 21 projects on VA's partially funded VHA construction list, eight are seismic in nature. Seismic projects are critical to ensuring VA's facilities do not risk the lives of veterans during an earthquake or other seismic events.

It is time for the projects that have been in limbo for years or that present a safety risk to veterans and employees to be put on a course to completion within the next five years. To accomplish this goal, the *IBVSO*s recommend that Congress appropriate $1.73 billion for FY 2017 to fund either the next phase or fund through completion all existing projects, and begin advance planning and design development on six major construction projects that are the highest ranked on VA's priority list.

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

Research Infrastructure

State-of-the-art research requires state-of-the-art technology, equipment, and facilities. For decades, VA construction and maintenance appropriations have not provided the resources VA needed to maintain, upgrade, or replace its aging research laboratories and associated facilities. The average age of VA's research facilities is more than 50 years old, and those conditions are substandard for state-of-the-art research.

The *IBVSO*s believe that Congress must ensure VA has the resource it needs to continue world class research that improves the lives of veterans and helps recruit high-quality health care professionals to work at VA. To do so, Congress must designate funds to improve specific VA research facilities in FY 2019 and in subsequent years. In order to begin to address these known deficits, the *IBVSO*s recommend Congress approve at least $50 million for up to five major construction projects in VA research facilities.

Minor Construction

In FY 2018, VA requested $372 million for minor construction projects. Currently, approximately 900 minor construction projects need funding to close all current and future year gaps within the next 10 years. To complete all of these current and pro-

jected projects, VA will need to invest between $6.7 and $8.2 billion over the next decade.

To ensure that VA funding keeps pace with all current and future minor construction needs, the *IBVSO*s recommend that Congress appropriate an additional $761 million for minor construction projects. It is important to invest heavily in minor construction because these are the types of projects that can be completed faster than other capital infrastructure projects and have a more immediate impact on services for veterans.

State Veterans Home Construction Grants

Grants for state extended-care facilities, commonly known as state home construction grants, are a critical element of Federal support for the state veterans' homes. The state veterans' home program is a very successful Federal-state partnership in which VA and states share the cost of constructing and operating nursing homes and domiciliaries for America's veterans.

State homes provide more than 30,000 nursing home and domiciliary beds for veterans, their spouses, and gold-star parents of deceased veterans. Overall, state homes provide more than half of VA's long-term-care workload, but receive less than 22 percent of VA's long-term care budget. VA's basic per diem payment for skilled nursing care in state homes is significantly less than comparable costs for operating VA's own long-term-care facilities. This basic per diem paid to state homes covers approximately 30 percent of the cost of care, with states responsible for the balance, utilizing both state funding and other sources.

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

With almost $1 billion in state home projects still in the pipeline, *The Independent Budget* recommends $200 million for the state home construction grant program to address a portion of the projects expected to be on the FY 2019 VA Priority Group 1 List when it is released this year.

Grants for State Veterans Cemeteries

The State Cemetery Grant Program allows states to expand veteran burial options by raising half the funds needed to build and begin operation of state veterans cemeteries. NCA provides the remaining funding for construction and operational funds, as well as cemetery design assistance. Funding additional projects in FY 2019 in tribal, rural and urban areas will provide burial options for more veterans and complement VA's system of national cemeteries. To fund these projects, Congress must appropriate $51 million.

OFFICE OF INFORMATION TECHNOLOGY

We are pleased to hear Secretary of Veterans Affairs David Shulkin's decision to have the Department adopt the same electronic health care record (EHR) system as the Department of Defense (DOD), putting an end to the saga of not being able to efficiently integrate military treatment records into a veteran's treatment plan. This plan will greatly improve the delivery of care to ill and injured veterans, and ensure truly integrated care as servicemembers transition from DOD to VA care.

While improvements to information technology (IT) systems are an important part of VA's mission, the cost of doing so cannot come at the expense of health care veterans have earned. We call on Congress to balance the needs of an improved VA with the need to ensure high quality health care is provided to all eligible veterans. In VA's fiscal year (FY) 2019 budget request, VA states it will transfer $782 million from its FY 2018 medical care and Office of IT appropriations to its EHR modernization program. We support an integrated VA/DOD EHR, but we do not endorse taking critical funds away from health care to pay for it.

We call on Congress to allocate the nearly $800 million VA needs in FY 2018 for EHR modernization from the additional fiscal year 2018 discretionary non-defense appropriations included in the recent bipartisan budget deal. Doing so would ensure VA can begin its work to provide a truly seamless transition for our servicemembers and our veterans.

GENERAL OPERATING EXPENSES (GOE)

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

The *IB* recommends approximately $3.104 billion for the VBA for FY 2019, an increase of approximately $194 million over the estimated FY 2018 appropriations level. Our recommendation includes approximately $92 million in additional funds in the Compensation account above current services, and approximately $18 million more in the VR&E account above current services to provide for new full-time equivalent employees (FTEE).

Compensation Service Personnel

In recent years VBA has made significant progress in reducing the claims backlog, which was over 610,000 claims in March 2013. Today, the claims backlog is roughly 79,000 claims, a decrease of 87 percent from its peak, and a decrease of about 18,000 claims compared to the one year prior. VA defines a backlogged disability claim as one pending over 125 days. Overall, the total pending claims workload decreased from about 390,000 in January 2017 to just over 320,000 claims today, a decrease of 18 percent in the past year. During that time, the average days to complete a claim dropped from 119 days last year to 103 days this January.

However, the trends on accuracy have gone the other direction. In January 2015, the 12-month issue-level accuracy was approximately 96 percent; today it is down to about 94.5 percent, though it has leveled off over the past 8 months. The 12-month claim-based accuracy measurement has dropped from approximately 91 percent in January 2015 to less than 85 percent today. While it is critical to continue reducing the backlog and the time it takes to complete a claim, VBA must refocus on completing claims accurately the first time.

In addition, VBA has a backlog of non-rating related claims, such as for dependency status changes, that must also be addressed in a timely manner. While continued advancements in the functionality of e-Benefits and other IT systems have been allowed veterans and their representatives directly make dependency changes more quickly, this non-rating related workload is too often given low priority status in Regional Offices. VBA must provide the resources and attention necessary to consistently complete this work in a timely manner.

It is also critical that VBA have sufficient funding for IT development and maintenance. In particular, VBA must devote additional resources to stakeholder IT enhancements in order to allow VSOs to more efficiently submit and review claims they represent. This will not only provide better service to veterans, it will also reduce some of the burden and workload that would otherwise fall on VBA personnel.

Another major driver of VBA workload is appeals processing. There were approximately 470,000 pending appeals of claims decisions at various stages between VBA and the Board of Veterans Appeals (Board), with approximately 350,000 requiring further processing at VBA Regional Offices.

Last year, Congress approved the Veteran Appeals Improvement and Modernization Act (P.L. 115–55) in order to help streamline the appeals process and provide better, timelier decisions for veterans. In November, VBA began early implementation of the law through the Rapid Appeals Modernization Program (RAMP) pilot that invites veterans with pending appeals to opt into the new system through the either a the Higher Level Review or Supplemental Claim option. RAMP may have the effect of redirecting some workload from the Board back to VBA, however once implemented, the new law will also eliminate many of the current appeal processes that take place at the AOJ, such as Statements of Case, and Form 9 Certification.

Over the past several years, VA has requested, and Congress has provided, additional funding to increase staffing at VBA to address the claims backlog. However, there have not been commensurate increases in funding to address the backlog of appeals pending inside VBA.

For FY 2019, the *IBVSO*s recommend an additional 900 FTEE for VBA. Of those, 500 should be allocated to the Compensation Service to address the pending and future appeals workload; another 350 should be allocated to address the growing backlog of non-rating related work such as dependency claims; and 50 should be allocated to the Fiduciary program to address increased workload in recent years, particularly related to veterans participating in VA's Caregiver Support programs. A July 2015 VA Inspector General report on the Fiduciary program found that,

"...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...." Last year the *IBVSO*s recommended 100 additional FTEE to address this problem, however, since VBA reallocated an additional 51 FTEE to the Fiduciary program this year, the *IBVSO*s have reduced our recommendation to 50 new FTEE for FY 2019.

Finally, as the Veterans Appeals Improvement and Modernization Act of 2017 continues to be fully implemented, including RAMP, VBA must develop more accurate workload, production and staffing models in order to accurately forecast future VBA resource requirements.

VR&E Service Personnel

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

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

Over the past four years, program participation has increased by an estimated 16.8 percent, while VR&E staffing has risen just 1.8 percent. VA projects program participation will increase another 3.1 percent in FY 2019, and it is critical that sufficient resources are provided not only to meet this rising workload, but also to expand capacity to meet the full, unconstrained demand for VR&E services.

In 2016, Congress enacted legislation (P.L. 114–223) that included a provision recognizing the need to provide a sufficient client-to-counselor ratio to appropriately align veteran demand for VR&E services. Section 254 of that law authorizes the Secretary to use appropriated funds to ensure the ratio of veterans to Vocational Rehabilitation Counselors (VRC) does not exceed 125 veterans to one full-time employment equivalent. Unfortunately, for the past three years, VA has requested no new personnel for VR&E to reach this ratio.

In order to achieve the 1:125 counselor-to-client ratio established by Congress, the *IBVSO*s estimate that VR&E will need another 143 FTEE in FY 2019 for a total workforce of 1,585, to manage an active caseload and provide support services to almost 150,000 VR&E participants. At a minimum, three-quarters, of the new hires should be VRCs dedicated to providing direct services to veterans.

GENERAL ADMINISTRATION

The General Administration account is comprised of ten primary divisions. These include the Office of the Secretary; the Office of the General Counsel; the Office of Management; the Office of Human Resources and Administration; the Office of Enterprise Integration; the Office of Operations, Security and Preparedness; the Office of Public Affairs; the Office of Congressional and Legislative Affairs; and the Office of Acquisition, Logistics, and Construction; and the Veterans Experience Office (VEO). This marks the first year that the VEO has been included in the divisions of General Administration. Additionally, a number of the divisions reflect changes to the structure and responsibilities of those divisions. For FY 2019, the *IB* recommends approximately $355 million, an increase of more than $25 million over the FY 2018 estimated level. This increase primarily reflects an increase in current services based on the impact of uncontrollable inflation across all of the General Administration accounts.

BOARD OF VETERANS' APPEALS

With the enactment of the Veterans Appeals Improvement and Modernization Act (P.L. 115–55), the Board in 2018 will be developing and implementing the new appeals system scheduled to begin in February 2019. Once fully implemented, the Board will operate five separate dockets concurrently, which will require new training and new IT functionality to manage this workload. The Board has presented its implementation plans to Congress and must adhere to the timelines laid out in order to finalize new regulations and prepare its workforce. In addition, sufficient IT resources must be provided to the Board to complete development of new workload management tools.

Once the new appeals system is stood up in 2019, overall workload coming into the Board is expected to begin leveling off, or perhaps begin to decrease, as veterans take advantage of the expanded options to resolve appeals at the AOJ level. Thus, it is too early to project whether the Board will require more or less resources in its future state.

For FY 2018, the Board is projecting that it will produce 81,000 decisions, the highest total in the Board's history, though there will still remain a significant backlog of appeals in the pipeline to the Board. VA's budget submission for FY 2018 requested funding to increase FTEE levels to 1,050, continuing staffing increases in recent years to expand capacity and allow the Board to address both the backlog of legacy appeals and the transition to the new appeals system.

For FY 2019, the *IBVSO*s do not recommend any additional staffing increases at the Board; however, it is critical that the Board complete the hiring and training of new personnel as rapidly as possible. Further, it will be critical for VA and Congress to carefully and regularly monitor workload, timeliness, quality and other metrics to ensure that the Board is and remains appropriately staffed in the future.

NATIONAL CEMETERY ADMINISTRATION

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

In a strategic effort to offer all veterans burial options within 75 miles of their home, the NCA continues to expand and improve the national cemetery system, by adding new and/or expanded national cemeteries. Due to a continued increase in demand for burial space which is not expected to peak until 2022, NCA must continue to expand national cemeteries and provide more burial options for veterans. 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.

The *IBVSO* strongly believe that VA national cemeteries must honor the service of our veterans and fully supports NCA's National Shrine initiative which ensure our Nation's veterans having a final resting place deserving of their sacrifice to our Nation. The *IBVSO*s also support NCA's Veterans Legacy Program, which helps educate America's youth of the history of national cemeteries and the veterans they honor.

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

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

With the above considerations in mind, *The Independent Budget* recommends $311 million for FY 2019 for the Operations & Maintenance of the NCA.

ADMINISTRATION LEGISLATIVE PROPOSALS

Medical Foster Homes

The Independent Budget supports the proposal to include in VA's medical benefits package the authority to pay for care only in VA-approved Medical Foster Homes and specifically for veterans for whom VA is currently required to provide more costly nursing home care. VA estimates cost reductions that will increase annually from $12 million up to nearly $90 million over five-years if Congress enacts this proposal.

Treatment of Other Health Insurance

The Independent Budget opposes the proposal to end the current practice of offsetting a veteran's copayment debt with reimbursements it receives from that veteran's health plan. This will shift the cost of over $50 million of care annually from the Federal Government on to the backs of ill and injured veterans.

The *IB* also opposes the proposal to impose punitive enforcement to make veterans pay over $8 million annually of the care they receive from VA if the veteran fails to provide third-party health plan coverage information and any other information necessary to VA for billing and collecting from the third-party payer.

Clarify Evidentiary Threshold for Ordering VA Examinations

VA seeks to amend 38 U.S.C. § 5103A(d)(2) to clarify the evidentiary threshold at which VA, under its duty to assist obligation in § 5103A, is required to request a medical examination for compensation claims. *The Independent Budget* oppose this

proposal which would raise the threshold for obtaining medical evidence and make it more difficult to receive favorable claims decisions. While this proposal estimates it would save the Federal Government over $900 million in ten years, it does not reflect the amount of rightful compensation that would be lost to veterans nor does it contemplate the additional resources necessary to resolve an increase of appeals on claim denials.

