

MILITARY CONSTRUCTION, VETERANS AFFAIRS, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 2018

WEDNESDAY, JUNE 21, 2017

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

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

Present: Senators Moran, Murkowski, Hoeven, Collins, Boozman, Capito, Rubio, Schatz, Tester, Murray, Udall, Baldwin, and Murphy.

DEPARTMENT OF VETERANS AFFAIRS

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

ACCOMPANIED BY:

**POONAM L. ALAIGH, M.D., ACTING UNDER SECRETARY FOR
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OPENING STATEMENT OF SENATOR JERRY MORAN

Senator MORAN. Good afternoon. The subcommittee will come to order.

Mr. Secretary, welcome.

This is our seventh subcommittee hearing of 2017. Thank you all for being here today, and we are going to discuss the fiscal year 2018 and 2019 budget requests for the Department of Veterans Affairs.

As far as Federal domestic spending goes, in this year's budget cycle, the Department of Veterans Affairs is in a more comfortable place. With a \$4.4 billion or 6 percent funding increase for the Department, the budget request before us today, in light of the circumstances of everyone else, could be considered generous.

I have always believed, however, that the Department's stewardship of those funds is the real issue at hand, not just the dollar amount. And I want to hear today from the VA how it plans to improve cost estimating, manage spending more prudently and to be more transparent with Congress.

Most of us are aware there is a question before this subcommittee and the Oversight Committee, of which I am also a member, the Senate Veterans Affairs Committee, about additional needs for this year, fiscal year 2017; and next year, fiscal year 2018, in Community Care discretionary spending and the Veterans Choice Program, which is mandatory spending.

I hope progress is being made on the authorizing side on this problem as we speak. Efforts are underway, but I want to hear from you today, Mr. Secretary, how we can help avoid situations where you do not have the funds needed to provide the care that veterans expect.

I hope today's hearing will cover all aspects of the VA and urge my colleagues to leave no stone unturned. We will look forward to hearing about the very recent decision on the electronic health record system, a decision, Mr. Secretary, that I commend you for making, your plans to decrease veteran suicide and protect veterans from over-prescription of opioids; how we can be of help in increasing access to care through increasing internal VA care and improving care in the community, especially in my world for rural veterans. And we are also interested in hearing about your increased efforts in regard to telemedicine. In your efforts also, Mr. Secretary, it will be good to hear about the appeals backlog and modernizing the disability claim appeals process.

As I have mentioned to you before, at our last hearing, Mr. Secretary, and in all of our personal conversations, I hope you take the opportunity today to talk about the needs and constraints you have financially, as well as all the needs and constraints you have statutorily. And your openness today will help us best help you and the veterans that we all desire to serve.

Let me introduce the panel. The panel is the Honorable David J. Shulkin, M.D., the Secretary of the Department of Veterans Affairs. He is accompanied today by Poonam Alaigh, M.D., the Acting Under Secretary for Health at the Veterans Health Administration; Mr. Thomas J. Murphy, the Acting Under Secretary for Benefits at the Veterans Benefits Administration; and Ronald E. Walters, the Interim Under Secretary for Memorial Affairs at the National Cemetery Administration.

Welcome to all of you.

There are a number of other VA experts in the room as well, and we are delighted to have them and we look forward to whatever expertise they can provide you, Mr. Secretary, and us as we discuss these issues.

[The statement follows:]

PREPARED STATEMENT OF SENATOR JERRY MORAN

Welcome to our seventh subcommittee hearing of 2017. The subcommittee will come to order. Good afternoon. Thank you all for being here today to discuss the fiscal year 2018 and the fiscal year 2019 budget request for the Department of Veterans Affairs.

As far as Federal domestic spending goes, in this year's budget cycle, the Department of Veterans Affairs is in a comfortable place. With a \$4.4 billion or 6 percent funding increase for the department, the budget request before us today is generous. I have always believed, however, that the department's stewardship of those funds, rather than the dollar amount, is the real issue at hand.

I want to hear from you today about how the VA plans to improve cost estimating, manage spending more prudently and be more transparent with Congress. Most of

us are aware there is a question before this subcommittee and the Senate Veterans Affairs Committee—also responsible for oversight of the department—about additional needs this year and next year in community care discretionary spending and the Veterans Choice Program mandatory spending.

I know progress is being made over on the authorizing side on this problem as we speak. I support these efforts, but I want to hear from you today how we can help you avoid situations where you don't have the funds needed to provide the care veterans expect.

I hope today's hearing will cover all aspects of VA, and I urge my colleagues to leave no stone unturned. We look forward to hearing about the very recent decision on the electronic health record system—a decision, Mr. Secretary, I commend you for making—your plans to decrease veterans suicide and protect veterans from the over prescription of opioids; how we can help you increase access to care—through increasing internal VA care and improving care in the community—especially for our rural veterans coupled with your efforts to increase telemedicine—issues this subcommittee cares very deeply about; and your efforts to address the appeals backlog by modernizing the disability claims appeals process.

As you I've mentioned to you before, at our last hearing with you, Mr. Secretary, and in our personal conversations, I hope you take the opportunity today to talk about the needs and constraints you have financially as well as the needs and constraints you have statutorily. Your openness today will help us know how to best help you.

I'd like to introduce our panel:

- A welcome back to the Secretary—the Honorable David J. Shulkin, MD, is the Secretary of the Department of Veterans Affairs. He is accompanied by:
- Poonam L. Alaigh, M.D., the Acting Under Secretary for Health at the Veterans Health Administration;
- Mr. Thomas J. Murphy, the Acting Under Secretary for Benefits at the Veterans Benefits Administration; and
- Mr. Ronald E. Walters, the Interim Under Secretary for Memorial Affairs at the National Cemetery Administration. Welcome to all of you.

I note there are quite a few other VA experts seated behind the panel who are present today to support this hearing, and I thank you for being here.

Senator MORAN. I now recognize my colleague and friend, the Senator from Hawaii, for his opening remarks.

OPENING STATEMENT OF SENATOR BRIAN SCHATZ

Senator SCHATZ. Thank you, Mr. Chairman. Thank you for holding this hearing to review the VA's fiscal year 2018 budget request and the 2019 advanced appropriation request. We have had a number of important hearings over the last few months to shape our appropriations bill, and I want to thank you for your leadership and our great partnership.

This process, our process, stands in contrast to the way our Republican colleagues plan to bring a healthcare bill to the Floor next week. There have been no hearings or public discussion. Americans are still left in the dark. Members of the Senate are still left in the dark. This is not the way to make a law impacting one-sixth of the economy.

We know that the House bill would be a disaster, and we also know that the VA will not be spared from this bill, including any proposed cuts to Medicaid that will likely affect veterans' health care and possibly shift costs to VA. I am hoping we can find a few Republican Senators who simply refuse to vote for a bill for which there was no hearing. I hope they will.

Secretary Shulkin, thank you for being here to discuss the VA's budget request. I am glad to see VA's discretionary funding is up \$4.3 billion from last year. The administration's increased request is driven almost solely by the demand for more funding to cover the

medical care accounts and a recognition of the responsibility to pay for the growing healthcare demands of veterans, even while it has proposed cuts to almost all other domestic agencies.

I am worried, however, that the proposed increase may not be enough but that it is paid for with cuts to other important veteran programs, as well as other domestic accounts. Much of the fault lies with Congress, which has refused to lift the ridiculous BCA (Budget Control Act) caps. We need to lift them so that we can pass an entire 2018 budget.

But the VA is also responsible for the situation that we find ourselves in today, and I have some concerns about whether this budget is enough. The VA has encountered significant unplanned costs since it submitted its budget, including an unexpected surge in the use of Choice, which is now forecasted to run out of money by the end of the fiscal year, resulting in the need for an infusion of hopefully mandatory funding relief.

The VA has also decided not to appeal the judicial ruling that holds VA responsible for the payment of veterans' emergency care at non-VA facilities. I think that is the right decision. And the VA has decided to pursue an electronic health record contract that was not budgeted for in the request. And I do not disagree with these decisions, but they are not inexpensive.

I have concerns with the proposed funding distribution in the budget request. For example, the request proposes an increase in funding for about a half-a-billion for Medical Services, which, as far as I can tell, does not account for annualizing the cost of the medical care providers hired under Choice or any other increase in utilization in in-house VA services.

I also have concerns that hit closer to home. Dr. Shulkin, top of the list for me is the status of a proposed one-stop-shop community-based outpatient clinic in Hilo. I will submit a question for the record that I would like to pursue with you, but the bottom line is I want to know where VA is on getting a new CBOC for Hilo because this is the highest priority for Big Island veterans. This project has been in the VA's SCIP pipeline for years.

I know there are very many worthy competing projects, but you should know that our veterans in Hilo are currently visiting a CBOC that has to move because it is in a tsunami flood zone. We have unique circumstances. The VA leased a temporary space in an industrial part of Hilo that it plans to move into next year, but our veterans tell me—and I know—it is hard to get to and, quite simply, too many of them will not want to use it once the VA moves. This situation is not acceptable and we need to fix it. If developing a one-stop-shop CBOC in Hilo means that more veterans will feel encouraged to utilize care that is the kind of access to care that the SCIP process should take into consideration.

The VA also needs to invest even more in telehealth and remote patient monitoring. You have done great work, but let us try to find opportunities to do more. And I did appreciate hearing from you about how VA is leading on telehealth.

Thank you, Secretary Shulkin. Thank you, Mr. Chairman. I look forward to your testimony.

Senator MORAN. Thank you, Senator Schatz.

Mr. Secretary, welcome, and I recognize you now for your opening statement.

SUMMARY STATEMENT HON. DR. DAVID J. SHULKIN

Secretary SHULKIN. Thank you. Mr. Chairman, Ranking Member Schatz, thank you both for your opening statements. I think you raised really important issues, and I think you are encouraging us to have a candid conversation today, which I know we can do and it will be productive.

And, Ranking Member Schatz, we will certainly get back to you about Hilo. I understand the concern that you have over making the right decision there, and I would be glad to talk more about the SCIP process and telehealth and any of the other issues that you have. If it is just the two of you, you will have lots of time for questions and we can have a good conversation.

I think you know my intent as the Secretary is really to build an integrated healthcare system that provides veterans with high-quality care when they need it and where they need it, whether it is at the VA or in the high-performing Community Care network. And I think that is what this budget that the President has submitted is designed to do. It is not designed to privatize VA. It is designed to provide veterans the best care available in the most timely fashion.

The challenge is to balance those resources year to year to meet the changing demands of care. More veterans are now coming to VA for more of their care and more are also opting for Choice. Since January 1, we have authorized over 8.2 million Community Care appointments. That is 2.6 million more than last year or a 46 percent increase. This past March, April, May were the highest months ever for Choice usage. And that is why we are asking for more Community Care funding for fiscal year 2018.

But, as I said before, that does not mean that we are privatizing VA. So, let me be clear on what this budget says.

Perfect timing, Senator Tester, so we can go over these numbers. For fiscal year 2018, we expect to spend over \$50 billion on VA Medical Services and just \$12.6 billion on Community Care. So, when you count all the sources of funding, that is our direct appropriations, carryover, transfers in and out, or medical care collections and reimbursements, when you count all of those, we are talking about an 8.3 percent increase for Community Care versus a 5.7 percent increase in VA Medical Services.

And I think, Senator Tester, one of the reasons why we sometimes have different numbers, we are putting in not just the appropriations but we are putting in our full budget amount, which includes the carryovers and the collections and other dollars.

So, let me just go over that again. The 8.3 percent increase in Community Care is \$965 million more in this year's proposed budget. The 5.7 percent increase in Medical Services, what the VA is getting, is \$2.7 billion, so that is \$965 million versus \$2.7 billion, so in total dollars the Medical Services is increasing three times the amount that is going to Community Care.

Let me talk about another issue. Again, we are having to shift funds among our many separate Community Care accounts to cover our obligations. Two years ago, which I am sure you remember

well, we had to shift funds from the Choice account to cover obligations in the Community Care accounts. Now, we are doing this in reverse to cover our increased use of Choice.

The necessity of those shifts is a product of the unpredictability of Community Care charges, charges that fluctuate month to month. A single authorization for Community Care can cover one, two, three or more appointments. The authorization might never be used or the authorization might be used 3 months after it was issued. VA might not get the bill for many months after that.

The even bigger part of the problem is the fact that we have so many accounts and so little flexibility in how we manage them, our proposed veterans CARE program—remember, that stands for Coordinated Access Rewarding Experience, the CARE program—would solve this recurring problem permanently by modernizing and consolidating all of our Community Care accounts, Choice included.

The President's budget would address this problem in 2018 and 2019 by providing additional funds for Choice and the necessary resources for continuing our ongoing modernization of VA. The budget reflects the President's strong personal commitment to the Nation's veterans. It requests \$186.5 billion for VA, \$104.3 billion in mandatory funding, \$82.1 billion in discretionary funding for a total increase of \$6.4 billion, or 3.6 percent over 2017. It provides \$2.9 billion in mandatory funding to continue the Choice program in 2018, plus a 7.1 percent increase in discretionary funding for VHA to improve patient access and timeliness of care.

It supports the strengthening of our foundational services, as well as the modernization and consolidation of VA Community Care through the veterans' CARE program announced two weeks ago, so veterans can make the right decisions about their care, together with their provider, giving them yet another reason to choose VA.

We are already taking many steps to move VA modernization forward in accountability, transparency, same-day services, online access, suicide prevention, and other areas. And I detailed several of these in the State of the VA talk that I gave at the White House last month.

But to keep up our modernization momentum, we need your help. We have identified over 1,000 facilities that are vacant or underutilized. We are working now to dispose of 142 facilities, and with your help, we could do many more.

We need Congress to fund our IT modernization to keep our legacy systems from failing and to replace our Vista system with the system in use by DOD called MHS GENESIS. This will ultimately put all patient data in one shared system, enabling seamless care between VA and DOD without the manual and electronic exchange and reconciliation of data that we currently do in our separate systems.

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

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

I would like to close on this note: VA's mission is to care for veterans and their families. To me, that is what the VA budget process is, a discussion that we make sure that we have the right things for veterans, their families, and taxpayers. I do not support any policy that will hurt veterans or their families, so when it comes to discussions about offsets like individual unemployability, we have heard from veterans and we will work with Congress to find other solutions.

Thank you, and we look forward to your questions.
[The statement follows:]

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

Good morning, Chairman Moran, Ranking Member Schatz, and Distinguished Members of the Subcommittee. Thank you for the opportunity to testify today in support of the President's 2018 Budget and 2019 Advance Appropriation (AA) Request and to define my priorities to continue the dynamic transformation within the Department of Veterans Affairs (VA). I am accompanied today by Dr. Poonam L. Alaigh, Acting Under Secretary for Health; Thomas Murphy, Acting Under Secretary for Benefits; and Ron Walters, Interim Under Secretary for Memorial Affairs. I also want to thank Congress for providing the Department its full 2017 budget prior to the start of the fiscal year—this is significant and has been extremely beneficial to our ability to provide services and care to Veterans. The 2018 budget request fulfills the President's strong commitment to all of our Nation's Veterans by providing the resources necessary for improving the care and support our Veterans have earned through sacrifice and service to our country.

FISCAL YEAR 2018 BUDGET REQUEST

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

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

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

MODERNIZING VA

As you all know, I was part of the VA team for the last year and a half prior to being confirmed as the Secretary of Veterans Affairs. I came to VA during a time of crisis, when it was clear Veterans were not getting the timely access to high-quality

ity healthcare they deserved. I soon discovered that years of ineffective systems and deficiencies in workplace culture led to these problems. I know that the organization has made significant progress in improving care and services to Veterans. But I also know that VA needs more changes to the way we do business for Veterans and the country as a whole, in order for all to say, “That is a different organization now.” VA needs to continue to fix numerous areas of the business, including access, claims and appeals processing, and many of our core functions, to ensure that the basics are done correctly. Beyond that, VA has to deliver to Veterans revolutionary leaps in care, benefits, and services. Congress, along with our VA employees, Veterans Service Organizations (VSO), and private industry, will play a critical role in making those revolutionary leaps a reality.