Elimination of Payment of Benefits to the Estates of Deceased Nehmer Class Members and to the Survivors of Certain Class Members

VA seeks to amend 38 U.S.C. § 1116 to eliminate payment of benefits to the estates of deceased Nehmer class members and to survivors of certain class members when such benefits are the result of presumptions of service connection established pursuant to § 1116 for diseases associated with exposure to Agent Orange and certain other herbicide agents. This proposed legislation would deny veterans' families benefits that would have otherwise been due to their deceased veteran family member as a result of exposure to these toxic chemicals while in service. *The Independent Budget* opposes any such legislation.

Clarify Chemicals at Issue for Purposes of Presumptive Service Connection for Veterans Serving in the Republic of Vietnam

VA seeks to amend 38 U.S.C. § 1116 to define the harmful chemicals, specifically Tetrachlorodibenzo-p-dioxin (TCDD), used in herbicides by claiming those were only used in Vietnam. Herbicides with TCDD were used outside of Vietnam and suggesting otherwise appears to be an attempt to save money at the expense of disabled veterans. *The Independent Budget* strongly opposes this proposal to limit disability benefits based on the location of herbicide exposure.

Amendment of Policy to Eliminate Pay Cap for Registered Nurses

The Independent Budget supports VA's proposal to eliminate the pay cap for registered nurses to ensure it is able to hire and retain high-quality nurses.

Legal Services for Homeless Veterans

Legal issues are often a significant barrier to homeless reintegration. *The Independent Budget* supports the proposal to authorize VA to enter into agreements with entities to provide legal services to veterans who are homeless or at risk of becoming homeless.

Modernizing VA: Anywhere to Everywhere VA Telehealth

The Independent Budget supports the proposal to clarify that VA health care professionals have authority to practice telemedicine across state lines, regardless of where the veteran is located. Doing so would ensure veterans no longer have to travel long distances to receive telemedicine.

Extend the Authority for Operations of the Manila VA Regional Office

The Independent Budget supports extending VA's authority to operate the Manila VA Regional Office.

Spousal and Dependent Inscriptions on Veteran Headstones and Markers

The Independent Budget supports VA's proposal to inscribe veterans' headstones, upon request, to honor their spouses or dependent children.

Mr. Chairman, thank you for the opportunity to submit testimony and to present our views regarding FY 2019 and FY 2020 advance funding requirements to support VA's ability to deliver benefits and services to veterans, their families and survivors. We would be happy to respond to any questions that you or Members of the Committee may have.

Chairman ISAKSON. Thank you for your patience, Mr. Fuentes. We appreciate it very much and we appreciate the VSOs very much.

Senator Manchin.

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

Senator MANCHIN. Thank you, Mr. Chairman, and thank you, Dr. Shulkin. I wish you and your staff well, and I do support you.

Secretary SHULKIN. Thank you.

Senator MANCHIN. With that being said, everyone here, Democrat and Republican, wants to do the best for the veterans. It is the only organization that keeps us bipartisan.

Secretary SHULKIN. Yes.

Senator MANCHIN. It truly is, and I think that everybody is well intended here.

With that, have you all done a survey with veterans, all the different veteran organization groups on them supporting either the veterans system that we have, the delivery of health care that we have, or privatizing it?

Secretary SHULKIN. Yes. Yes. The survey—first of all, we now do what many good businesses do. We do a just-in-time survey——

Senator MANCHIN. Right.

Secretary SHULKIN [continuing]. On the day of service, to find out if there are problems or not, so we are learning real time.

Senator MANCHIN. We have taken out the satisfaction with handing out opiates, though, have we not?

Secretary SHULKIN. We have. Yes, thank you for pushing on that issue.

Our survey that we track the closest is whether veterans trust the VA. That is essentially our Dow Jones Industrial Index that we follow. We went from a 46 percent trust rate in 2014, to now 70 percent. We need to do better than that, but we are showing that we are improving direction.

The Veterans of Foreign Wars, actually, just did a survey, which I am sure Mr. Fuentes was going to talk about. It showed that 87 percent of their membership wants to get their care in the VA and are feeling good about it.

Senator MANCHIN. But, what you are saying there is exactly correct, because I have talked to everyone in West Virginia VA offices, my four hospitals, and all my clinics, and every—I have not had a veteran saying, "I wish I could go," because they can if they want. We can make arrangements for them. I just want to make sure we do not get thrown into this big bucket of one-size-fits-all and everything gets changed and the people who are——

Secretary SHULKIN. Right.

Senator MANCHIN [continuing]. Really understanding the veterans best are the ones that should be giving the service.

With that, you announced—you had an announcement held in the D.C. VA medical center last week.

Secretary SHULKIN. Yes.

Senator MANCHIN. And you said the Veteran Integrated Service Network, which we refer to as VISNs, 1, 5, and 22 would be coming under the leadership of one individual.

Secretary SHULKIN. Right.

Senator MANCHIN. The person is also going to be leading the charge on changing all the VISNs nationwide. The thing is, I am thrown in with Los Angeles.

Secretary SHULKIN. Yes.

Senator MANCHIN. West Virginia is being thrown in with Los Angeles. I am saying if Los Angeles has got a problem and I have got a problem, I could be in real trouble.

And that leads me to the autoclave. Do you remember the Clarksburg VA situation we had?

Secretary SHULKIN. Of course.

Senator MANCHIN. OK. And you all—I understand we have a temporary, mobile autoclave there.

Secretary SHULKIN. Yes.

Senator MANCHIN. It will be up and running in 2 weeks. We do not have any idea when a permanent autoclave is going to be there. We have had nothing, they said because of money problems with VISNs that they are just not sure. And we need to, Mr. Secretary——

Secretary SHULKIN. OK.

Senator MANCHIN [continuing]. Just for the sake of the patients, for the sake of that hospital, have to have something permanently done there on a timely basis.

That leads me to another story. As you remember, on Super Bowl Sunday, I had a conversation with Dr. Clancy about the fact that a senior executive, who had——

Secretary SHULKIN. Yes.

Senator MANCHIN [continuing]. Not performed adequately at a hospital in Oregon was being transferred to Huntington, WV.

Secretary SHULKIN. Yes.

Senator MANCHIN. I am grateful that she took my call, and I will tell you, she acted promptly. I am so appreciative. So, he never got to——

Secretary SHULKIN. I forgot she was watching the Super Bowl, knowing Dr. Clancy.

Senator MANCHIN. He never got to West Virginia——

Secretary SHULKIN. Yes.

Senator MANCHIN [continuing]. Which I am very grateful. I should have probably never had to make that call, and how that person would get——

Secretary SHULKIN. Right.

Senator MANCHIN [continuing]. This assumed promotion after they had messed up. So, I received calls from veterans. They were very grateful. But, they are scared now. Is anybody watching, and how is your——

Secretary SHULKIN. Yes.

Senator MANCHIN [continuing]. How does that work, and where did that person end up?

Secretary SHULKIN. Right. Right. First of all, we know that if you make a call it is important to you, so we always take that seriously, and we very much——

Senator MANCHIN. And I know we all feel the same way.

Secretary SHULKIN. Absolutely. So, of course, we respected your opinion on this.

This individual, that was leaving from Oregon, actually was getting a demotion. He was going from a medical center director, demoted down one position——

Senator MANCHIN. Well, he was coming to West Virginia. We thought that was a promotion.

Secretary SHULKIN. I can understand that. But, he had agreed that he would take a lesser position in order to be mentored and appropriately supervised so that hopefully he could continue to contribute to the mission of VA. When he chose not to—when we had a discussion and he ended up not going to West Virginia, he is now

working in a service delivery part of VA, I think it is food services, somewhere in the Midwest, at a level below where he was serving before.

Senator MANCHIN. I know you also have more flexibility on sometimes just eliminating people who have not been able to get up to the par of service——

Secretary SHULKIN. Yes.

Senator MANCHIN [continuing]. The delivery service for our VA.

Secretary SHULKIN. Right.

Senator MANCHIN. When do you get to that? When do you determine——

Secretary SHULKIN. Yes.

Senator MANCHIN [continuing]. This person is not going to get to the level that you need?

Secretary SHULKIN. Right. In our determination here, this was just simply a position where he was not——

Senator MANCHIN. Over his head?

Secretary SHULKIN. Yes. I think that is a good way to say it. But, there was not an allegation of wrongdoing or any type of concern about his behavior. This was simply, I think you said it well——

Senator MANCHIN. Yes.

Secretary SHULKIN [continuing]. May be a little bit over his head at that point.

Senator MANCHIN. Sure. I want to thank all of you. I just would hope, on the autoclave—I am making one more pitch—we just——

Secretary SHULKIN. We have got it.

Senator MANCHIN [continuing]. Please.

Secretary SHULKIN. Thank you.

Senator MANCHIN. Thank you, sir.

Chairman ISAKSON. Thank you all for your testimony. Mr. Fuentes, again, I apologize for the break in our session, but thank you for being here.

Dr. Shulkin, thank you.

Secretary SHULKIN. Thank you.

Chairman ISAKSON. The record will be kept open for 7 days for comments anybody wants to submit for the record. With that being said, we stand adjourned.

[Whereupon, at 3:07 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

Question 1. The fiscal year (FY) 2019 budget request for Vocational Rehabilitation and Employment discretionary appropriations shows a reduction of $59.3 million in "Other Services" and attributes this change to more favorable pricing in the Transition Assistance Program (TAP) contract.

a. Please provide specific information on the total dollar amount of that contract; the number of individuals and services provided under that contract; and how dollars, individuals, and services under this contract have changed from FY 2017 to the expected FY 2019 requirements.

Response. VA's TAP contract was competitively awarded to Booz Allen Hamilton in September 2017 and is funded at a level that provides VA benefits briefings and assistance to 100 percent of Servicemembers who are transitioning from active duty service. The total value for the 9-month base year and four, 12-month options is $230,963,330. The duties under the contract remain the same from fiscal year (FY) 2017 and include the following requirements to support over 250K transitioning Servicemembers (TSM), their families, and caregivers achieve their personal post-military goals: provide Benefit Advisors to 300+ military installations worldwide to deliver the VA Benefits I and II briefings, which are offered as 4- and 2-hour courses

of instruction; educate transitioning Servicemembers on the wide-array of VA benefits, services, and support tools, including (but not limited to) health care, education, Vocational Rehabilitation & Employment, compensation, life insurance, home loans, as well as an orientation to online benefits portals such as eBenefits and MyHealth*e*Vet including facilitated healthcare registration, one-on-one assistance, warm hand-off to VA Healthcare for those at risk for homelessness or in crisis; and provide support to Military Commanders conducting Capstone events to ensure TSMs are ready for the military to civilian transition. For those TSMs who are unable to attend the in-person six-hour classroom session, the contract supports development of VA virtual modules housed on DOD's Joint Knowledge Online portal. In addition, the new award supports full execution of the Military Life Cycle (MLC) training, which embeds transition planning and preparation for meeting career-readiness standards throughout a Servicemember's military career.

VRE's FY 2018 Total TAP funding level was $111 million, but based off prior years of execution (see below), the FY 2019 request was reduced to $63.3 million, a reduction of $47.5 million, and is now included in VBA's Office of Transition and Economic Development. The Veterans Opportunity to Work (VOW) to Hire Heroes Act of 2011 required VA and the Department of Defense (DOD) to collaborate on Military Lifecycle (MLC) training. This portion of TAP funding was not part of the prior contract as VA and DOD were not prepared to execute. In FY 2019, VA will begin executing the MLC portion of TAP. As a need is identified, these funds will be resourced internally in the year of execution and requested in future budget submissions.

b. Please also provide any other changes in personnel and services outside of the TAP contract that have also contributed to the $59.3 million reduction in the appropriations request.

Response. No other changes in personnel and services outside of the TAP contract are attributed to the overall $59.3 million decrease for VR&E in the FY 2019 Budget request.

Question 2. The Department of Veterans Affairs (VA) 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 the proposed Infrastructure Initiative specific to VA.

Response. VA supports the White House Infrastructure Initiative as it will provide authorities needed for VA to help modernize its real property portfolio and make much needed capital improvements to Veterans facilities. The specific details of the authorities are explained below.

Authority to Retain Proceeds from Sales of Properties:

Under current law, VA has limited authority to retain the proceeds from sales of its properties and cannot exchange its existing facilities for the construction of new facilities. Under current law United States Code (U.S.C.) 38, section 8118, the Secretary may transfer real property under the jurisdiction or control of the Secretary to another department or agency of the United States, to a state, or to any public or private entity, including an Indian tribe. The authority is limited as related proceeds need to first be re-appropriated and can only be used for other disposal activities, minor medical construction, and historic properties. This authority has been in place since 2004 and expires in December 2018, but due to the various constraints it has never been utilized by the Department.

Authorizing expanded authority for VA to retain proceeds from sales of its properties and exchange its existing facilities or land for new construction would provide VA flexibility to better fulfill its mission, including making much needed capital improvements for new construction and renovations and for funding lease or service costs in a facility. Authorizing the retained funds to remain available until expended would allow VA to make these investments without the need for further authorization and appropriation.

Exchange Property for Construction of New Facilities:

Under current law, VA cannot exchange its existing facilities for the construction of new facilities. This hinders VA's ability to provide upgraded infrastructure for our Nation's Veterans. Authorizing VA to exchange its existing owned land and facilities for construction of new Federal facilities, provided VA identifies such facilities as a long-term capital requirement in its annual budget submission, would provide VA additional flexibility to construct new facilities for our Nation's Veterans.

Pilot for VA to Exchange Land or Facilities for Lease of Space:

Currently, VA cannot exchange its existing land or facilities for a lease of space in a private facility to be built on former VA land. This hinders the VA's ability to provide upgraded infrastructure for our Nation's Veterans. Creating a pilot program for up to five projects would allow VA to exchange existing VA land or facilities for a lease of space in a private facility to be built on the former VA land would provide additional flexibility to better meet the needs of our Nation's Veterans. Under this pilot, VA-occupied space would be built to the same commercial standards as the remainder of the facility. The space could be in a stand-alone building or part of another building.

The terms of the lease arrangements executed under the pilot authority would include, but not be limited, to the following:

- VA would get the value of the exchanged facility in rent credits or rent credit plus services equal to the value of the exchange.
- The private sector financing (construction financing or loan) could not be based on the full faith and credit of the U.S. Government or guaranteed U.S. Government tenancy.
- The lease term, after credits, would be a maximum of 7 years. Any future lease or lease extension after the initial term also would be limited to 7 years.
- The lease and service rates during the credit timeframe and any subsequent lease term would be at market or less.
- The explicit dollar amount of termination (e.g. one year of rent payments) would be required to be included in the agreement, and VA would budget rent and termination in accordance with Office of Management and Budget (OMB) Circular A–11.
- The lease would be structured to assure that VA had exit privileges and that VA would have an exclusive right, but not the obligation, to renew or extend the term of the lease.