Focus on Execution

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

Make Bold Change

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

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

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

FIVE PRIORITIES

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

GREATER CHOICE FOR VETERANS

The Choice Program is a critical program that has increased access to care for millions of Veterans. Coming into this new administration, extending the Choice Program was one of my top priorities for quick action, as VA anticipated that based on Veteran program participation, there would be an estimated \$1.1 billion in unobligated funds left on the original expiration date of August 7, 2017. On April 19, 2017, the President signed into law the Veterans Choice Program Improvement Act (Public Law 115–26), allowing the Choice Program to continue until the Veterans

Choice Fund is exhausted. Without this legislation, VA would have been unable to use funding specifically appropriated for the Choice Program by Congress, so we commend Congress for passing this legislation swiftly and in a bipartisan manner. This legislation also provides VA and Congress more time to develop a long-term solution for community care.

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

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

As these numbers demonstrate, demand for community care is high. In 2018, VA plans to spend a total of \$13.2 billion to support community care for Veterans. Community care will be funded by a discretionary appropriation of \$9.4 billion for the Medical Community Care account (\$254 million above the enacted advance appropriation), plus \$2.9 billion in new mandatory budget authority for the Choice Program. As stated in the budget request, this, combined with an estimated \$626 million in carryover balances in the Veterans Choice Fund, would have provided a total of \$13.2 billion in 2018 for community care. However, as of June 9, 2017, \$9.2 billion of the Choice Fund has been obligated and \$7.1 billion has been expended. These levels represent a significant acceleration of funds being expended from the Veterans Choice Fund, and consequently, I have updated the estimates VA previously put forth regarding when Choice Program funds would be fully obligated.

In March 2017, VA issued the highest number of authorizations in a month since the start of the program, followed closely by April and May. Over the 3 month period between March and May 2017, VA issued nearly 800,000 authorizations for Choice Program care, a 32-percent increase over the same time period in 2016. As a result, VA anticipates that Choice Program funds will be fully obligated sooner than previously expected. Based on VA's latest risk-adjusted cost estimates and volume projections, the program will be unable to carry over the previously estimated \$626 million, resulting in a need for the total \$3.5 billion in new mandatory budget authority to continue the Choice Program in fiscal year 2018.

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

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

Empower Veterans through Transparency of Information

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

MODERNIZING OUR SYSTEM

Infrastructure Improvements and Streamlining

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

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

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

Electronic Health Record Interoperability and IT Modernization

The 2018 Budget continues VA's investment in technology to improve the lives of Veterans. The planned IT investments prioritize the development of replacements for specific mission critical legacy systems, as well as operations and maintenance of all VA IT infrastructures essential to deliver medical care and benefits to Veterans. The request includes \$358.5 million for new development to replace four specific mission critical legacy systems, including the Financial Management System, and establish an Integrated Project Team to develop the requirements and acquisition strategy for a new enterprise health information platform. It also invests \$340 million for information security to protect Veterans' information and improve VA's information networks' resilience.

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

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

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

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

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

FOCUS RESOURCES MORE EFFICIENTLY

Strengthening of Foundational Services in VA

VA is committed to providing the best access to care for Veterans. To deliver the full care spectrum as defined in VA's medical benefits package, VA will focus on its foundational services—those areas in which it can excel—and build community partnerships for complementary services. VA developed the following guiding principles, centered on improving the health, well-being, and experience of Veterans receiving care from VA and in the community. These principles include:

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

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

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

When all new cemeteries are opened, nearly 95 percent of the total Veteran population—about 20 million Veterans—will have access to a burial option in a Veterans' cemetery within 75 miles of their home.

VA/DoD/Federal Coordination

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

Deliver on Accountability and Effective Management Practices

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

- Increase flexibility to remove, demote, or suspend VA employees for poor performance or misconduct;
- Provide authority to recoup bonuses of employees for poor performance or misconduct;
- Enable recovery of relocation expenses that occur through fraud or malfeasance; and
- Ensure that VA has the ability to retain high performers by paying them a salary that is competitive with the private sector and performance awards that are commensurate with other Federal agencies.

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

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

- forming a fraud, waste, and abuse advisory committee comprised of experts from the private sector and other government organizations;
- identifying cutting edge tools and technologies available in the private sector; and
- coordinating all fraud, waste, and abuse detection and reporting activities through a single office.

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

IMPROVE TIMELINESS OF SERVICES

Access to Care and Wait Times

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

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

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

- \$69.0 billion in discretionary budget authority (\$2.65 billion above the 2018 AA enacted level of \$66.4 billion and a \$4.6 billion (7.1 percent) increase over the 2017 enacted level);
- \$2.9 billion in mandatory budget authority to continue the Veterans Choice Program; and
- \$3.3 billion in medical care collections.

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

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

Accelerating Performance on Disability Claims

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

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

tion to accelerate claims decisions. Submission of claims submitted through the DRC process will result in claim decisions within 30 days of submission to VA.

Decisions on Appeals

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

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

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

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

The new process, described in the legislation currently pending, will provide a modernized process going forward. However, VA is also committed to concurrently reducing the pending inventory of legacy appeals. VA has worked collaboratively with stakeholders to identify opt-ins that would make the new process available to Veterans who would otherwise have an appeal in the legacy process. After assessing these various options, and collaborating with our partners, we have identified two opt-ins that we intend to implement to address the issue of the legacy appeals inventory.

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

SUICIDE PREVENTION—ELIMINATING VETERAN SUICIDE

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

healthcare) services supplemented by programs designed to help individuals and families engage in care and to address suicide prevention in high-risk patients.

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

Other than Honorable Expansion

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

CLOSING

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

Senator MORAN. Secretary, thank you very much. It seems like we have had these conversations in a couple of settings numerous times over the last several weeks, and I appreciate your testimony today. I appreciate it in the VA Committee, and I appreciate the conversations that we have had.

But the topic I want to initially deal with, as you might expect, is the funding shortfall. The shortfall that you indicated when we were together last week, you said, "If there is no action by Congress to fund the Choice program, it will dry up by mid-August." That would be mandatory spending, which generally would involve the Authorizing Committee. And we had this conversation there. I wanted to make sure that Senator Tester was here while you and I had this conversation because during our Authorizing Committee hearing, I indicated that Senator Tester was wrong, and I enjoyed saying it, and it hurts me to say that I now understand that Senator Tester is right.

Senator TESTER. Could you repeat that? I did not hear that.

[Laughter.]

Senator MORAN. The conversation you and I had, Mr. Secretary—

Secretary SHULKIN. Yes.

Senator MORAN [continuing]. Involved a memo that was sent out by the Department of Veterans Affairs on June 7 in which the crux of what quit referring veterans to Choice because of the lack of money available to pay for those Choice visits. You then, or the Department rescinded that June 7 directive and apparently replaced it by a June 12 memorandum.

And Senator Tester indicated in our Authorizing Committee hearing that those two memos were the same. Where I disagreed with Senator Tester was I thought they accomplished something different because the second memo says, "Continue to send veterans with eligibility for the Veterans Choice program, as identified in Veterans Access Choice and Accountability Act, those eligible based on residence, 40 miles from their residence to the closes VA facility, wait times of 30 days from the clinically indicated date, or other criteria such as special criteria for residents of Alaska, Hawaii, and New Hampshire."

That to me was different. I think you and I agreed that is the crux of the difference between the June 7 and the June 12 memo.

Secretary SHULKIN. Yes.

Senator MORAN. In other words, Choice was reinstated.

Secretary SHULKIN. Yes.

Senator MORAN. My understanding of why it was—in part at least why it was reinstated, I assume it is because it is good for veterans for Choice to continue.

Secretary SHULKIN. Yes.

Senator MORAN. And you indicated to me and to others that you would work with Congress to find a funding solution for Choice and that, therefore, let us keep the program going while we find that resolution of how to pay. Is that?

Secretary SHULKIN. That is correct.

Senator MORAN. A fair summary of where—

Secretary SHULKIN. That is a good summary.

Senator MORAN. Good. I was fearful that you would disagree with me about Senator Tester and I would have to repeat that he is correct. The reason I think he is correct is because the evidence that I get from the field in the VA is veterans are not now being referred to Choice. And so I am worried that, while the memo says one thing, the actual practice at the VA is another.

Secretary SHULKIN. Yes. Right.

Senator MORAN. And so my impression, based upon conversations across the field from veterans and employees within the VA is we are not referring individuals to Choice.

Secretary SHULKIN. Yes.

Senator MORAN. So, the reason I am fearful that Senator Tester is right, while the words say one thing, the practice is something different.

Secretary SHULKIN. Right.

Senator MORAN. You and I agreed in our conversation at the Veterans Committee hearing that the outcome of not continuing Choice, taking a hiatus from referring veterans to Choice would very likely mean that the entities Health Net and TriWest, which the VA has hired to manage Choice, our conversation was that that network is important. And you agreed with me that if we stopped

providing patients for Choice, the networks will go away and they will not be in a position to be helpful, their networks will disappear, and when, if we are successful in finding the money to fund Choice, then we have no network to associate the program with. Is that a fair assessment of?

Secretary SHULKIN. It is.

Senator MORAN. Our conversation?

Secretary SHULKIN. It is.

Senator MORAN. So, Mr. Secretary, my question is what is the status of this? Are veterans being referred to Choice? Is this a matter of the VA memo saying one thing to placate me and others and the practice to be something different? I do not know that I want to go back there——

Secretary SHULKIN. Yes.

Senator MORAN [continuing]. But your predecessor indicated that there were people within the VA he should not have relied upon, and I do not know whether you are relying upon people who are telling you one thing but the outcome is something different. So, I take this development very seriously because I think the VA is headed on a different path than what you assured me they were on.

Secretary SHULKIN. Yes. Okay. So, you wanted this to be a candid discussion, and I see you started it out that way, which is good. Everything that you have said is absolutely accurate. And our intent is exactly the same, which is to keep the Choice program going. We think it is very important for veterans, and we want to see it fully funded.

I have described why we are in the situation that we are today because more veterans than ever are accessing Choice. And let me explain why that is. Our fiscal year 2017 budget was \$2 billion less for Community Care than our 2016 budget. So, from 2016 to 2017, our budget was reduced in Community Care by \$2 billion. That means that what we did was we created a program called Choice First, which encouraged our medical centers, instead of using Community Care, to go to the Choice program. And that is why you have seen a large increase in the use of Choice.

When the money started to run out quicker than we expected, instead of it lasting til the end of the fiscal year—we project that it will last to August 7. We wanted to clarify to the field two things: Continue to use Choice, keep that network alive, continue to use Choice because we believe in it for the statutory reasons, the reasons why Choice was established, 40 miles, 30 days; but now, no longer use Choice first when you have Community Care funds. So, the message was to try to balance this out while we could work out the types of solutions that you and I have talked about, to be able to fund Choice in the level that we think that we need it.

So, our field, this is very confusing because we are constantly having to readjust the way that we use these two separate accounts, Community Care and Choice. It is not the right way to manage. We are seeking to manage this under a singular fund. We are trying to balance the need to keep the Choice network and the Choice program active but also make sure we do not interrupt veterans from getting the care that they need.

I met yesterday with all of our network directors personally to make sure that they understood what we were trying to accomplish so that there would not be confusion in the field, and certainly, we will continue to clarify this policy. Our intent is to find a solution working with you so we do not have to constantly be balancing these two accounts in different ways.

Senator MORAN. Are you agreeing with my assessment based upon my conversations with people within the VA and veterans across the country that Choice is not being utilized to the degree that your memo says it should be?

Secretary SHULKIN. No. We hope that the field is taking our guidance on the memo, to continue to use Choice and to continue to use Choice appropriately, certainly, as you have written the law, the statutory requirements for Choice. What we are saying is instead of using Choice for everything.

Senator MORAN. Right.

Secretary SHULKIN. Use Community Care.

Senator MORAN. You know that those referrals are continuing or are you just that is occurring?

Secretary SHULKIN. Yes.

Senator MORAN. Yes. Okay.

Secretary SHULKIN. Yes. We see the activity every day.

Senator MORAN. My time is well expired, but let me ask this follow-up question. So where are you in the more—Senator Schatz indicated that money available the end of the fiscal year, we think it is actually mid-August when we extended the Choice Act. We thought it was January. Those dates have altered over a period of time. But where are you—what does OMB or the administration tell you that they would support an increased mandatory spending to fill the problem for fiscal year 2017 and 2018?

Secretary SHULKIN. Well, 2017 and 2018, we have several—

Senator MORAN. Yes, 2017 and 2018.

Secretary SHULKIN [continuing]. Yes, 2017 and 2018. We have several options on the table that you and I have discussed. One is for us to just fix this problem administratively, stop using Choice and use Community Care. We think that is the worst option, and you and I agree; that would not be healthy for lots of reasons.

The second option would be to transfer money from our Medical Services account over to the Choice program. There are concerns, legitimate concerns that Senator Tester, Senator Murray and others have expressed about that, but that would be an option for us to fill up the coffers in the Choice program.

And the third option would be for the appropriators, who we are talking to right now, to look at an early appropriation for 2017 and 2018 and do that sooner. I think we should be discussing all of those options.

Senator MORAN. What I am being reminded—

Secretary SHULKIN. Yes.

Senator MORAN. And what I think is true, the appropriators are responsible for discretionary spending, but you need mandatory money

Secretary SHULKIN. Yes.

Senator MORAN. If you are going to keep the Choice program alive.

Secretary SHULKIN. I am sorry. In the mandatory fund, a reauthorization of the Choice program, 2017, 2018. Thank you for that correction. And all of those are options. I think they all have advantages and disadvantages. We would like to work with Congress to make sure that we are picking the right choice between those options.

Senator MORAN. In your conversations with the third-party administrators, do they agree that the volume of Choice referrals today is sufficient to keep them in business, sufficient that they are breaking even?

Secretary SHULKIN. No. No, I think that the Choice contractors right now, since we have released that memo, are experiencing significantly decreased volume than before. Clearly, March, April, May were very good months for them, and now, they have experienced decreased volume. And according to some of my recent interactions with them, they are running at a loss. And that is not our intent. We want to be good partners with them. We value what they do. We would like to get this situation corrected and fixed. We would like to be able to have additional funds in the Choice program to be to continue using it.

Senator MORAN. The Right Honorable Senator Tester.

Senator TESTER. Gosh, Mr. Chairman, I thank you very much. And no offense taken in any of that stuff, and you know that. And I very much appreciate your comments, and I want to thank the ranking member for allowing me to go. I appreciate that, too.

But one thing before I go, you know, if you keep treating me this nice, I might end up supporting that bioresearch facility in the middle of Tornado Alley, which happens to be in Kansas.

But that aside, good to have you here, Secretary.

Secretary SHULKIN. Thank you.

Senator TESTER. Good to have your team here.

Secretary SHULKIN. Thank you.

Senator TESTER. I think it needs to be duly noted that Jake is not here and make sure you point that out to him because, you know, we will hold him accountable on that, okay?

Secretary SHULKIN. Okay.

Senator TESTER. Okay. So, I want to approach this budget from a little different perspective today than I have in the past, and I appreciate——

Secretary SHULKIN. Yes.

Senator TESTER [continuing]. Your opening statement and I appreciate you talking about the direct care versus the Community Care. But let us talk about some other issues——

Secretary SHULKIN. Sure.