Increase Lease Authorization Levels:

Current law requires VA to obtain congressional authorization for any lease above $1 million in annual rent. This differs from the General Services Administration (GSA) prospectus threshold which currently carries a threshold of $3.095 million and is reevaluated periodically. These differing thresholds require VA to seek authorization for more leases. Increasing the authorization threshold for VA major medical leases (38 U.S.C. 8104) from the current threshold of $1 million in annual rent to the current GSA prospectus threshold of $3.095 million and updating it periodically would reduce the number of VA authorization requests and keep VA in sync with GSA, whose delegation of authority VA uses to execute these medical leases. This would streamline VA's lease process, which could shorten the initial approval timeline and increase speed to market for all VA Major Leases.

Question 3. The FY 2018 omnibus appropriations bill includes $685 million for state veterans home construction grants, a significant increase over the $90 million request. The Committee has not yet received the FY 2018 state veterans home construction grant priority list. Please provide the FY 2018 priority list as well as an estimate of the number of projects that will be completed with the additional funding provided in FY18.

Response. VA plans on funding the projects ranked from 1–52 in the funding order column on the far right of the priority list. Attached is the signed list.

VA State Home Construction Grants Priority List FY 2018

VA Priority List Group 1 (State Matching Funds)

Rank	FAI No.	State	Locality	Description	Ranking	Estimated VA Share	Cumulative	Funding Order*
1	39-053	OH	Georgetown	Safety: Fire Alarm Replacement, Spa, Electrical and Courtyard Renovations	1.1.E	$ 498,030.00	$ 498,030.00	1
2	48-027	TX	Statewide	Safety: Fire Alarm and Detection	1.1.E	$ 453,180.00	$ 951,210.00	2
3	48-029	TX	Statewide	Safety: Legionella Control	1.1.G	$ 2,240,030.00	$ 3,191,240.00	3
4	40-060	OK	Statewide	Safety: Emergency Electronic Medical Records	1.1.H	$ 1,675,551.88	$ 4,866,791.88	4
5	48-028	TX	Statewide	Safety: Nurse Call and Anti Wander	1.1.H	$ 1,009,255.00	$ 5,876,046.88	5
6	55-069	WI	King	Bed Replacement: 200 Bed Facility	1.4.B	$ 52,000,000.00	$ 57,876,046.88	6
7	13-020	GA	Milledgeville	Renovation: Nursing Unit	1.4.B	$ 4,096,560.00	$ 61,972,606.88	7
8	26-027	MI	Grand Rapids	Bed Replacement: 120 Bed Facility	1.4.B	$ 38,035,333.67	$ 100,007,940.55	50
9	26-028	MI	Southeast Michigan	Bed Replacement: 120 Bed Facility	1.4.B	$ 41,954,702.89	$ 141,962,643.44	51
10	25-081	MA	Chelsea	Bed Replacement: 154 Bed Facility	1.4.B	$ 128,815,622.00	$ 270,778,265.44	52
11	09-018	CT	Rocky Hill	Renovation: ADA Upgrades	1.4.C	$ 1,468,434.50	$ 272,246,699.94	8
12	50-011	VT	Bennington	Renovation: Electronic Medical Records	1.4.D	$ 792,179.05	$ 273,038,878.99	9
13	12-017	FL	Pembroke	Renovation: Roof, Windows, Doors, Siding, Emergency Generator, Nurse Call, Elopement System and Cameras	1.4.D	$ 3,575,000.00	$ 276,613,878.99	10
14	12-019	FL	Port Charlotte	Renovation: Fire Alarm System, Nurse Call and Elopement System, Emergency Generator and Building Retortification	1.4.D	$ 3,575,000.00	$ 280,188,878.99	11
15	26-021	MI	Grand Rapids	Renovation: HVAC Controls	1.4.D	$ 1,023,100.00	$ 281,211,978.99	12
16	29-043	MO	Cape Girardeau	Renovation: Floors, HVAC, Doors, Windows, Walls, Kitchen, Dining, Nursing Unit, Laundry, Nurse Call, Fire Alarm, Pavilion and Storage	1.4.D	$ 8,703,163.21	$ 289,915,142.20	13
17	29-042	MO	St. Louis	Renovation: Floors, Chapel, HVAC, Electrical, Restrooms, Nurse Stations, Therapy and Nutrition Rooms, Offices, and Storage	1.4.D	$ 12,455,402.05	$ 302,370,544.25	14
18	25-078	MA	Chelsea	Renovation: HVAC, Boilers, Hot Water, Windows and Photovoltaic	1.4.D	$ 5,019,381.90	$ 307,389,926.15	15
19	42-043	PA	Philadelphia	Renovation: Floors, Doors, Elevator, Boilers, Hot Water Heaters, Pumps, HVAC, Roof, Nursing Unit, Canteen and Cameras	1.4.D	$ 3,997,500.00	$ 311,387,426.15	16
20	55-072	WI	King	Renovation: Boilers, Generator, HVAC, Electrical, Windows, Doors, Ladder Cage, Painting and Tank Spill Curb	1.4.D	$ 3,024,468.72	$ 314,411,894.87	17
21	36-026	NY	Long Island	Renovation: Air Handler Units	1.4.D	$ 1,895,165.70	$ 316,307,060.57	18
22	36-027	NY	Long Island	Renovation: LED Lighting and Electrical System Upgrade	1.4.D	$ 1,224,096.25	$ 317,531,156.82	19
23	36-025	NY	Long Island	Renovation: Resident Lift Systems	1.4.D	$ 2,421,316.89	$ 319,952,473.71	20
24	39-049	OH	Sandusky	Renovation: Windows	1.4.D	$ 1,474,422.30	$ 321,426,896.01	21
25	39-050	OH	Sandusky	Renovation: HVAC Wall Units and Chillers	1.4.D	$ 3,742,375.00	$ 325,169,271.01	22
26	40-057	OK	Talihina	Renovation: HVAC	1.4.D	$ 1,759,035.85	$ 326,928,306.86	23
27	42-046	PA	Erie	Renovation: Floors, Walls, Windows, Lighting, Bathrooms, Boilers, Water Treatment, HVAC, Nursing Unit, Storage and Camera	1.4.D	$ 5,265,000.00	$ 332,193,306.86	24
28	34-034	NJ	Vineland	Renovation: HVAC, Roof, and Mold Remediation	1.4.D	$ 2,008,597.50	$ 334,201,904.36	25
29	06-068	CA	Yountville	Renovation: Central Power Plant	1.4.D	$ 9,380,397.00	$ 343,582,301.36	53
30	29-046	MO	Cape Girardeau	Renovation: Fire Alarm, Nurse Call, Water Heater	1.4.D	$ 801,039.69	$ 344,383,341.04	54
31	29-047	MO	Warrensburg	Renovation: Water Systems, Doors, Building and Electrical Upgrades	1.4.D	$ 1,226,486.30	$ 345,609,827.34	55
32	29-048	MO	St. Louis	Renovation: Front Entrance, Air Handler, Chiller and Water Softener Upgrades	1.4.D	$ 1,507,955.23	$ 347,117,782.57	56
33	29-049	MO	Mexico	Renovation: HVAC, Electrical, Fire and Nurse Call System Upgrades	1.4.D	$ 1,748,048.60	$ 348,865,831.17	57
34	06-070	CA	Yountville	Renovation: Chilled Water System	1.4.D	$ 6,636,307.60	$ 355,502,138.77	58
35	06-069	CA	Yountville	Renovation: Steam Distribution System	1.4.D	$ 7,932,426.45	$ 363,434,565.22	59
36	39-051	OH	Georgetown	Renovation: Roof, Flooring, Electrical and Kitchen Upgrades	1.4.D	$ 1,927,249.51	$ 365,361,814.73	60
37	29-044	MO	St. James	Renovation: Kitchen, Flooring, Wall, Doors, Bathroom, Nurse Call and Fire Alarm	1.4.E	$ 3,732,081.60	$ 369,093,896.33	26
38	10-002	DE	Milford	Renovation: Kitchen and Dining	1.4.E	$ 1,560,000.00	$ 370,653,896.33	27
39	33-010	NH	Tilton	Renovation: Laundry, Kitchen, Heat Pumps and Wanderguard	1.4.E	$ 1,072,500.00	$ 371,726,396.33	28
40	19-049	IA	Marshalltown	Renovation: Laundry Facility	1.4.E	$ 3,762,907.23	$ 375,489,303.56	29
41	29-038	MO	St. Louis	Renovation: Storage Buildings and Pavilion	1.4.F	$ 647,966.16	$ 376,137,269.72	30
42	38-008	ND	Lisbon	Renovation: Resident Arts and Craft Studio	1.4.F	$ 629,857.70	$ 376,767,127.42	31
43	01-011	AL	Huntsville	Renovation: Interior Wall Coverings, Corner Guards, and Handrails	1.4.F	$ 1,146,860.00	$ 377,913,987.42	32
44	01-012	AL	Bay Minette	Renovation: Interior Wall Coverings, Corner Guards, and Handrails	1.4.F	$ 1,146,860.00	$ 379,060,847.42	33
45	37-012	NC	Salisbury	Renovation: Day Room Addition, Patio, Main Entrance, HVAC, Electrical, Flooring, Walls, Lighting, Nurse Stations and Dining	1.4.F	$ 2,600,000.00	$ 381,660,847.42	34
46	36-023	NY	St. Albans	Renovation: Kitchen, Service Elevator, and Recreation Room	1.4.F	$ 4,290,000.00	$ 385,950,847.42	35
47	39-052	OH	Sandusky	Renovation: Handrails, Interior Doors, Lighting, Flooring, and Bathroom	1.4.F	$ 7,234,241.30	$ 393,185,088.72	61
48	04-009	AZ	Yuma	New Construction: 60 Bed Facility	1.5	$ 16,944,414.60	$ 410,129,503.32	36
49	37-015	NC	Wake Co.	New Construction: 120 Bed Facility	1.5	$ 25,279,020.00	$ 435,408,523.32	37
50	51-011	VA	Virginia Beach	New Construction: 120 Bed Facility	1.5	$ 29,948,750.00	$ 465,357,273.32	38
51	51-012	VA	Vint Hill	New Construction: 120 Bed Facility	1.5	$ 31,027,587.50	$ 496,384,860.82	39
52	04-010	AZ	Flagstaff	New Construction: 60 Bed Facility	1.5	$ 18,411,250.00	$ 514,796,110.82	40
53	37-016	NC	Guilford County	New Construction: 120 Bed Facility	1.5	$ 25,279,020.00	$ 540,075,130.82	41
54	17-028	IL	Chicago	New Construction: 200 Bed Facility	1.7	$ 42,575,000.00	$ 582,650,130.82	42
55	32-003	NV	Reno	New Construction: 90 Bed Facility	1.7	$ 32,817,222.75	$ 615,467,353.57	43
56	30-004	MT	Butte	New Construction: 60 Bed Facility	1.7	$ 8,937,500.00	$ 624,404,853.57	44
57	47-016	TN	Cleveland	New Construction: 108 Bed Facility	1.7	$ 26,224,263.00	$ 650,629,116.57	45
58	15-002	HI	Honolulu	New Construction: 120 Bed Facility	1.7	$ 40,358,357.00	$ 690,987,473.57	46
59	45-009	SC	Columbia	New Construction: 108 Bed Facility	1.7	$ 26,192,507.25	$ 717,179,980.82	47
60	45-008	SC	Florence	New Construction: 108 Bed Facility	1.7	$ 25,944,694.75	$ 743,124,675.57	48
61	45-010	SC	Gaffney	New Construction: 108 Bed Facility	1.7	$ 26,738,344.75	$ 769,863,020.32	49
					Total Priority Group 1 Applications	**$ 769,863,020.32**		

VA State Home Construction Grants Priority List FY 2018

VA Priority List Groups 2-8 (No State Matching Funds)