Senator TESTER [continuing]. That are impacting the budget that may not have been there when this budget was drafted, okay?

Decision not to appeal the Staub decision, which I believe was the right decision on your part, could cost the VA up to \$2 billion. The decision to purchase electronic health record system could run as high as \$16 billion; addressing the holes in Choice and Community Care, \$4 billion; responding to the influx of veterans after the repeal of the Affordable Care Act could impact up to 700,000 veterans—I believe those are your numbers—which would be extremely costly to the VA, but, quite frankly, the cost of war and one

that we need to pay for; non-reoccurring maintenance for VA facilities to address \$10 million in backlog code deficiencies; current inventory of pending appeals, getting those down, \$800 million.

All these items are compounded by the reality we have more and more medical appointments projected each year, and we do not have the doctors, nor the facilities or the professionals on the ground to really get this done. And you are also seeing aging veterans with more complex needs. We are seeing folks that are surviving war that would never have survived before that have some real issues that we have to deal with both physically and mentally.

So, you are kind of boxed in. Your request needs to be signed off by folks above you. But I do think you need to be absolutely straightforward with us, and I think that if you are, you know us well enough that if you tell us what the VA needs now and into the future and you can justify that, I think you are going to have receptive ears around this dais.

So, I think that if we continue talking about and throwing budgets up that do not fully address the problems of our veterans in this country—and we have been at war now for 15 years—and we have got Vietnam vets that are getting older and you know the story; we have been through it before—I think we just run a cycle of never getting to a point where we can honestly sit down and say we are giving to veterans what they have earned. Would you want to respond to that?

And by the way, you are not the only one. Ag, Interior, we have to go to Energy in a minute, it is going to be the same conversation where everything is cut, cut, cut with the expectation that we are going to bring all this up. I do not think we can bring it all up. And so would you want to respond to that?

Secretary SHULKIN. Sure. You certainly paint quite an impressive picture there, and, you know, again, this is what the budget process is about, to have these types of discussions. And I think we needed to have these discussions in years past because I think your history is right that we have not requested the right type of budget to meet the demands of our veterans, and that is where we have fallen short.

I do believe that this President's budget allows us to meet the mission of the VA. I stand behind the President's budget. I think there are a couple things as you went down that list. It does not include a request for a new electronic medical record, and that is the exception.

I think that some of the costs that you have talked about are reasonable estimates, but they are higher than I would put as estimates.

Senator TESTER. You do not think Staub would be \$2 billion?

Secretary SHULKIN. I do not think Staub will be \$2 billion.

Senator TESTER. What are your projections on that? Not that I will hold you to them but what are your projections on that?

Secretary SHULKIN. Less than \$2 billion.

[Laughter.]

Senator TESTER. Oh, great.

Secretary SHULKIN. Okay. You know, the appeals process, I do not—although I gave a number of what it would cost if we just

wanted to hire people, I think we have broken processes. I am not suggesting we throw more money at this right now.

So, I really do appreciate the spirit in which you are addressing this because I know you want to meet the needs of our veterans.

Senator TESTER. Yes.

Secretary SHULKIN. That is where you are coming from. I actually think this budget is a good budget, and I will appreciate the support for modernizing our IT systems.

Senator TESTER. Well, I would just say that I think there is some—and I am not doubting your word. I think you do believe it is a good budget. I think there are some glaring holes in it. And I would also tell you that this is about veterans and it is not about the—it is about the budget as it applies to veterans. And in the end when I go into a restaurant in Montana and I am sitting there and I have a veteran that comes up to me and says, you know what, your Choice program stinks; I used to wait 30 days for an appointment; now I am waiting 6 months. Those kind of things do not happen unless we are screwing up, okay? And so I just bring that up.

I am going to put the rest of my questions for the record, but they all revolve around the first question I asked.

Once again, thank you all for being here.

Secretary SHULKIN. Thank you.

Senator MORAN. Senator Boozman.

Senator BOOZMAN. Thank you, Mr. Chairman.

First of all, I want to thank you for coming to Fayetteville, Arkansas, and seeing the VA. The feedback was excellent. I think you got to visit with a number of different groups in the sense of visiting with the Administration, visiting with providers, and most importantly, visiting with veterans. And so, again, that seemed to go very, very well.

Secretary SHULKIN. Yes.

Senator BOOZMAN. And I know you are a busy guy, but I do appreciate the fact that you are somebody that is out in the facilities doing—I do not think there is any substitute for that, and certainly, that is what we are all about.

I would like to ask you a couple things about eye care, and one of them has to do with the eye care in the status of the eye care centers. DOD is doing a registry, but VA seems to be lagging, maybe marginalizing that. Would you look into that for me and see what the deal is?

Secretary SHULKIN. Yes, sir.

Senator BOOZMAN. And again, I think that really is very, very important.

The other thing that I would like to talk to you about is the Technology-Based Eye Care Services (TECS) program in Atlanta. This is a program, a pilot program. What they do is they use a reliance on the autorefractor. This is a machine, that you look through and it tells you what your prescription is. The problem is that it has got about 23 percent error rate, but the manufacturers themselves say that this is not appropriate to use in that manner as far as prescribing glasses.

The concern is also that the people actually doing that, there is no licensure for them also doing that. And then the other problem is after that you have got a situation where many of them need an

appointment because of inconsistencies that are found, so you are kind of double-dipping. They see them, get kind of a third-world experience, and that truly is a third-world—there is no example of this going on in private practice in America, okay—

Secretary SHULKIN. Okay.

Senator BOOZMAN. In the way that it is being done from what I understand. I think the better choice, something that we really need to look at, we have got a problem. Eye care is growing tremendously because people are doing a good job and veterans are seeking out, but I really wish that you would look at how it is being delivered. I think the idea that we are using technology is excellent, and you are coming up—you and your teams are coming up with out-of-the-box thinking. But I really think you ought to look at the way that eye care is being delivered and put the technology in the hands of the optometrists, the ophthalmologists that are in place and again give them the support staff, and then they will be able to see more patients in an effective manner and cut out all this other stuff because we really do have some problems in that area, but that is the way to go as opposed to this other.

Secretary SHULKIN. Okay.

Senator BOOZMAN. Can you comment on that at all? I do not know if you know anything about it.

Secretary SHULKIN. Yes, not nearly as much as you do.

Senator BOOZMAN. Well, I did it for 23 years. So I have gotten a good and we are very proud of that.

Secretary SHULKIN. Yes. It is really a terrific. First of all, I would like to comment on Arkansas. First, what a beautiful State. And we were there not only to visit the Fayetteville VA, which is a five-star facility and doing tremendous things

Senator BOOZMAN. That is a recent acquisition and yes they have made great progress but also to learn from Walmart and to learn about their logistics and the challenges of how they are having to change their business model as the world evolves. So that was extraordinarily helpful to learn from really best practices and to learn from industry outside the health care, so thank you. Thank you for helping us arrange that trip, and certainly, Representative Womack as well.

The eye care issue I will look into it. I really do not know that much about it. We are trying to use technology. I have seen where we are using tele-retinal exams and, you know, leveraging our professionals using tele-technology, but I will look into the TECS programming in the eye care model.

Senator BOOZMAN. Good. And, you mentioned seeing other companies, other people that have done a good job thinking outside the box. That is certainly the direction that we need to go. And again, I compliment you on getting out and exploring all different avenues in the sense of trying to move us in the right direction in a very efficient manner.

So many industries, and it does not matter if it is the eye care business or the VA business or whatever it is, many of these have changed more in the last 10 or 15 years than since the creation of the business to begin with.

Secretary SHULKIN. Yes. Right.

Senator BOOZMAN. And so it is just a constant battle. And certainly, with, you know, an entity the size of the VA, it is a real challenge.

Thank you, Mr. Chairman.

Senator MORAN. Senator Schatz.

Senator SCHATZ. Thank you, Mr. Chairman.

Mr. Secretary, thank you for your service. Thank you to your team.