Rank	FAI No.	State	Locality	Description	Ranking	Estimated VA Share	Cumulative	Funding Order*
62	12-027	FL	West Florida	New Construction: 112 Bed Facility	4.0	$ 42,555,411.60	$ 812,418,431.92	
63	25-080	MA	Holyoke	Renovation: Adult Day Health Care	5.A	$ 5,084,436.76	$ 817,502,868.68	
64	25-062	MA	Holyoke	Renovation: Resident Toilet and Baths	5.B	$ 438,750.00	$ 817,941,618.68	
65	40-044	OK	Talihina	Renovation: Replacement 50 Bed Facility	5.B	$ 8,658,000.00	$ 826,599,618.68	
66	25-074	MA	Holyoke	Renovation: Replacement 258 Bed Facility	5.B	$ 76,080,156.75	$ 902,679,775.43	
67	17-043	IL	Quincy	Renovation: Kent Building - Phase 1	5.B	$ 12,727,057.85	$ 915,406,833.28	
68	21-021	KY	Wilmore	Renovation: Nursing Unit	5.B	$ 4,380,999.35	$ 919,787,832.63	
69	26-025	MI	Grand Rapids	Renovation: Nursing Unit	5.B	$ 1,675,050.00	$ 921,462,882.63	
70	23-027	ME	South Paris	Renovation: 32 Bed Nursing Unit	5.B	$ 1,442,335.70	$ 922,905,218.33	
71	26-029	MI	Marquette	Bed Replacement: 140 Bed Facility	5.B	$ 57,619,290.95	$ 980,524,509.28	
72	26-033	MI	Detroit	Bed Replacement: 140 Bed Facility	5.B	$ 69,615,934.70	$ 1,050,140,443.98	
73	26-031	MI	I94 Corridor	Bed Replacement: 140 Bed Facility	5.B	$ 52,272,626.25	$ 1,102,413,070.23	
74	26-030	MI	Flint/Saganaw	Bed Replacement: 140 Bed Facility	5.B	$ 48,544,047.50	$ 1,150,957,117.73	
75	26-032	MI	N. Lower Peninsula	Bed Replacement: 126 Bed Facility	5.B	$ 58,781,758.75	$ 1,209,738,876.48	
76	19-044	IA	Marshalltown	Renovation: ADA Ramp	5.C	$ 739,687.00	$ 1,210,478,563.48	
77	06-056	CA	Yountville	Renovation: Power Plant	5.D	$ 4,941,083.94	$ 1,215,419,647.42	
78	06-062	CA	Yountville	Renovation: Wastewater Line Repair	5.D	$ 373,867.00	$ 1,215,793,514.42	
79	23-018	ME	Bangor	Renovation: HVAC, Carpet, and Dining Room	5.D	$ 440,553.75	$ 1,216,234,068.17	
80	27-045	MN	Minneapolis	Renovation: Tuck Pointing	5.D	$ 1,365,000.00	$ 1,217,599,068.17	
81	40-054	OK	Statewide	Renovation: Roofing	5.D	$ 4,432,723.10	$ 1,222,031,791.27	
82	42-047	PA	Spring City	Renovation-Floors, Adult Day Health Care, Water Main, Boilers, Chiller, and Hot Water Heaters	5.D	$ 2,496,000.00	$ 1,224,527,791.27	
83	55-076	WI	King	Renovation: Roofing, Flooring	5.D	$ 691,228.20	$ 1,225,219,019.47	
84	36-029	NY	LISVH	Renovation: Door Replacement	5.D	$ 877,500.00	$ 1,226,096,519.47	
85	09-019	CT	Rocky Hill	Safety: Alarms, Threat Detection	5.D	$ 1,272,960.00	$ 1,227,369,479.47	
86	55-077	WI	Union Grove	Renovation: Roof Replacement and Nursing Station Upgrades	5.D	$ 661,986.00	$ 1,228,031,465.47	
87	34-035	NJ	Paramus	Renovation: Chillers, Cooling and Heating Panels	5.D	$ 1,936,525.50	$ 1,229,967,990.97	
88	40-055	OK	Clinton	Renovation: Main Entrance, Pharmacy, Laboratory, and Physical Therapy	5.E	$ 2,308,509.46	$ 1,232,276,500.43	
89	12-025	FL	Land O Lakes	Renovation: Dining, Dayrooms, Nursing Units, and Restrooms	5.E	$ 2,740,101.00	$ 1,235,016,601.43	
90	36-030	NY	LISVH	Renovation: Dining Rooms	5.E	$ 2,000,700.00	$ 1,237,017,301.43	
91	40-043	OK	Talihina	Renovation: Food Service and Canteen	5.E/F	$ 3,818,100.00	$ 1,240,835,401.43	
92	06-047	CA	Yountville	Renovation: Chapel Renovation	5.F	$ 1,487,707.00	$ 1,242,323,108.43	
93	06-057	CA	Yountville	Renovation: Administrative Building	5.F	$ 2,945,800.00	$ 1,245,268,908.43	
94	27-034	MN	Minneapolis	Renovation: Pharmacy Remodel	5.F	$ 1,313,413.40	$ 1,246,582,321.83	
95	29-041	MO	St. James	Renovation: Chapel and Pavilion	5.F	$ 1,012,657.10	$ 1,247,594,978.93	
96	36-028	NY	Stony Brook	Renovation: Controlled Substance Management System	5.F	$ 695,552.00	$ 1,248,290,530.93	
97	29-045	MO	Cameron	Renovation: Facility Renovations	5.F	$ 9,036,472.27	$ 1,257,327,003.20	
98	47-017	TN	Arlington	New Construction: 144 Bed Facility	8.0	$ 52,132,976.35	$ 1,309,459,979.55	
99	18-001	IN	Lafayette	New Construction: 65 Bed Facility	8.0	$ 8,611,535.00	$ 1,318,071,514.55	
100	06-060	CA	Yountville	New Construction: 280 Bed Facility	8.0	$ 87,540,173.63	$ 1,405,611,688.18	
101	17-045	IL	Anna	New Construction: 44 Bed Facility	8.0	$ 11,895,000.00	$ 1,417,506,688.18	
102	41-006	OR	Roseburg	New Construction: 154 Bed Facility	8.0	$ 23,945,597.65	$ 1,441,452,285.83	
103	24-008	MD	Fort Howard	New Construction: 120 Bed facility	8.0	$ 40,583,934.95	$ 1,482,036,220.78	
104	21-022	KY	Bowling Green	New Construction: 90 Bed Facility	8.0	$ 19,500,000.00	$ 1,501,536,220.78	
					Total Priority Group 2-8 Applications	**$ 731,673,200.46**		

VA Priority List FY 2017 Conditional Approvals**

Rank	FAI No.	State	Locality	Description	Obligated VA Share
	25-079	MA	Holyoke	Safety: Emergency Egress and American Disabilities Act Upgrade	$ 911,829.75
	09-016	CT	Rocky Hill	Safety: Fire alarm and suppression system	$ 3,100,630.00
	17-049	IL	Quincy	Safety: Legionella Control Project	$ 4,173,000.00
	40-058	OK	Statewide	Safety: Emergency Generator	$ 1,245,582.10
	12-026	FL	Indian River, St Lucie, Marian Counties	New Construction: 120 Bed Facility	$ 37,990,524.00
	12-028	FL	Orange County, Orlando	New Construction: 118 Bed Facility	$ 5,640,050.00
	32-005	NV	Boulder City	Renovation: Bed Replacement, Nursing Unit, HVAC, Water Treatment, and Anti-Wander	$ 636,826.20
	23-026	ME	Augusta	Bed Replacement: 138 Bed Facility	$ 49,199,538.36
				Total 2017 Conditional Grants	**$ 102,897,980.41**

*FY18 Distribution of Funds Based on Public Law 115-141, Section 253

**Funds were committed for conditional approval during FY 2017. These funds will be awarded provided that all requirements are met within 180 calendar days of the conditional approval. Failure to meet all requirements within 180 calendar days will result in the loss of the funds conditionally awarded and, at the state's request, ranking of the project on the FY 2019 Priority List. All grant applications are subject to 38 CFR Part 59.

Approved

Carolyn M. Clancy, MD
Executive in Charge
Office of the Under Secretary for Health
Department of Veterans Affairs

4/12/18
Date

Question 4. The Federal Acquisition Regulation states that if at all possible, orders of $3,500 or less (micro-purchases), should be distributed equitably among qualified suppliers that offer reasonable prices. Please provide VA's methodology for determining whether a supplier is deemed qualified and its prices are considered reasonable.

Response. VA purchases including micro-purchases are governed by the FAR. Federal Acquisition Regulation (FAR 48 CFR 1), Part 13—titled "Simplified Acquisition Procedures and Public Law 115–91 contain regulations that must be followed when making purchases. Specifically, Simplified Acquisition Procedures (SAP)—Methods prescribed in FAR Part 13.3 for purchasing goods or services. SAPs are designed for relatively simple Government requirements, and their use is subject to designated micro-purchase thresholds in FAR.

If the purchase will be made via a Government Purchase Card (GPC) the cardholder will refer to VA Financial Policy Volume XVI, Chapter 1B which deals with

purchases under the micro-purchase threshold when using a GPC. In that chapter the cardholder will be directed to follow the FAR and the Simplified Acquisition Procedures.

In addition to telling cardholders to follow the FAR, Chapter 1B also states "To ensure that VA receives the best possible pricing for goods and services, prior to selecting a vendor, every effort should be made to locate the items on a Government-wide or Departmental contract. Open market orders are used as a last resort when a cardholder is unable to satisfy requirements for supplies and services using an existing government contract."

Question 5. Although there are two years left on the contract, the Committee understands VA is moving forward with a new national broker contract, expected to be awarded by the end of FY 2018. Please provide answers to the following:

Response. To clarify VA's forecasted award date, VA forecasts award by end of Calendar Year 2018, not end of FY 2018.

a. What are the training requirements and basic certifications that companies and their leasing staff must have/maintain, prior to and after award?

Response. VA is continuing the process of market research to determine the training and certification requirements companies and their leasing staff will need prior to and after award. VA is using market research to draft the requirements documents prior to entering the solicitation portion of the acquisition process. All training and certifications requirements that companies and their leasing staff must have and maintain prior to and after award will be provided in the solicitation, which will be posted to FBO.gov during the procurement process for vendors to respond.

b. What, if any, prior completed work with the Federal Government must a company show to be considered a qualified vendor?

Response. VA is continuing the process of market research to determine any requirements for a company to show prior completed work with the Federal Government. VA is using market research to draft the requirements documents prior to entering the solicitation portion of the acquisition process. The final requirements will be stated in the solicitation, which will be posted to FBO.gov during the procurement process for vendors to respond.

c. How do you conduct market research to ensure that a best value competition takes place?

Response. VA conducts market research using techniques described in Federal Acquisition Regulations and VA Acquisition Regulations to inform VA's acquisition strategy. VA posted a Sources Sought notice on FBO.gov for vendors to respond by February 21, 2018, and conducted an Industry Day on February 15, 2018. Additionally, VA continues to conduct market research through researching Vendor Information Pages database for Service Disabled Veteran Owned Small Business or Veteran Owned Small Business concerns, as well as researching through Government and commercial information resources to continue to define requirements and promote competition.

Question 6. VA's testimony submitted for the hearing indicates VA is implementing a Veterans Integrated Service Network (VISN) level gap coverage plan that will enable facilities to request gap coverage providers in areas that are struggling with staffing shortages. Please provide the following information:

a. The process that will be used to request additional resources.

Response. The" Gap Coverage" VISN initiative is a partnership with V-IMPACT (Virtual Integrated Multi-Site Patient Aligned Care Team), a tele-primary care hub and spoke model catering specifically to filling vacancies within a VISN, as well as the tele-mental health hubs, Clinical Pharmacy Services, and the Interim Staffing Program. A LEAF (LIGHT, ELECTRONIC, ACTION, FRAMEWORK) request portal has been developed by the Gap Coverage team, streamlining the process to request staffing coverage in primary care, mental health, and clinical pharmacy. The Symphony platform has added capabilities to allow VISN leaders to easily identify the location of clinical staffing capacity as well as where the demand is located.

b. The approval process for those requests and a breakdown of the offices and individuals with oversight over the gap coverage plan.

Response. VISN executive leadership will be responsible for designating staff to process and coordinate these requests with relevant service lines in their VISN. VISN leadership teams may identify staffing using the tools identified above, and currently in pilot use.

c. The types of resources expected to be provided in addition to telehealth services such as temporary staff, additional funding, etc.

Response. The tools above will be made available to VISNs requesting additional resources. Eight V-IMPACT Hubs (funded by the Office of Rural Health (ORH)) serving seven VISNs are currently operational in the Veterans Health Administration (VHA). In order to sustain and grow these eight hubs for FY 2019, the V-IMPACT Office has requested $35.1 Million from ORH. To optimally cover vacancies across the enterprise, VHA would benefit from VISN-level hub expansion. We have identified six additional VISNs that are prepared to implement V-IMPACT Hubs in FY 2019, if additional funding is identified.

Question 7. The budget request indicates that an additional 5,500 HUD-VASH vouchers would be available to veterans in late 2017 or early 2018. How does the budget request for case management ensure a sufficient number of case managers to support the number of active vouchers?

Response. HUD awarded 5,211 additional Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH) vouchers in April 2018 from FY 2017 HUD appropriations provided for this purpose. VA is working with HUD to allocate another $540 million in HUD funding for new HUD-VASH vouchers, estimated to be 5,000 new vouchers, by September 30, 2018 from FY 2018 HUD funds appropriated for HUD-VASH. This would increase the total number of HUD-VASH vouchers awarded since 2008 to approximately 98,000.

VA is committed to providing case management support for all HUD-VASH vouchers awarded by HUD and is currently reviewing the budget needs to support case management services for these additional vouchers. The HUD-VASH program will make a request for any additional funding in future budgets, should it be needed, to support case management services for these additional vouchers.

Question 8. The FY 2019 revised request for the Program of Comprehensive Assistance for Family Caregivers is nearly $180 million less than the advance appropriation request. What factors contributed to the revised request?

Response. The FY 2019 revised request reflects an updated budget estimate to more accurately reflect the funding needs for FY 2019 and beyond. The original estimates that were provided for FY 2019 were based on assumptions in FY 2015 that are no longer accurate. The estimates derived from the assumptions that Veterans would continue to apply for the Program of Comprehensive Assistance for Family Caregivers (PCAFC) at the same rate of previous years, new admissions and discharges would continue at the same rate, and Veterans would remain in the same tier levels; however, this is not the case. The percentage of Veterans and caregivers applying and being approved for PCAFC decreased from 24 percent growth in FY 2015 to 3 percent growth in FY 2016. Also, the number of Veterans in tier level 3 decreased 10 percent in FY 2016. These two factors caused the reduction of total monthly stipend payments. Caregiver Support Program partnered with the Office of Community Care to make changes to the current model. The changes were accounted for in the new estimates and a new trend line was established.

The updated estimates also exclude the costs of care in the community and more accurately reflect the funding needs for VA services in current FY 2018 and the 5-year projection.

Question 9. The budget request for the Veterans Benefit Administration includes a request for an additional 605 full-time equivalent (FTE) employees to assist with processing appeals and reducing the notice of disagreement inventory to less than 7,000.

a. How was the number of additional FTEs determined?

Response. The 605 FTE was based upon modeling that indicated a need for additional FTE to both reduce the legacy claims and appeals inventory and allow for timely processing of the new appeals system.

b. By what date does VBA expect to meet this goal of reducing the notice of disagreement inventory?

Response. There are several variables that could affect the legacy inventory and a timeline concerning when it will be reduced. Early estimates generated with assumptions and Rapid Appeals Modernization Program data indicate a reduction of the legacy inventory over the next 3 to 5 years with the addition of the 605 FTE in FY 2019. Once the new legislation is implemented, the Appeals Management Office (AMO) will have more complete workload data, allowing AMO to more accurately track the reduction timeline of the legacy inventory.

Question 10. The budget request projects that the Board of Veterans' Appeals' appeals inventory will increase by 31 percent by the end of 2019. Please explain how this request will support the Board in continuing to reduce its appeals inventory while also implementing the new system under the Appeals Improvement and Modernization Act.

Response. The Board's pending inventory is contingent upon the rate of certification of appeals by Veterans Benefits Administration (VBA) to the Board, as well as the Board's productivity. With VBA requesting an additional 605 FTE in its 2019 budget, the Board expects an increase in its legacy inventory in FY 2019. The Board continually monitors workload projections and requirements and adjusts its resource requirements as necessary. While the Board projected to end 2018 with 165,660 pending appeals, it is pleased to report that through March 31, 2018, the Board's inventory was 157,656, which is 4,078 appeals below its projected inventory level of 161,734 for March. VBA's RAMP effort, allowing Veterans to withdraw their legacy appeal in order to opt into the new framework, will also decrease the number of appeals from the legacy process.

The Board has experienced tremendous growth over the last 3 years and the 2019 President's Budget request of $174,748,000 would represent a 76-percent increase in budget authority from 2015 levels. The Board hired over 300 employees in FY 2017, with plans to hire another 150 new employees in FY 2018. With the Board currently behind on its hiring targets in 2018, it projects to continue its upward hiring into 2019. The Board plans to continue to monitor its workload measures very closely and develop appropriate resource requirements presented to OMB and Congress as it has done in the past.

Question 11. The budget request for the Office of Mental Health and Suicide Prevention lists a number of goals for the 2018–2020 period. The goals include increasing mental health hiring, expanding collaborative partnerships with the private sector, and reducing negative perceptions of seeking mental health care.

a. Please describe in detail how VA plans to achieve each of the goals for the 2018–2020 period.

b. Please provide the funding resources needed, aggregated by fiscal year, to achieve these goals.

VA Response:

Goal 1: Reduce and eliminate death by suicide among Veterans through a public health approach across communities, by promoting health and well-being, and by providing ready access to high quality mental health care.

VA's comprehensive approach to suicide prevention is organized according to a public health prevention framework consistent with that developed by the National Academy of Medicine, which sorts prevention strategies into three levels:

1) *Universal strategies* to reach all Veterans in the U.S.

2) *Selective strategies* are intended for some Veterans that fall into subgroups that may be at increased risk for suicidal behaviors (e.g. women Veterans, Veterans living in rural areas, Veterans with substance use challenges, Veterans who have recently transitioned from military service).

3) *Indicated strategies* are designed for the relatively few individual Veterans identified as having a high risk for suicidal behaviors, including someone who has made a suicide attempt.

To achieve this goal for the 2018–2020 period, specific key activities over the next 2 years related to each of the three levels of prevention strategies are outlined below.

ALL	SOME	FEW
Caring contact programs for transitioning Veterans	Universal screening and assessment for suicide risk	Veterans Crisis Line (VCL)
Universal lethal means education and training	Transition readiness assessment and warm handoffs for care	Suicide Prevention Coordinators at every VA facility
Broad messaging campaigns to increase awareness of mental health services and to reduce stigma	#BeThere Peer Support Call and Outreach	Use of predictive modeling to identify and reach out to Veterans at highest risk (REACH-VET)
Education materials for all community members on recognizing and responding to signs of distress	Training for a broad range of community health care providers on suicide assessment, prevention, and intervention	Further predictive modeling efforts across DOD/VA

ALL	SOME	FEW
Promote the establishment of Whole Health ''clinics'' that will provide services for any Veteran who wishes to participate	Build and expand partnerships for access to mental health services throughout the community	Clinical Practice Guidelines
Promote responsible media reporting about suicide	Mental health hiring initiative	Safety planning training and standardization
#BeThere prevention initiative and public awareness and education campaigns	Gatekeeper training for intermediaries who may be able to identify Veterans at high-risk (S.A.V.E.)	Distribute gun locks or Naloxone nasal spray kits at VA facilities
Cross-sector partnerships to involve peers, family members, and the community (e.g., Johnson & Johnson, Department of Defense, Department of Homeland Security, and various Veteran Service Organizations)	Provide immediate and easy access to evidence-base mental health services, promote a recovery model of mental health care, incorporate families into Veterans' care (consistent with law), and implement Measurement Based Care	
Build community partnerships to support and expand efforts for all levels		
Incorporate program evaluation into all efforts		
Implement a National Strategy for Suicide Prevention for Veterans		
Support and expand Mayor's Challenge program[1] in all three areas		
Create and disseminate resources, tool kits, and technical support for local VA facilities and regions to develop, implement, and evaluate a comprehensive suicide prevention strategy		
Lead efforts to set, promote and support a national research agenda for suicide prevention for Veterans		

[1] The Mayor's challenge is a collaborative effort between Substance Abuse Mental Health Services Administration and VA to engage cities (mayors, government staff, and community partners) to establish and implement a strategic plan for the elimination of suicide in their city.

Approximate annual expenditure, which the VHA Office of Mental Health and Suicide Prevention will support within its budget, is $34.5,000,000.

Goal 2: Advance predictive analytics through intergovernmental and non-VA partnerships to expand this groundbreaking approach to addressing Veteran self-harm.

VA will engage in multiple predictive analytics projects. First, VA has a partnership with Johnson & Johnson (J&J) to advance suicide prevention efforts, among other things, and one of the major projects in this partnership will be work in predictive modeling. VA and J&J will explore other sources of data that might meaningfully contribute to the fit and performance of the models predicting risk of suicidal behaviors and allow incorporation of predictive modeling with partnering healthcare systems. Second, a work group with representatives from both DOD and VA are developing a collaborative approach to predictive analytics as part of Executive Order 13822. DOD and VA are enhancing data streams and infrastructure to support advanced analytics in identifying risk of adverse outcomes associated with service transition. In addition, the REACH VET initiative will continue to address needs of those Veterans at highest statistical risk and predictive risk information will be used more broadly in assessing Veterans needs through expansion of risk based dashboards to support clinical decisionmaking.

Approximate annual expenditure is $5,000,000, which the VHA Office of Mental Health and Suicide Prevention will support within its budget.

Goal 3: Open a third VCL location to meet increase demands for crisis intervention services.

VCL is continuing to expand to meet the needs of Veterans and Servicemembers in crisis, including full implementation of the automatic transfer function that directly connects Veterans who call their local VA Medical Center (VAMC) to VCL by pressing a single digit (7) during the initial automated phone greeting. More than 78 percent of all Community Based Outpatient Clinics also offer this feature, with

additional sites planned. In January 2018, VCL opened a third call center on the campus of the Eastern Kansas Health Care System in Topeka, Kansas. As of August 2018, the Topeka call center has 50 trained responders. Funding of $28.5 million was allocated in FY 2018 to cover the opening and funding is included in the FY 2019 Budget request to sustain its operations.

Goal 4: Increase Veterans' access to care through increased mental health staff hiring and expansion of telehealth services.

VHA Workforce Management and Consulting in partnership with the Office of Mental Health and Suicide Prevention have established the Mental Health Hiring Initiative upon the request of former VA Secretary David Shulkin. The Initiative seeks to add 1,000 net new providers in Mental Health by the end of December 2018.

- Additional providers will ensure VAMCs continue to meet access expectations for crises, engagement into care, and sustained treatment.
- Facilities with mental health staffing lower than the recommended minimum and that also have poor access, quality, and satisfaction performance are receiving additional Human Resources support and planning.
- Additional Educational Debt Repayment Program funding has been made available through existing resources.
- Telemental Health Services continue to expand through VA video connect and tele Hub Services.
- Tele Services continue to expand, providing rural veterans increased access and convenience.

Funds are being allocated within current facility budgets.

Goal 5: Promote the development of skills in VA providers to diagnose and assess Posttraumatic Stress Disorder (PTSD) by developing a computer-based training using simulated virtual patient technology that will allow clinicians to practice and receive customizable feedback on giving CAPS–5 to a lifelike virtual patient.

The Clinician-Administered PTSD Scale (CAPS), developed at the National Center for PTSD more than 20 years ago, is the gold standard interview for diagnosing PTSD. CAPS training has traditionally relied on face-to-face instruction followed by practice cases with supervision. Live training is time intensive and demand has surpassed what is feasible to deliver in person, particularly since a 2013 revision to the CAPS to align with revised diagnostic criteria by the American Psychiatric Association. Technology offers a more flexible, scalable, solution that is less expensive in the long term. In FY 2017 the National Center created an online course to describe requirements for administering and scoring the CAPS–5, but the course does not help clinicians practice the CAPS in order to become proficient. In 2018, the Center plans to develop an additional CAPS–5 course that uses cutting-edge Responsive Virtual Human Technology to create an online virtual interview environment. The new course will allow clinicians to verbally administer the CAPS to a virtual patient who will respond naturalistically (like an actual patient). A virtual coach will give feedback during the administration, and feedback will be provided at the end specifying whether the learner is proficient or needs further practice. In FY 2018, the Center budgeted $1.5 million to build the course with a virtual male combat Veteran patient. In FY 2019, the Center is planning to add a second virtual patient, a woman Veteran who has experienced military sexual trauma, for a cost of $1.2 million. Over the next 3 years, there will be ongoing maintenance and enhancement costs of approximately $400,000 per year, which the Center will support from its recurring budget.

Goal 6: Continue expansion of Brain Bank activities and promote research to enhance the assessment and treatment of PTSD through the identification of biomarkers and novel treatment strategies.

VA's National Posttraumatic Stress Disorder Brain Bank (PTSD Brain Bank) was formally established in 2014, thanks in part to Congressional support led by U.S. Senator Patrick Leahy (D-VT). It is the first and only facility of its kind devoted exclusively to PTSD and consists of a consortium of five VA medical centers as well as the Uniformed Services University of Health Sciences.

The PTSD Brain Bank currently has 168 brains, including 56 PTSD brains, and has received commitments of more than 100 additional brains by the end of 2018. Donors can be either Veterans or non-Veterans. Because of the importance of acquiring suitable comparison tissue, the PTSD Brain Bank also collects tissue from donors who had no psychiatric illness during their lifetimes, or who suffered from a non-PTSD disorder such as depression.

Donations of tissue to the PTSD Brain Bank can occur in two ways. In many cases, consent for donation is obtained from next-of-kin shortly after their loved one dies. Other tissue comes from individuals who enroll in advance and personally consent to have their brain tissue go to the PTSD Brain Bank after death (called antemortem donors). The advantage of acquiring commitments from antemortem donors is that detailed data can be collected on their medical and psychological histories while they are alive.

The National Center for PTSD will continue to acquire more brain tissue for the Brain Bank. Acquisition of post-mortem tissue will be through arrangements with medical examiner networks, organ donation facilities, and the Duke Autopsy Program. The Center will also continue to recruit potential donors through strategic partnerships with longitudinal research registries and with organizations that support the Center's mission. Additionally, the Center will continue to invest in research staff and facilities to allow multimodal analyses of brain tissue. Toward the broader goal of identifying biomarkers and novel treatment strategies, the Center will continue to provide salary support for investigators engaged in this work (e.g., imaging, genetics, treatment development, clinical trials) and facilitate collaboration between investigators within and beyond the National Center. The Brain Bank receives a recurring budget of $1.5 million per year; this budget is supplemented when additional funds become available. Other research efforts are supported through the Center's recurring budget; high priority projects and infrastructure are further supported as additional funds become available.

Goal 7: Expand collaborative partnerships with the private sector to enhance and complement VA's efforts to improve Veterans' mental health and reduce Veteran suicide.

As a key component of our strategy to prevent Veteran suicide across the all, some, and few domains, VA is developing a national network of public and private partnerships aimed at Veterans both inside and outside VA's system to inform them about mental health resources and care that are available to them through VA and community resources. These partnerships allow each party to continue to provide services to Veterans under its own respective authority, but each agrees to do so in a manner that effectively complements the contemporaneous or coordinated delivery of each party's services, thereby maximizing outcomes for Veterans and their families.

VA Suicide Prevention, program within the Office of Mental Health and Suicide Prevention, currently has 20 public private partnerships across the following sectors: Veterans Service Organizations (VSO), Federal Agencies, Employers, Health care Organizations (including those providing physical, mental health and substance abuse care), Lethal Means Education and Suicide Prevention, Communication and Media, Technology and Innovation, and Broad Sector Engagement. Over the next 2 years, VA suicide prevention will continue to expand its public private partnerships portfolio in alignment with of our strategic priorities.

Approximate annual funding is $1,500,000 to cover VA overhead and other costs associated with the implementation of these agreements, as they do not include an exchange of funds. VHA Office of Mental Health and Suicide Prevention will support this effort within its budget.

Goal 8: Continue outreach efforts to increase awareness of mental health services and resources, reduce negative perceptions about seeking mental health care and improve mental health literacy among Veterans and their families and friends.

As the largest integrated health care system in the country, VA is committed to providing timely access to high-quality, recovery-oriented mental health care that anticipates and responds to Veterans' needs, such as treatment for PTSD, substance use disorders, depression, and suicidal ideation. Recovery empowers the Veteran to take charge of his or her treatment and live a full and meaningful life. Encouraging more Veterans to seek mental health treatment by providing accurate information about the evidence-based care that VA provides is a primary goal of VA's mental health education and outreach efforts. VA's mental health communication materials are strategically developed and refined using best practices and lessons learned and are then distributed nationally via event and conference attendance, website and webpages, social media platforms, television, and radio to directly confront and combat common misperceptions and inaccurate information about mental health and suicide in this country and eliminate the stigma many Veterans associate with these topics and with seeking mental health care.

Specific programs to increase awareness of mental health services and resources used to reduce negative perceptions about seeking mental health care and improve

mental health literacy among Veterans and their families and friends are outlined in the table in the response to Goal 1 above. Specifically, these include 1) outbound calls to transitioning servicemembers to provide information on access to peer support, VA mental health care, eligibility for health care and for VA benefits, lists of local and national resources, and names and contact information for immediate needs; 2) a broad communications campaign targeting all servicemembers, Veterans and family members with key messages about access to mental health care; and 3) a broad communications strategy to change attitudes and behaviors about suicide prevention, reduce the stigma associated with seeking help, and increase knowledge of important protective factors that reduce risk; and 4) active promotion of responsible media reporting on mental health and suicide-related issues.

For example, VA's award-winning Make the Connection national outreach program was specifically developed to reduce negative perceptions about seeking mental health care and improve mental health literacy among Veterans and their families and friends. VA will continue this campaign to increase awareness of mental health services and resources. Specific activities include: developing and maintaining existing relationships with VSOs, Community Based Organizations, and, other government departments and agencies who have supported the campaign and distributed messaging; executing online advertising employing keyword, display banner, social media and video advertisements; producing and distributing public service announcements; and, promoting Veterans' stories of resilience and recovery across a variety of platforms.