I want to follow up on the question of unanticipated costs. You have said that the budget that we are working with is a good budget. I will not get into a dispute about that, but I will just offer unanticipated costs. You have decided I think appropriately to move forward with a new Electronic Health Records (EHR) system. You have decided I think again rightly on Staub and Choice is running out of money, so it seems to pretty plain to see that we do not have enough money in this budget. Is that accurate?

Secretary SHULKIN. Well, I think that what you have suggested is that we are going to continue to bring forth recommendations as we see the need to modernize this system and to do better for veterans. So, the electronic medical record, a decision 17 years in the making we are bringing forward, we do not know the cost of it yet so we were not able to build it into this budget.

On the Staub case, that is the right thing to do, and I am willing to absorb those costs into our budget because it is consistent with what we should be doing, consistent with the court ruling.

Financial projections we have to do better on. We have a financial management system that is over 20 years old that we now decided to start replacing that will help us do a better job. And we also have some accountability for that as well.

So, you know, all that we can do is make our best projections. I wish we were perfect. Today, as I sit here right now, I feel comfortable with the President's budget, but you may be right and I may be wrong.

Senator SCHATZ. Well, I think the thing is, you know, let us say it is not \$2 billion for Staub. It is also not zero right?

Secretary SHULKIN. You are right.

Senator SCHATZ. And let us say you do not know how much the Electronic Medical Records (EMR) system is going to cost. You have got to do specs, you have got to work with DOD, and I know you want to measure twice, cut once, both on the tech side and on the clinical side, so I understand you do not want to just pick a number. But it is not zero.

Secretary SHULKIN. It is not zero.

Senator SCHATZ. And we are about to mark this bill up, and it is difficult to do a markup. When lacking information, we are expected to sort of book it at zero. And so how do we work with you to get some fidelity to not overfund a priority that is not yet well-articulated? But it makes me extremely nervous that you say you can absorb these costs because, especially with Staub, you are actually not providing more care; you are reimbursing people who improperly had to, you know, do their own copayments. And so that is a pretty hard cost.

And then the EMR thing is a brand new hard cost. I mean, you are going to have to cannibalize your budget to some extent in order to pay for those two things, are you not?

Secretary SHULKIN. Well, on the EMR, we have in this budget \$200 million to start the process of change management. The majority of the cost of the EMR, especially in the first 2 years, is going to be all internal change management to get ready for the installation of a new EMR. So, we will come in the 2019 budget with firm numbers so that we can have the appropriate discussion about whether this is something that you can support. In the 2018 budget I believe we have the dollars to start preparing for this process.

You know, the Staub case and a number of other things that will happen over the course of this year are management accountabilities that we are going to have to assume the responsibility for. And part of what I have said when I took over this department is that we cannot continue to always come to you and ask for more and more money. We have seen that over the past decade that this budget has doubled for VA. And we also see what is happening in some of the other domestic budgets and that I know you are very aware of. And every dollar that we get means that there is a dollar for something else that I think is, you know, equally as important.

So, we are trying to be fiscally responsible while at the same time making sure that we are doing better for veterans. A 6.3 percent increase in our budget we think is a reasonable number.

Senator SCHATZ. In my limited time left, can you walk me through from the veterans' perspective, setting aside budget and appropriations, from the veterans' perspective how are they going to be informed of their rights under your Staub decision? Do they get a letter? Is there any case management? Do you track down the copay they—I am not sure that that is even possible. If I am an individual veteran and you know, 4 years ago I paid through private pay, I paid \$250 for an ER visit, how do I even know that I am entitled to reimbursement?

Secretary SHULKIN. Right. So right now, a veteran files a claim, and now is the worst of all processes. They are just put into a pending status. We have 600,000 claims pending. It is my intention—and I have been clear on this—I want to start going through those claims and paying those claims. So, we have sent over to OMB an interim final rule. That was the very fastest way that I could go about starting the process for rulemaking so I am allowed to pay those bills. So, as soon as we get that through OMB—and I do not know exactly how long that is going to take—but as soon as we possibly can, we are going to start paying those 600,000 claims. And that is when the veterans will get notified of exactly what our payment obligation is. I do not know any way to do this faster.

Senator SCHATZ. But at the mechanical level, you figure out who was responsible for the original claim and the private payer then.

Secretary SHULKIN. Yes. Remember, this case relates only to veterans with other health insurance so there is a primary payer, whether it is Medicare or a private insurer, that has paid their obligation hopefully, and then there is a leftover portion.

Senator SCHATZ. Right.

Secretary SHULKIN. We will then apply the law as you wrote it and as was upheld in the Staub case to VA's paying its portion of that.

Senator SCHATZ. Okay. And I will take the rest for the record, but I would like you to maybe walk us through how it works for the individual veteran so that we can talk about it.

Secretary SHULKIN. Sure.

Senator SCHATZ. I am not sure that our constituents who are veterans actually would understand whether they just wait or they go through a process or they have to file a claim. How does this all work? And I would appreciate that for the record.

Senator MORAN. Senator Collins.

Senator COLLINS. Thank you, Mr. Chairman.

Dr. Shulkin, it is good to see you again. I want to follow up on my colleague from Arkansas in thanking you again for coming to Maine and follow up on the questions raised by the chairman about the Choice program.

As you are probably not surprised to learn, I have significant concerns about the recent policy changes regarding Choice and access to Community Care. When you last appeared before this committee in May, Dr. Yehia noted that the model in northern Maine developed during the ARCH program should be used as a standard-bearer for how VA coordinates Community Care.

But now, my understanding that the Maine VA will no longer be permitted to use provider agreements to purchase care from providers, as they had been doing, which in some cases may force our veterans to travel literally hundreds of miles for specialty care, 250 miles from Aroostook County to the Togus VA in Augusta or even an additional 160 miles beyond that to the VA in Boston.

I am concerned also that the veterans are now having to go through Health Net, something they have not had good experience with, instead of dealing directly with Cary Memorial Hospital and the Caribou CBOC. And these changes really disrupt the continuity of care for veterans in a system that was working really well.

So, my question for you—and I realize your financial constraints are a terrible problem—but if Congress were to authorize additional emergency funding or more flexibility for you to transfer funds among accounts, would the VA be able to revert back to its earlier practices with regard to Choice and Community Care, and would you do so?

Secretary SHULKIN. The easiest question I will get all day. Yes. We agree with you, Senator that the system was working well, and we want desperately to continue to have a system that works that way. And the solutions that you talked about, either one of those would work for us.

Senator COLLINS. Thank you. The second issue that I want to bring up with you concerns a hearing that I chaired just last week before the Senate Aging Committee on military and veteran caregivers, of which there are some 5.5 million in this country. And we had extraordinarily moving testimony from the spouses of veterans who were suffering from traumatic brain injury, from ALS, from posttraumatic stress disorder and the RAND Corporation also released a report that was commissioned by the Elizabeth Dole Foun-

dition. And Elizabeth Dole has done so much extraordinary work in this area.

In March, you expressed support for expanding the VA's program of comprehensive assistance to family caregivers to veterans of all eras. I just do not understand why it only applies to post 9/11 veterans rather than veterans from all eras and conflicts.

And Senator Murray and I have introduced legislation again this Congress that would authorize this expansion, and we hope this is something we can accomplish. And I really wish every Member of the Senate could have been at our hearing. It was so moving listening. It happened to be three wives who are taking care of their husbands, and all I could think of is they are allowing them to stay at home. That is so much less expensive than institutional care.

So, I know that there is concern about cost, but I am going to ask you a leading question here. But do you not agree that increasing the availability of caregiver support for veterans can reduce VA expenditures in other areas, especially for institutional care?

Secretary SHULKIN. Well, I was wrong. This question is easier than the last one.

[Laughter.]

Secretary SHULKIN. Yes, I do agree.

Senator COLLINS. Then, let us do it. Let us get it done. As I said, I so wish every Member could have been there. It was just so moving to listen to the sacrifices made by these spouses for their husbands and all that they were doing to keep them home.