VA's communication/outreach work on this topic encourages more Veterans to reconsider their attitudes and beliefs about mental health and seeking mental health care and to consider VA as the best resource to contact should a mental health issue arise. VA is dedicated to increasing the number of Veterans who receive mental health care, preventing Veteran suicide, and ensuring every Veteran who needs assistance with a mental health challenge or crisis is aware of and educated about VA's programs and resources.

Approximate annual expenditure is $7.5 million, which the VHA Office of Mental Health and Suicide Prevention will support within its budget.

Question 12. The budget request for FY 2019 proposes to merge the Medical Services Appropriations Account with the Medical Community Care Appropriations Account. The proposal suggests that having two accounts hampers Medical Center Directors from properly managing their budgets and, therefore, make decisions of where to provide care when there are temporary personnel shortages. However, the Medical Community Care Appropriations Account was created to ensure a dedicated funding stream for community care and provide Congress with better oversight of the funds spent on care provided inside and outside VA.

a. Should Congress merge the two accounts, what oversight processes are in place to ensure funding intended for community care is actually spent on community care?

Response. The accounting structure to capture and identify care purchased from the community will remain in place to enable VA to identify and report separately on the costs of VA-provided care and for care from community providers and Federal partners. For example, the following tables, which were included in the revised FY 2019 Congressional Justification volume, display the detail available which mirrors the detail currently reported for the separate Community Care appropriation.

Care in the Community Obligations by Program
Includes Veterans Choice Program
(dollars in thousands)

Description	2017 Actuals			2018 Budget Estimate			2018 Current Estimate		
	Veterans 2/ Choice Fund (0172)	Medical Community Care (0140)	Subtotal	Veterans Choice Fund (0172)	Medical Community Care (0140)	Subtotal	Veterans 2/ Choice Fund (0172)	Medical Community Care (0140)	Subtotal
Health Care Services:									
Ambulatory Care	$3,068,201	$1,589,371	$4,657,572	$1,203,111	$2,342,023	$3,545,134	$2,179,984	$2,530,720	$4,710,704
Dental Care	$108,406	$133,401	$236,807	$45,100	$101,300	$146,400	$72,900	$157,229	$230,129
Inpatient Care	$971,966	$2,043,692	$3,015,658	$1,551,789	$1,551,789	$3,103,578	$685,994	$2,209,990	$2,895,984
Mental Health Care	$34,179	$176,436	$210,615	$0	$315,099	$315,099	$24,100	$204,700	$228,800
Prosthetics	$14,052	$0	$14,052	$5,200	$0	$5,200	$22,203	$0	$22,203
Rehabilitation Care	$0	$0	$0	$0	$0	$0	$0	$0	$0
Health Care Services [Total] 1/	$4,191,804	$3,942,900	$8,134,704	$2,805,200	$4,310,211	$7,115,411	$2,985,181	$5,102,639	$8,087,820
~~Long-Term Services and Supports Community Care:~~									
Community Nursing Home	$0	$869,690	$869,690	$0	$1,032,400	$1,032,400	$0	$892,889	$892,889
Community Non-Institutional Care	$592,765	$655,158	$1,247,923	$694,800	$805,000	$1,499,800	$680,672	$687,128	$1,367,800
State Nursing Home	$0	$1,252,899	$1,252,899	$0	$1,290,362	$1,290,362	$0	$1,225,026	$1,225,026
State Home Domiciliary	$0	$58,086	$58,086	$0	$54,400	$54,400	$0	$54,400	$54,400
State Home Adult Day Care	$0	$944	$944	$0	$1,195	$1,195	$0	$1,195	$1,195
Community Long-Term Services and Supports [Total]	$592,765	$2,836,777	$3,429,542	$694,800	$3,183,357	$3,878,157	$680,672	$2,860,638	$3,541,310
~~Other Health Care Programs Community Care:~~									
CHAMPVA, Spina Bifida, FMP, & CWVV	$0	$1,287,571	$1,287,571	$0	$1,639,249	$1,639,249	$0	$1,397,281	$1,397,281
Caregivers (non-CHAMPVA)	$0	$1,171	$1,171	$0	$3,373	$3,373	$0	$1,208	$1,208
Camp Lejeune Family	$0	$1,368	$1,368	$0	$6,664	$6,664	$0	$1,398	$1,398
Other Health Care Programs community care [Total]	$0	$1,290,110	$1,290,110	$0	$1,649,286	$1,649,286	$0	$1,399,887	$1,399,887
SubTotal Obligations	**$4,784,569**	**$8,069,787**	**$12,854,356**	**$3,500,000**	**$9,142,854**	**$12,642,854**	**$3,665,853**	**$9,363,164**	**$13,029,017**
VA Prior-Year Recoveries	$699,650	$0	$699,650	$0	$0	$0	$0	$0	$0
Total Obligations	$5,484,219	$8,069,787	$13,554,006	$3,500,000	$9,142,854	$12,642,854	$3,665,853	$9,363,164	$13,029,017

1/ Includes cost of proposed CARE Act
2/ Excludes O&T components

Care in the Community Obligations by Program
Includes Veterans Choice Program
(dollars in thousands)

Description	2019 Advance Appropriation			2019 Revised Request			2020 Advance Appropriation		
	Veterans Choice Fund (0172)	Medical Community Care (0140)	Subtotal	Veterans Choice Fund (0172)	Medical Community Care (0160)	Subtotal	Veterans Choice Fund (0172)	Medical Community Care (0160)	Subtotal
Health Care Services:									
Ambulatory Care	$1,187,907	$2,344,979	$3,532,886	$1,152,215	$3,483,460	$4,635,675	$0	$5,857,622	$5,857,622
Dental Care	$60,304	$101,300	$161,604	$37,800	$167,386	$205,186	$0	$177,730	$177,730
Inpatient Care	$1,551,789	$1,361,860	$2,913,649	$344,947	$1,816,429	$2,161,376	$0	$2,889,287	$2,889,287
Mental Health Care	$0	$320,145	$320,145	$12,500	$199,400	$211,900	$0	$299,900	$299,900
Prosthetics	$5,200	$0	$5,200	$11,152	$0	$11,152	$0	$0	$0
Rehabilitation Care	$0	$0	$0	$0	$0	$0	$0	$0	$0
Health Care Services: [Total]	$2,805,200	$4,128,284	$6,933,484	$1,558,614	$5,666,675	$7,225,289	$0	$9,224,539	$9,224,539
Long-Term Services and Supports: Community Care:									
Community Nursing Home	$0	$1,104,700	$1,104,700	$0	$963,651	$963,651	$0	$1,033,734	$1,033,734
Community Non-Institutional Care	$694,800	$928,600	$1,623,400	$341,386	$1,110,099	$1,451,485	$0	$1,529,900	$1,529,900
State Nursing Home	$0	$1,367,993	$1,367,993	$0	$1,245,709	$1,245,709	$0	$1,274,975	$1,274,975
State Home Domiciliary	$0	$54,206	$54,206	$0	$61,764	$61,764	$0	$61,196	$61,196
State Home Adult Day Care	$0	$1,317	$1,317	$0	$1,322	$1,322	$0	$1,417	$1,417
Community Long-Term Services and Supports: [Total]	$694,800	$3,456,816	$4,151,616	$341,386	$3,382,545	$3,723,931	$0	$3,901,222	$3,901,222
Other Health Care Programs: Community Care:									
CHAMPVA, Spina Bifida, FMP, & CWVV	$0	$1,774,076	$1,774,076	$0	$1,463,185	$1,463,185	$0	$1,529,841	$1,529,841
Caregivers (non-CHAMPVA)	$0	$3,439	$3,439	$0	$1,620	$1,620	$0	$1,624	$1,624
Camp Lejeune Family	$0	$7,630	$7,630	$0	$1,429	$1,429	$0	$1,460	$1,460
Other Health Care Programs community care [Total]	$0	$1,785,145	$1,785,145	$0	$1,466,234	$1,466,234	$0	$1,532,925	$1,532,925
Total Obligations: 1/ 2/	**$3,500,000**	**$9,370,245**	**$12,870,245**	**$1,900,000**	**$10,515,454**	**$12,415,454**	**$0**	**$14,658,686**	**$14,658,686**

1/ Includes cost of proposed CARE Act

2/ The Budget includes $12.4 billion in total obligations for Choice/Community Care in FY 2019. Programmatic resources total $14.2 billion, 9.1 percent above 2018 after adjusting for the impact of the change in timing of obligations.

VA is proposing to establish a community care funding model that mirrors the successful model currently used for VA's Consolidated Mail Outpatient Pharmacies (CMOP). Under this model, each VAMC and the Deputy Undersecretary for Health

for Community Care (DUSHCC) would determine an estimated amount of funding for community care at the beginning of the fiscal year, and the VAMC would preposition those funds with the DUSHCC to manage the purchase of and payment for care purchased by VA from community providers. During the course of the year, each VAMC and the DUSHCC would monitor the initial funding amount and make appropriate adjustments based on changes in actual demand as the fiscal year progresses.

Oversight of VA Medical Care budget execution will occur at all leadership levels, culminating at the Monthly Management Review chaired by the Deputy Secretary. VA would also be able to provide execution reports, similar to the reports currently provided for Choice funding, to Congress if desired, to monitor the relative funding of care provided in VAMCs and purchased from community providers.

Merging the Medical Services and Medical Community Care accounts, together with using a CMOP-like funding model for community care, would enhance each VAMC's ability to rapidly address the dynamic nature of health care management. These changes would enable VA field staff to respond rapidly and effectively to unanticipated changes in the health care environment throughout the year and will maximize VA's ability to focus our resources on the services Veterans most need. In short, rather than creating a potential incentive to determine where care is delivered based on funds available in the two separate appropriations, this proposal allows each VAMC Director to determine where they can effectively enhance the capability of their facilities with the confidence that funds will be available to accomplish that goal.

b. What processes are currently in place to help VA Medical Center Directors better manage their budgets?

Response. VHA instituted the Veterans Equitable Resource Allocation (VERA) Model in April 1997 to allocate funds to VISNs. VERA ensures that the allocation of funds is equitably distributed based on Veterans who use VA's health system rather than simply being based on historic funding patterns. The implementation of VERA aided in the transformation of VA's health care system from individual medical centers and clinics focused primarily on inpatient care to a fully integrated system with expanded primary and ambulatory care capability. VERA has been, and will continue to be, a critical component of VA's success in implementing the mission and vision of VHA.

The VERA Model gives each network a "tailored" allocation price that reflects the unique characteristics of each network. For example, network funding is based on a combination of the number of patients, adjustments for regional variances in labor and contract costs, high cost patients, education support, research support and equipment. While VERA has significantly improved the allocation of the Veterans' health care budget, VHA will continue to review and examine the VERA Allocation Model to assure its continued relevance and to identify needed improvements.

Since VERA was introduced in 1997, there have been nine external assessments of VERA. These independent reviews validated that the VERA methodology is meeting its objectives and the original intent of Congress under Public Law 104–204. The process for refining the VERA methodology can be internally generated by VA users of the VERA system or externally generated by outside VERA evaluators.

The three reports below are used by VHA Office of Finance as part of the financial metrics routinely used to ensure sound financial performance.

- VHA Directive 1733, The Financial Quality Assurance Reviews, establishes the requirements for performing and conducting the finance quality assurance program, performing self-assessment reviews, and evaluating the quality of work within finance operations and related activities. These self-assessments are submitted to the VHA Office of the Chief Financial Officer (CFO) for compilation and data analysis.
- The financial indicators were developed to provide a means of evaluating performance and promoting improvements in financial management within VHA. This is a monthly report that includes indicators for potential issues that alerts leadership at medical centers to review.
- The Expenditure Pace Report is a VHA CFO established report identifying open obligations that have been identified as requiring action based on criteria established by the VHA CFO Finance staff. Medical center staffs review the information and must provide a justification for obligations remaining open or they are closed by the VHA CFO staff.

In addition, VHA Office of Finance uses many formal and ad hoc reports based on the needs identified by financial statement audits, data analysis, investigations, improper payment reviews, external requests, and cost accounting audits. Below is a sampling of additional reports and audits routinely used within the VHA Office of Finance.

• Fund Availability Reports are monthly reports prepared by the VHA Office of Budget staff to identify available funds at each VAMC and identify obligations rates to highlight any anomalies.

• Operational Plans are prepared by each VISN identifying their spending plan by category and month for the year. VISNs are required to account for actual obligation-to-plan differences greater than 3 percent each month with results tracked by VHA senior leaders.

• The Medical Center Allocation System was established to standardize the methodology for distributing VISN-level VERA Model funds to medical centers within each VISN. We require VISNs to document and substantiate any differences with the system proposed allocations and identify any expected outcome changes.

• Financial Statement Audit and Office of Inspector Corrective Action Plans—When reviews identify deficiencies, VAMCs are required to provide corrective action plans on a regular basis until corrections are completed.

• Improper Payments Review requires that VAMCs provide samples of payment documents that are reviewed. Once the review and analysis are completed, VAMCs are required to prepare and implement corrective action plans to improve the payment processes.

• The Managerial Cost Accounting Office oversees audits on a regular basis that identify areas where costs are outliers compared to other facilities. They work with the VAMC until costing errors are corrected.

Oversight of VAMC budget execution will continue to occur at all leadership levels, culminating at the Monthly Management Review chaired by the Deputy Secretary. VA would continue to provide periodic execution reports, similar to the reports currently provided for Choice funding, to Congress if desired, to monitor the relative funding of care provided in VAMCs and purchased from community providers.

c. If Congress does not merge the two accounts, what other options could VA employ to more effectively manage the two accounts?

Response. VA uses an actuarial model, the Enrollee Health Care Projection Model (EHCPM), to develop health care requirements for Veterans. EHCPM develops estimates for both community care and care provided in VAMCs. VA will continue to include separate estimates for community care funded within the Medical Services appropriation in the President's Budget request. VA will also continue to discretely account for community care obligations using the same underlying accounting structure currently in place for the separate Medical Community Care appropriation. VA is submitting a legislative proposal to allow VA to use a model similar to that used for the Consolidated Mail Outpatient Pharmacy program, where the funds will initially reside with each VAMC, but will be provided by the VAMC to the DUHUCC to manage during the year. Based on the demand for community care and the ability of the VAMC to provide more care in house at lower cost, the amount provided can be rapidly adjusted to meet changes in each VAMC's ability to provide care in-house.

As stated earlier, oversight of VA Medical Care budget execution will occur at all leadership levels, culminating at the Monthly Management Review chaired by the Deputy Secretary. VA would also be able to provide periodic execution reports, similar to the reports currently provided for Choice funding, to Congress if desired, to monitor the relative funding of care provided in VAMCs and purchased from community providers.

Question 13. The budget request for FY 2019 and the advance appropriation request for FY 2020 for the Medical Support and Compliance Appropriations Account support a total FTE of 51,097 for both fiscal years. This appropriations account provides funding for the Veterans Health Administration (VHA) Central Office; VA medical centers, VISN headquarters, and other activities.

a. Please provide the total FTE for VHA Central Office; the VA medical centers; VISN and other field activities; and VHA National Consolidated Activities.

b. For each total above, please break the totals out by General Schedule grade or Title 38 employees.

Response. See the following table "Employment Summary, Medical Support & Compliance, FTE by Grade, FY 2017–FY 2020." FY 2018–FY 2020 assumes similar relationship as found in the FY 2017 actuals.

EMPLOYMENT SUMMARY, MEDICAL SUPPORT & COMPLIANCE
FTE BY GRADE, FY 2017–FY 2020

	FY 2017[1]					FY 2018 - 2020[1]				
	VHA Central Office	VAMC	VISN	National Consolidated Activities	Total	VHA Central Office	VAMC	VISN	National Consolidated Activities	Total
SES[2]	30	113	13	4	160	30	113	13	4	160
Title 38	207	3,027	130	497	3,861	208	3,036	130	499	3,873
GS-15	153	138	81	116	488	154	138	81	116	489
GS-14	540	623	269	451	1,883	542	625	271	452	1,890
GS-13	435	2,100	199	1,083	3,817	436	2,107	200	1,086	3,829
GS-12	205	3,718	92	1,484	5,499	206	3,730	92	1,489	5,517
GS-11	98	3,896	48	932	4,974	98	3,908	48	935	4,989
GS-10	0	96	4	2	102	0	96	4	2	102
GS-09	62	3,886	46	1,025	5,019	62	3,898	46	1,028	5,034
GS-08	1	1,961	17	309	2,288	1	1,967	17	310	2,295
GS-07	34	4,970	33	2,211	7,248	34	4,985	33	2,218	7,270
GS-06	6	6,364	8	2,524	8,902	6	6,385	8	2,532	8,931
GS-05	4	3,164	0	699	3,867	4	3,174	0	701	3,879
GS-04	0	1,662	0	67	1,729	0	1,667	0	67	1,734
GS-03	1	92	0	1	94	1	92	0	1	94
GS-02	0	20	0	0	20	0	20	0	0	20
GS-01	0	1	0	1	2	0	1	0	1	2
Wage Grade	1	963	0	22	986	1	966	0	22	989
FTE Sub Total	1,777	36,794	940	11,428	50,939	1,783	36,908	943	11,463	51,097
	Grand Total		50,939			Grand Total		51,097		

Footnotes:
1/FY 2017 through FY 2020 Full Time Equivalents (FTE) are estimates
2/SES = Senior Executive Service

Question 14. According to the budget request, VA providers have difficulty in querying state Prescription Drug Monitoring Programs (PDMP) databases and incorporating PDMP data into a veteran's electronic health record. To improve the ability to check and integrate data from the PDMPs, VA will need to utilize technology based solutions.

a. How much funding resources does VA estimate will be needed to make these improvements?

Response. The first 2 years of implementing a VA Enterprise Wide Interface between VA's EHR (CPRS) and the State PDMPs is estimated to cost just over $9 million, and the first 8 years are estimated to cost just over $33 million. These estimates are for all of VA (Enterprise Wide Cost), largely due to software licensing fees (priced currently at around $37.50 per VA staff member query user per year).

b. Please describe in detail the VA's plan to improve VA provider's interaction with PDMPs.

Response. The multi-program office, enterprise wide endeavor to implement a VA Enterprise Wide Interface between VA's EHR (CPRS) and the State PDMPs, if approved for funding, will serve to more readily provide State PDMP query information within VA's EHR in real time, and at the point of care, for prescribing VA health care providers and their allied health staff and clinical delegates.

Similar endeavors with non-VA health care organizations have led to dramatic increases in prescriber queries, as well as dramatic decreases in opioid prescriptions, as evidenced by the February 2017 report by the Centers For Disease Control regarding the PDMP Electronic Health Records Integration and Interoperability Expansion program. Moreover, there are a handful of private vendors that have emerged as top candidates for collaborating with VA for the creation and maintenance of such an interface, and VA Office of Information and Technology (OI&T) is aware of these possible vendors so that they can commission a very high yield and successful competitive solicitation and bid process for a contracted vendor (or sole source award at their discretion), should this project be approved for funding and resourcing consideration.

Section 134 of the Mission Act will support the implementation of a VA Enterprise Wide Interface, as this act considers any licensed VA health care provider or their delegate within VA to be an authorized recipient or user for the purpose of querying and receiving data from the national network of State-based prescription

drug monitoring programs, to support the safe and effective prescribing of controlled substances to covered patients. This Act further prohibits States (notwithstanding any general or specific provision of law, rule, or State regulation) from restricting access or sanctioning the licenses of licensed VA health care providers or their delegates when accessing that State's prescription drug monitoring programs.

In summary, the Mission Act (notwithstanding any superseding law, rule or regulation) allows for Federal Supremacy and Team Based health care delivery with respect to the querying of a national network of State-based prescription drug monitoring programs, and the current marketplace supports the pursuit of a VA Enterprise Wide Interface, as at least one private non-VA software vendor has developed an electronic gateway that connects or will connect 48 State-based prescription drug monitoring programs as of July 2018.

c. What factors will VA utilize to determine whether a commercial-off-the-shelf product could be used to improve the interaction with the PDMPs?

Response. There are a few private vendors who have emerged as quite proficient in this realm of building interfaces between Health care Institution EHRs and the State PDMPs. The group convened by VA that is working on the National Service Request for a VA Enterprise-wide interface has made some pricing inquiries with one or more of these vendors to assist with budget forecasting for VA and for our colleagues in OI&T, but they have otherwise purposefully kept their distance from interacting more meaningfully with any particular vendor. VA sincerely hopes (with approval and funding for implementation) that a fair and unbiased solicitation could ensue to develop the VA Enterprise-wide interface with a contract awarded vendor (vs. a sole source solicitation if VA OI&T's contracting teams felt this was in VA's best interests and could legitimately justify such an action). To that end, VA has not met/discussed project-related thoughts and ideas with any one particular vendor or another, to avoid creating an unfair level of competition for any future projects that VA OI&T would send for solicitation.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. DAN SULLIVAN TO HON. DAVID J. SHULKIN, M.D., SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 15. FUTURE OF COMMUNITY CARE IN ALASKA: Sec. Shulkin, now that the VA is moving from a 2 region model (Triwest/HealthNet) toward the CARE concept and a 4 region model, it is my understanding that the Community Care (CC) office received successful bids for Regions 1–3, but not for Region 4—which includes Alaska. Please provide an update on what happened during that bid, some of the contributing factors for why it failed and what the VA is planning to do moving forward.

Response. VA determined it was not in the best interest of the Government to make an award in CCN Region 4. Unfortunately, VA cannot release the specific details of what happened or contributing factors due to the sensitive nature of the acquisition process. The updated draft solicitation for CCN Region 4 was posted to FedBizOpps on Friday, May 25. Alaska is not included in CCN Region 4. VA understands the unique challenges of Alaska and is taking this opportunity to explore all possible options for providing community care to these Veterans.

Question 16. TRIBAL SHARING AGREEMENTS: When you became Secretary, you promised early and thorough engagement with our Alaska Native healthcare partners to work out some of your differences in serving these rural Veterans. I understand there has been some turnover and that there are critical vacancies that still need to be filled, but, can you tell me who you currently have leading on this important issue, if they are able to make commitments on your behalf and what progress has been made on the VA's end to come to an agreement with all parties?

Response. VA has established and continued partnerships with Alaska Tribal Health Programs (THPs) through signed reimbursement agreements. Under these agreements, VA reimburses Alaska THPs for Direct Care Services provided to eligible American Indian (AI)/Alaska Native (AN) Veterans and non-Native Veterans. In early 2017, VA and the Alaska THPs renewed these agreements through June 30, 2019, and VA would like to renew them again, if renewal is agreeable to the Alaska Tribal Health Programs, in the future.

APPENDIX

PREPARED STATEMENT OF MS. JAN THOMPSON,* PRESIDENT, AMERICAN DEFENDERS OF BATAAN AND CORREGIDOR MEMORIAL SOCIETY

AMERICAN PRISONERS OF WAR OF JAPAN

PROTECTING THE HISTORY OF WORLD WAR II

CHAIRMAN ISAKSON, RANKING MEMBER TESTER, AND MEMBERS OF THE SENATE VETERANS' AFFAIRS COMMITTEE, Thank you for allowing us to present the unique concerns of veterans of World War II's Pacific Theater to Congress. The American Defenders of Bataan and Corregidor Memorial Society (ADBC-MS) represents surviving POWs of Japan, their families, and descendants, as well as scholars, researchers, and archivists. Our goal is to preserve the history of the American POW experience in the Pacific and to teach future generations of the POWs' sacrifice, courage, determination, and faith—the American spirit.

Today, I want to speak to you about how integral the American POW history with Japan is to our greater understanding of how we need to care for and remember all our veterans. These veterans had the highest rate of post-conflict hospitalizations and psychiatric disorders of any generation. Their traumas have had multi-generational consequences. Their history of perseverance and patriotism speaks to the need for the civic remembrance of our country's veterans.

OUR HISTORY

April 9th will mark the 76th anniversary of the Bataan Death March. By March 1942, Imperial Japanese Armed Forces had destroyed the U.S. Asiatic Fleet and the U.S. Far East Air Force. On May 6, 1942, all the Philippines fell. These were the greatest military setbacks in American history and all happened in Asia where Imperial Japan started WWII for the United States.

On December 7, 1941, Imperial Japan attacked not only Pearl Harbor but also the Philippine Islands, Guam, Wake Island, Howland Island, Midway, Malaya, Singapore, Thailand, Hong Kong and Shanghai. Three days later, Guam became the first American territory to fall to Japan. Although the aim of the December 7th surprise attack on Hawaii's Pearl Harbor was to destroy the U.S. Pacific Fleet in its homeport and to discourage U.S. action in Asia, the other strikes served as preludes to full-scale invasions and military occupation.

Only in the Philippines did combined U.S.-Filipino units mount a prolonged resistance to Imperial Japan's invasion. They held out for five months. On April 9, 1942, approximately 10,000 Americans and 70,000 Filipinos became POWs with the surrender of the Bataan Peninsula. April 9th also marked the beginning the 65-mile Bataan Death March. Thousands died and hundreds have never been accounted for from the March and its immediate aftermath.

By June 1942, most of the estimated 27,000 Americans ultimately held as military POWs of Imperial Japan had been surrendered. If Filipino soldiers, who were released before the end of 1942, and American civilians in Japan and throughout the Pacific are also counted, this number is closer to 36,000. By the War's end, 40 percent or over 12,000 Americans had died in squalid POW camps, in the fetid holds of "Hell ships," or as slave laborers for Japanese corporations.

Surviving as a POW of Japan was the beginning of new battles: that of acceptance into society and living with then-nameless mental and physical ailments. In the first six years after the war, deaths of American POWs of Japan were more than twice those of the comparably-aged white male population. These deaths were

*Daughter of PhM2c Robert E. Thompson USN, USS Canopus (AS–9), Bilibid, Fukuoka 3B, & Mukden, POW# 2011 http://dg-adbc.org/

disproportionally due to tuberculosis, suicides, accidents, and cirrhosis. In contrast, 1.5 percent of Americans in Nazi POW camps died (as noted above this number was 40 percent as POWs of Japan) and in the first six years after liberation Nazi POW camp survivors deaths were one-third of those who survived Japanese POW camps.

MEET THE SPECIAL NEEDS OF ALL VETERANS

As the representative of veterans with the highest rate of post-conflict hospitalizations and psychiatric disorders, we encourage Congress to fight for adequate medical care, disability benefits, housing, and job training. We are especially supportive of the DAV's efforts to expand access to the VA's Program of Comprehensive Assistance for Family Caregivers (PCAFC) to severely disabled veterans.

And we applaud the Senate Veterans' Affairs Committee for approving S. 2193, the Caring for Our Veterans Act of 2017 that extends caregiver benefits, which includes provisions to improve and phase in expanded eligibility for the VA's Comprehensive Program for family caregivers. We also recognize Chairman Roe for his leadership in the House to address this inequity and encourage him to introduce companion legislation.

The VA's current rule of granting benefits only to families of veterans injured on or after September 11, 2001 is plainly dismissive of members of our Greatest Generation, those veterans of WWII. Surviving POWs of Japan know well that their caregivers—their families—were instrumental in their reintegration into their communities and their ability to achieve the highest levels of recovery and quality of life. Family caregivers are critical members of every veteran's health care. The American POWs of Japan and their families know intimately the difficulty of re-incorporation into civil society with little support as well as the toll PTSD and war-related illnesses takes on the entire family.

My members would welcome opportunities to discuss with you their caregiving experiences so that Senators and Members of Congress can better understand the importance of expanding caregiver assistance to all generations of veterans.

PROGRESS TOWARD REMEMBRANCE, RECONCILIATION, AND PRESERVATION

An important aspect of showing respect and acceptance to returning servicemen and women is to ensure that they are not forgotten. This is the primary mission of the ADBC-MS. To this end, we have had a number of significant achievements in the last decade.

In 2009, the Government of Japan, through its then-Ambassador to the U.S. Ichiro Fujisaki, and again in 2010, through its then-Foreign Minister Katsuya Okada, issued an official apology to the American POWs of Japan. These Cabinet-approved apologies, first established as a Cabinet Decision on February 6, 2009, were unprecedented. Never before had the Japanese Government apologized for a specific war crime, nor had it done so directly to the victims.