Secretary SHULKIN. Yes. First of all, Senator Dole is an amazing person, and her foundation is doing amazing work. And I, too, have had the experience—I am sorry I was not at your hearing, but I have had the experience of spending time with our caregivers of our veterans, and they are just incredible people and very moving.

We are very supportive of this. As you know and Senator Murray certainly knows, we have suspended our rules and we were talking to Senator Murray and her staff about this to get this right. The one area of our budget that I remain a little bit concerned about is the amount that we have allocated for 2018 for caregivers. We took the 2017 projections and we just increased it a little bit. But I am concerned that it may not be enough, so I have instructed our financial officer to begin to look for additional funds that we could move towards caregiving because I think it is not only the right thing to do, but I do think it is cost-effective, particularly among veterans whose only alternative is to leave their home into institutional care.

Senator COLLINS. Thank you very much. And thank you, Mr. Chairman.

Senator MORAN. Thank you, Senator Murray.

Senator MURRAY. Well, first of all, Senator Collins, thank you for raising that, and I am delighted to be working with you on that. We do have concerns about a number of caregivers who have been told that they are no longer eligible this year. To me, as the daughter of a World War II veteran whose mother stayed home to care for him when he was in a wheelchair, this is absolutely critical and it should go to all eras. So, thank you for working, and we have got a lot of work to do.

Secretary SHULKIN. Yes.

Senator MURRAY. At the VA on this. We will continue to do it. Secretary Shulkin, let me go back to a discussion we have had here and that you and I talked about last week, and that is the Choice program shortfall. As a result of the problems in the Choice program, VA is no longer going to have \$626 million in carryover as expected for fiscal year 2018. And according to a VA briefing, to cover that shortfall of \$260 million, the VA is asking our hospitals to delay important equipment purchases and facility maintenance projects, and your budget documents actually show you have already transferred \$600 million from Medical Services to Community Care, correct?

Secretary SHULKIN. Those are our collections, which come into our Medical Services, and then we transfer into Community Care.

Senator MURRAY. So, that is another change in the budget for those needs. If that is not enough, VA would then take from Medical Services and Medical Collections, taking away from expected carryover in those budgets.

Secretary SHULKIN. Yes.

Senator MURRAY. So that will be something that you have to carry over.

Secretary SHULKIN. Yes.

Senator MURRAY. But my question is your budget submission for next year is based on those hundreds of millions of dollars of carryover being available, so exactly how much money will VA need above what is in the Choice and Community Care accounts?

Secretary SHULKIN. Yes. Well, first of all, you have done a good job on understanding those numbers, so I think you have it correct, but to make sure that I am going to add up all your numbers, correct, Mark, what—our chief financial officer probably is going to do better at this.

I think the question is what is the total amount of carryover dollars that we had expected that we may end up using?

Senator MURRAY. That you will no longer have.

Secretary SHULKIN. Yes.

Mr. YOW. We had in the budget \$1.652 billion in Medical Services carryover from fiscal year 2017 into fiscal year 2018. Right now, we believe we can resolve the problem with the Choice shortfall in fiscal year 2017 without dipping into that—

Senator MURRAY. No, my question is you are not going to have the carryover money for 2018 that you were expected. So, what is now the shortfall for 2018 from your budget request that is before this committee today?

Mr. YOW. Yes, ma'am, but we believe we have other offsets internally in 2017 that will provide us—

Senator MURRAY. Somebody else is going to lose out.

Mr. YOW. I am sorry.

Senator MURRAY. Somebody else will lose out? You are going to take money from somebody to make up this.

Mr. YOW. Well, we have taken money from the National Reserve, about \$104 million, and we have taken \$220 million that has been offered up by our VISN directors as being available for this. It is more important than what they had it set aside for.

Senator MURRAY. Well, my understanding is it is about \$4 billion or a little bit more than that that you will need in the Choice and Community Care account.

Secretary SHULKIN. For 2018.

Senator MURRAY. For 2018, about \$4 billion. So, Mr. Secretary, my question for you is why have you not submitted a request for additional appropriations for this year?

Secretary SHULKIN. Well, because I think that we will be able to cover this year, as Mark was saying, that we have identified the \$260 million in unobligated spending from our—asking our VISNs what they are not going to be spending. We have taken the \$104 million from our National Reserve, and we will be able to cover this year rather than make an emergency supplemental request for this year.

Senator MURRAY. So you have created a huge hole for next year. Because you have taken away the carryover that you are expecting and put into your budget request for this year?

Secretary SHULKIN. We have. At least by \$626 million, yes.

Mr. YOW. In Choice.

Secretary SHULKIN. What is that?

Mr. YOW. In Choice.

Secretary SHULKIN. In Choice, yes.

Senator MURRAY. In Choice.

Secretary SHULKIN. Yes.

Senator MURRAY. So this year's budget request is not enough?

Secretary SHULKIN. It is.

Senator MURRAY. It seems to me the right thing would be to do is to ask for a request for this year for the shortfall.

Secretary SHULKIN. One of the options to resolve this problem would be to have the authorizers of which you are one, consider that as an option for doing it now for 2017, 2018.

Senator MURRAY. Have you requested that?

Secretary SHULKIN. We are in discussions with you about how you would prefer to do this. I think that is one of the options, and the other option, as you are saying, is that we could fix this through transfers, but there are consequences to that. So, each of the options have advantages and disadvantages, and I believe that this needs to be a dialogue about where we want to go with this. But we want to see this fixed. I know you do, too, and we should come to the best conclusion as to the way to fix this.

Senator MURRAY. It seems to me if the Administration makes the request, it will be better served.

Secretary SHULKIN. Okay.

Senator MURRAY. Secretary Shulkin, I am very concerned about your budget for Medical Services. You are requesting barely a 1 percent increase, and that does not cover the basic medical inflation, increasing use of health care by veterans. It does not replenish the \$600 million VA transferred to Community Care, and it does not account for delays in equipment purchases and maintenance projects. So how do you meet the veterans' needs for health care?

Secretary SHULKIN. Yes. Senator Murray, I have different numbers than you have. I have a much larger increase in Medical Services. Mark, would you please—

Senator MURRAY. For your budget request?

Secretary SHULKIN. Yes.

Senator MURRAY. For 2018?

Secretary SHULKIN. Yes.

Mr. YOW. Yes, ma'am. What you are looking at is only the appropriation amount. We have five sources of funds. We have the appropriation, which obviously is the largest, but we also have the funds from the Choice law both for the Choice program and for the section 801 VACA funds that are applicable to Medical Services. We have medical care collections, we have reimbursements, and we have carryover. So when you look at the total obligations that we have got in the budget from 2017 to 2018, our Medical Services account grows by 5.7 percent, and our Community Care account grows by 8.2 percent.

Senator MURRAY. Okay. Well, what I am hearing you say is in all those accounts that you now are expecting a carryover from that you will not have, you are counting those in to this?

Mr. YOW. Right now, the only one we do not expect to have it in is in Choice, which would reduce the amount of growth for Community Care. It would not impact—

Senator MURRAY. But you are taking money from those other accounts for Choice?

Mr. YOW. In the current year, 2017.

Secretary SHULKIN. Not in 2018.

Mr. YOW. Not in 2018.

Senator MURRAY. Okay. Well, that is Choice, which is private sector. Inside VA, it is 1.2, correct?

Mr. YOW. No, ma'am.

Secretary SHULKIN. Mark, let me just try it because he helped me with this.

If you are looking only at the appropriation amount, it would be the amount you are talking about, but when he adds in his other five sources, it is 5.7 percent inside VA for Medical Services.

Senator MURRAY. Okay. Well, I will just conclude. You said you will defend this budget?

Secretary SHULKIN. Yes.

Senator MURRAY. Your job is to defend veterans—

Secretary SHULKIN. Yes.

Senator MURRAY [continuing]. And they are the ones that this committee cares about.

Secretary SHULKIN. Yes.

Senator MURRAY. So thank you.

Secretary SHULKIN. Thank you.

Senator MORAN. Senator Hoeven.