The Japanese Government in 2010 initiated the "Japan/POW Friendship Program" that sponsors trips for American former POWs to visit Japan and return to the places of their imprisonment and slave labor. Thus far, there have been nine trips, one each in the fall of 2010, 2011, 2012, 2013, 2014, and two in 2015, one in 2016 and 2017. In 2016, due to the advanced age of surviving POWs, only widows and children participated in the program. In all, 46 former POWs, all in their late–80s or 90s, as well as nine widows and five children have made the trip to Japan. A number of the caregiver companions to the POWs were wives, children, and grandchildren.

In 2017, one POW was able to participate in the trip: Henry Chamberlain, 95, of Washington state. He was an Army surgical technician in the field hospitals on Bataan. He witnessed many atrocities including the Japanese shelling of the hospitals and the gang rape of an American volunteer nurse by Japanese troops. He served as a medic in POW camps in the Philippines, but was sent to Japan in 1944 to mine lead and zinc. His trip to Japan in 2017 included an emotional visit to the site of the mine in Sendai owned by Mitsubishi Materials Corporation (MMC) where he was their slave laborer. He graciously and tearfully accepted their apology.

The year 2015, the 70th anniversary of the end of World War II, was particularly significant. Our last National Commander, the late Dr. Lester Tenney, was invited to witness Prime Minister Shinzo Abe's address to a joint meeting of Congress and to join at his celebratory gala dinner at the Smithsonian, where the Prime Minister offered his personal apology. Significantly, that day, April 29th, was also the reinstated birthday holiday of the wartime Emperor Hirohito. Later that year, Dr. Tenney was a guest of President Barack Obama at the White House's annual Veterans Day breakfast.

On July 19, 2015, the Mitsubishi Materials Corporation (MMC) became the first, and only, Japanese company to officially apologize to those American POWs who were used as slave laborers to maintain war production. The historic apology was offered to those who were forced to work in four mines operated by Mitsubishi Mining, Inc., the predecessor company of MMC. This apology was followed by a $50,000 one-time donation to the National American Defenders of Bataan & Corregidor (ADBC) Museum, Education & Research Center in Wellsburg, West Virginia.

The leaders of both Japan and the United States acknowledged the American POWs and their contribution to the steady relationship between two countries in their war anniversary speeches. In his September 2nd VJ day statement, President Obama echoed President Harry Truman and remembered "those who endured unimaginable suffering as prisoners of war." Japanese Prime Minister Shinzo Abe in his war anniversary statement on August 14th recognized "the former POWs who experienced unbearable sufferings caused by the Japanese military."

On May 27, 2016, President Barack Obama journeyed to Hiroshima, the site of the first atomic bombing, to become the first American president to mourn the dead and grieve with the living. There, the President was photographed embracing a survivor who had dedicated the greater part of his life to discovering the identities and honoring the memory of twelve American POWs who perished in Hiroshima.

In November 2016, another former POW of Japan, Airman Dan Crowley of Connecticut was a guest at President Obama's Veterans Day breakfast. On December 28th, the ADBC-MS vice president Nancy Kragh and I were guests of the President to witness Prime Minister Abe's condolences at Pearl Harbor.

As you can see, the American POWs of Japan are recognized as integral to the history of America's war in the Pacific.

TO REMEMBER ALL OUR VETERANS

The 115th U.S. Congress and the new Administration, however, appear to have forgotten this legacy. The ADBC-MS was dismayed last year when none of the 75th anniversaries of historic battles at the beginning of World War II was officially recognized by the whole of Congress. Surprisingly, December 7, 1941, "a date that will live in infamy," has not been commemorated with a Congressional resolution for decades. Nor have the April 9, 1942, Fall of Bataan and the start of the infamous Bataan Death March been remembered. This was the largest surrender in U.S. military history.

Our effort last year to have resolutions pass in the House and Senate commemorating April 9th, H. Res. 261 and S. Res 168, which is National Prisoner of War Remembrance Day as well as the 75th anniversary of the start of the Bataan Death March found little support in Congress, and no resolutions were adopted. This was a curious oversight in a year that saw the award of the Congressional Gold Medal to Filipino veterans of World War II for their service and sacrifice. The majority of the 85,000 soldiers on the Death March were Filipino, all under the command of American officers.

Part of this amnesia may be from the loss of the language of the War. My organization has found itself campaigning to protect the words that uniquely describe the POW experience with Imperial Japan. Too often, we find the word "death" removed from the historic designations of the Bataan "Death" March and the Thai-Burma "Death" Railway. There is also no other label for "Hell ships"—unmarked boats that held POWs in lower holds with little food, water, ventilation, or sanitation—other than "Hell ship." The majority of American POWs died on these ships or from their sinking. For Allied POWs the number of deaths on the "Hell ships" was second to those who perished building the Thai-Burma Death Railway. These vessels of inhumanity were far removed from being troop transports and should never be dignified as such.

This battle over language is not a theoretical problem. Over the course of this past year, my organization has had a prolonged and painful dialog regarding a memorial stone we want to install at the National Memorial Cemetery of the Pacific in Hawaii. This tablet is to explain that the 20 graves of 20 unknowns each at the Cemetery are for the 400 POWs killed aboard the Hell ship Enoura Maru that was bombed on January 9, 1945 in Takao Harbor, Formosa by American planes off the USS Hornet. Their remains had been retrieved in 1946 and moved to Hawaii.

Cemetery administrators objected to the use of "Hell ship." They felt it might offend some tourists. We were astonished that a term used since the Revolutionary War to describe vessels that held prisoners of war would be so easily dismissed. Fortunately, Under Secretary for Memorial Affairs of the Department of Veterans Affairs Randy Reeves agreed with us. My Congressman, Mike Bost, who is chair of

the Veterans' Affairs Subcommittee on Disability Assistance and Memorial Affairs, encouraged his decision.

Thus, we thank both Under Secretary Reeves and Congressman Bost for their help. The memorial stone will identify the Enoura Maru as a "Hell ship" and the POWs as "human cargo." We hope that both men will be able to join us in August for the dedication ceremony in Hawaii.

SUCCESS SHOULD ENCOURAGE MORE ACTION

The benefits of Japan's long-awaited acts of contrition have been immeasurable for former POWs and their families. The visitation program is a great success. It has given the participating veterans a peace of mind and their families a connection to their fathers' challenges. For the Japanese people touched by these visits there is a new perspective on the War.

But we are concerned for the future. There is no formal agreement between the U.S. and Japan to continue the visitation program, and Japan's Foreign Ministry must request annually a line-item in the budget for it. We know that despite the tens of millions of dollars being expended by Japan on "Takehashi" exchange programs in the United States, the funds for the POW Friendship exchanges have been slashed.

This is profoundly shortsighted. And it is something that should worry Members of Congress. History does not end when the last witness dies. The proliferation of distorted history in Japan is cause enough to encourage greater work of historical preservation. An active, ongoing program of remembrance and education is what will guarantee that Japan does not fall into moral complacency.

For the POW families, it is clear that a POW's captivity is not merely an individual trauma—the pain has spanned several generations. The wives, children, and siblings of those who died suffered irreparable loss. The families of those who survived suffered from the long-term physical and mental health problems caused by the former POW's years in cruel captivity. New research has found that trauma changes one's DNA, which is then passed on to the victim's progeny.

CONCERNS WITH MOVING BACKWARDS

To our dismay, there appears to be backtracking in Japan regarding the American POWs history. It was not until February 2016 that the 2014 biographical film Unbroken about American Olympian and aviator Louis Zamperini's ordeal as a POW was shown in Japan. It was preceded by a venomous campaign of misinformation and slander denouncing the scenes of abuse and torture as untrue. In contrast, surviving POWs believed the film did not show the full depravity and squalor of their imprisonment.

We are concerned by the 2015 designation of the sites of Japan's "Meiji Industrial Revolution: Iron and Steel, Shipbuilding and Coal Mining" on the UNESCO World Industrial Heritage list. In five of these eight new World Heritage areas there were 26 POW camps that provided slave labor to Japan's industrial giants including, Mitsui, Mitsubishi, Sumitomo, Aso Group, Ube Industries, Tokai Carbon, Nippon Coke & Engineering, Nippon Steel & Sumitomo Metal Corporation, Furukawa Company Group, and Denka. This was not noted in the application nor given mention today.

Japan stated on July 4, 2015, that it "is prepared to take measures that allow an understanding that there were a large number of Koreans and others [emphasis added] who were brought against their will and forced to work under harsh conditions in the 1940s at some of the sites." However, we do not know how the Japanese government interprets "others," and U.S. Government officials have not asked. Frankly, we have not seen any effort toward including the history of the 13,000 Allied and American POWs held at the UNESCO-designated sites.

Many of the 60 companies that requested and acquired POW slave laborers during the War still exist and are members of Japanese consortia—headed by JR East and JR Central—that want to participate in high-speed rail and other infrastructure projects in the United States. Neither has acknowledged or apologized for their use of POW slave labor. By contrast, their French (SNCF) and German (Siemens) competitors have been held accountable for their behavior during WWII.

It is also unsettling that no one has objected to the selection of Osaka as the host city for the G20 leaders' summit in 2019 and of Fukuoka as the venue for the meeting of G20 finance ministers and central bank Governors. The Japanese government is also promoting Osaka to the Bureau of International Expositions to be the site for Expo 2025. These internationally forward-focused events contrast sharply with the parochial, anachronistic views of the city's leaders.

Over the past three years, the mayors of Osaka have distinguished themselves as outspoken deniers of Pacific War history—even threatening to end the sister city relationship with San Francisco over the American city's refusal to accept the Osaka mayors' false and pernicious construction of war history.

The G20 is composed of Argentina, Australia, Brazil, Britain, Canada, China, France, Germany, India, Indonesia, Italy, Japan, Mexico, Russia, Saudi Arabia, South Africa, South Korea, Turkey, the United States and the European Union. Over half of the member states had nationals who were forced into becoming sex slaves to Imperial Japan's Armed Forces. Nearly every G20 country had nationals who were held, abused, and died as POWs of Japan having fought as Allies against Japan.

Osaka and Fukuoka were areas of the greatest number of slave labor camps using American and Allied POWs in mines, factories, mills, and on docks, many of which have become UNESCO World Industrial Heritage sites. It was at Fukuoka prefecture's Port of Moji where most of the POWs arrived in Japan. Fukuoka's international airport was originally an Imperial Army airfield (Mushiroda Airfield) built by British, Dutch, and American POWs. In Fukuoka, eight American aviators were vivisected at the local university. Hours after the Emperor declared the war over, seventeen Americans were beheaded on the slopes of the city's Mt. Abura.

Today, no G20 country would plan an international conference in Warsaw or Gdansk given Poland's new revisionist Holocaust law. The same should be true for Osaka. We object to American participation in any conference or Expo held by a city that publicly and willfully embraces a discredited and dishonest historical narrative. That the Japanese government, in the midst of Osaka's controversy with San Francisco, would select such a city is both arrogant and indecent.

WHAT WE ASK CONGRESS

We ask Congress to encourage the Government of Japan to hold to its promises and responsibilities by preserving, expanding, and enhancing its reconciliation program toward its former American prisoners. We want to see the trips to Japan continued. We want Japan's Ministry of Foreign Affairs to publicize the program, its participants, and its achievements. We want to see a commitment to remembrance. We believe that both countries will be stronger the more we examine our shared history.

We ask Congress to encourage Japan to turn its POW visitation program into a permanent Fund supported by Japanese government and industry. This "Future Fund," not subject to Ministry of Finance yearly review, would support research, documentation, reconciliation programs, and people-to-people exchanges regarding Japan's history of forced and slave labor during WWII. Part of Fund's educational programming would be the creation of visual remembrances of this history through museums, memorials, exhibitions, film, and installations. Most important, the Fund would support project among all the arts from poetry, literature, music, dance, and drama to painting, drawing, film, and sculpture to tell the story to the next generation.

We ask Congress to ask and to legislate that the U.S. State Department represents the interests of American veterans with Japan. It is only the U.S. Government that can persuade Japan to continue the visitation program, to create a Future Fund, and to ensure that the Sites of Japan's Meiji Industrial Revolution include the dark history of POW slave labor.

We ask Congress to press the Japanese government to create a memorial at the Port of Moji, where most of the "Hell ships" docked and unloaded their sick and dying human cargo. The dock already features a monument to the Japanese soldiers who departed for war from this port. Nowhere in Moji's historic district is there mention of the captive men and looted riches off-loaded onto its docks. This must change.

CONGRESSIONAL GOLD MEDAL

Most important, we ask Congress to approve an accurate and inclusive Congressional gold medal for the American POWs of Japan. It is long overdue. Over the past few years, there have been Congressional gold medals given to groups that included American POWs of Japan. Eight members of the Doolittle Raiders were POWs, at least one Nisei member of the Military Intelligence Service was a POW, and nearly all the officers of the Filipino troops who were awarded Congressional Gold Medals were American. Seventy-seven years after the start of the War in the Pacific, it is time to recognize all those who the fought the impossible and endured the unimaginable in the war against tyranny in the Pacific. Moreover, as I have de-

scribed above, the Gold Medal would also recognize that we are the only American wartime group to have negotiated our own reconciliation with the enemy.

HIGH PRICE OF FREEDOM

The American POWs of Japan and their families paid a high price for the freedoms we cherish. In return for their sacrifices and service, they ask that their government keep its moral obligation to them. They do not want their history ignored or exploited. What they want most is to have their government stand by them to ensure they will be remembered, that our allies respect them, and that their American history be preserved accurately for future generations.

The torment of the American POWs of Japan is not just another facet of war history. Nor is it simply another saga of WWII suffering. It is a history of resilience, survival, and the human spirit, good and bad. And it has become an example of a path toward reconciliation and justice between Japan and its former victims.

We ask Congress for support and to help our veterans in their unique quest for justice and remembrance. It should not be forgotten that our robust and successful alliance is as much a product of mutual interests as of blood, steel and, as Japanese Prime Minister Shinzo Abe said in his 2015 address to Congress, of tolerance. Today's alliance between Japan and the United States rests on how well we honor the memory of those who liberated Japan and its occupied territories.

In the United States this history is being forgotten, and in Japan it is being revised. We cannot let this happen, on either side of the Pacific.

It is a sacred trust of both Congress and Department of Veterans Affairs to continue to fight for its WWII veterans and to defend their history.

Thank you for this opportunity to address your committee.