Senator HOEVEN. I would like to thank all the witnesses for being here. Secretary Shulkin, thank you for being here and for your work on behalf of veterans.

One of the subjects you and I have talked about before is making sure that veterans can get access to nursing care close to home. Also, we want to make sure that they can access home-based health care, right?

Secretary SHULKIN. Yes.

Senator HOEVEN. So, the whole concept behind the Veterans Choice legislation is that veterans can get care in the local commu-

nity when there is not a VA institution nearby that has the service they need, right?

Secretary SHULKIN. Yes.

Senator HOEVEN. And so you have been hard at work implementing that. We worked with the healthcare providers. You have been very good about helping us set up a pilot program in our State that has really empowered our local VA healthcare center in Fargo, which serves North Dakota and half of Minnesota, to cut through the red tape and some of the problems we have had with the third-party providers and really cut down the wait time for veterans to get appointments and get in to get health care, and also, through the Veterans Care Coordination Initiative, which is what we call it, to make sure that providers get paid so they will provide that service to veterans in the local communities. It is working. You have made a real difference.

We need to do that now with long-term care and with home-based care, and we cannot right now because in some cases you are not and in some cases you probably do not have authority to enter into provider agreements with nursing homes and home-based care service providers. Tell me how we are going to—you know that this is something I am trying to move in legislation, and I would like your thoughts on how we are going to get this done because this is a fundamental issue of veterans getting long-term care in their homes and in their communities.

Secretary SHULKIN. Yes.

Senator HOEVEN. And I would like you to address that because this is something we need folks on both sides of the aisle working together to get done, just like we did on Veterans Choice.

Secretary SHULKIN. Yes. Mark, I am going to ask again, I thought we were making progress on being able to utilize our Choice funds for both home health aides and our long-term care facilities.

Mr. YOW. Right now, sir, what I think you are talking about, though, is expanding it beyond Choice. We do have that authority for the Choice program. What we do not have is the authority to do it outside of Choice, and we would really like to have that for other normal Community Care accounts.

Senator HOEVEN. Right, for really any of the funds that you receive.

Secretary SHULKIN. Yes.

Senator HOEVEN. Right now, we are already—I mean, that is another one of my questions, how long until you run out of funding under the Choice program, which we need to make sure is appropriated for. We need to be able to make sure that—I mean, are you entering into those type of provider agreements with your Choice funds?

Mr. YOW. Only with Choice, but again with Choice they have done quite a bit so far.

Secretary SHULKIN. Yes.

Senator HOEVEN. How far is that taking you?

Mr. YOW. There were 600 valid agreements that had been put into—

Senator HOEVEN. So you are saying then for any nursing home that wants—to be able to take VA reimbursement, they should be

working with you under the Choice funding, and you will do that? And that restricts them how?

Secretary SHULKIN. Right.

Mr. YOW. We have the authority to use the sharing agreements for the community home health care that is not institutional. It is not the institutional care.

Senator HOEVEN. So you cannot do it with—the nursing homes?

Mr. YOW. Right. Not for nursing homes.

Senator HOEVEN. So, you are not doing it with nursing homes?

Mr. YOW. It is for non-institutional care.

Senator HOEVEN. Only for home-based care?

Mr. YOW. Yes, sir.

Senator HOEVEN. Okay. So, for home-based care we are making progress?

Secretary SHULKIN. Yes. We have proposed with technical assistance a revision to the Choice program that we are hoping that you will consider that we call the CARE program that actually builds in your concepts of working with the nursing homes under a single set of funds for Community Care so there is not separate Choice and Community Care funds.

Senator HOEVEN. And that would enable you to enter into provider agreements—

Secretary SHULKIN. Provider agreements?

Senator HOEVEN [continuing]. With either nursing homes or home care providers?

Secretary SHULKIN. Right. Exactly. Yes.

Senator HOEVEN. Okay. And you are doing that where?

Secretary SHULKIN. Well, now that the Choice program legislation is going to expire, we are hoping to work with you to replace it with a more effective program.

Senator HOEVEN. And include that provision in the legislation?

Secretary SHULKIN. Yes. And we provide the technical assistance for that.

Senator HOEVEN. So you will work with us to include that in the legislative proposal?

Secretary SHULKIN. Yes. That is correct.

Senator HOEVEN. Thank you. I appreciate it.

Senator MORAN. Senator Baldwin.

Senator BALDWIN. Thank you.

Secretary Shulkin, I wanted to thank you for fully funding the Jason Simcakoski Memorial Opioid Safety Act and PROMISE Act. I also want to say that I am closely monitoring the implementation of Jason's law and efforts to reduce opioid dependency at the VA.

The VA has been making good progress on this issue, and there are still big milestones coming up with regard to implementation of the law. I would appreciate it if we could set up a meeting with the folks that you have implementing these provisions to go over some of the details of implementation. If we could work together on that, that would be great.

Secretary SHULKIN. Absolutely.

Senator BALDWIN. I also want to acknowledge my partner on this legislation also on this committee, Shelley Moore Capito, and you would be welcome to join the briefing.

On June 1, Congresswoman Gwen Moore and myself wrote to you regarding a mistake that the VA made that is now affecting 11 veterans who are all police officers——

Secretary SHULKIN. Yes.

Senator BALDWIN [continuing]. At the Zablocki VA Medical Center in Milwaukee. A little bit of background on this, in 2015 the St. Louis Regional Benefit Office reviewed and approved an on-the-job officer apprenticeship program certifying that each veteran's eligibility to participate in the program and using their post 9/11 GI benefits. In February of this year, a VA auditor found that the VA erred in approving these veterans because they were past their first 3 years of employment.

These veterans are now receiving letters from the VA telling them that they each owe upwards of \$20,000. The VA has requested financial information from these veterans and their spouses in an attempt to collect on what was the VA's mistake. These veterans have families; they have mortgages. They do not have \$20,000 laying around for a mistake that the VA made.

So, Secretary Shulkin, since I wrote you on June 1, can you advise me as to whether the VA has made any progress on fixing this?

Secretary SHULKIN. Yes. Well, first of all, thank you for bringing this to our attention. I think you have it correct. The VA made the mistake, and this was our administrative error, and we are not going to seek recoupment of those funds from those 11 employees. We apologize for the mistake, and we thank you for bringing it to our attention.

Senator BALDWIN. Well, I appreciate hearing that. I know particularly these veterans who are police officers are going to be particularly relieved to hear that.

Secretary SHULKIN. Yes.

Senator BALDWIN. I take it since you have said it here publicly, it is now public and we will certainly work with you to relay that good news.

Secretary SHULKIN. Thank you.

Senator BALDWIN. Thank you.

Now, another issue, numerous Wisconsin veterans have brought to my attention the fact that it is nearly impossible to speak with a live human being when a veteran calls the Debt Management Center. In March, after hearing some of the complaints, a member of my staff endeavored to replicate this experience. It took him over two weeks and 15 phone calls to finally get through to the Debt Management Center phone line. And the wait time once the connection was made was 36 minutes. This is obviously unacceptable.

Secretary SHULKIN. Right.

Senator BALDWIN. Especially when you think about the fact that there are veterans with PTSD or other ailments who really do not need to deal with this type of dysfunctional system, adding stress and frustration in their lives.

So, my understanding is that the President's budget request calls for an increase of 14 full-time employees at the Debt Management Center. I am concerned that this additional staff will be sort of a bandaid. It will prop up what is a failing technological telecom system. So, I would like to hear from you what the VA plan is to iden-

tify a commercial callback solution to eliminate the veterans needlessly waiting on hold and experiencing the anxiety of not being able to get through.

Secretary SHULKIN. Yes. Senator, we have a new system that is in the process of being installed. It will be installed in August of this year. I do not have the exact date, but that is, you know, a few months away. And that includes as part of the system something called a virtual hold, which is the veteran can essentially hang up and will be called back in the order that they have received the call so that in the situation that you are talking about, they will receive a call back and not have to wait on the phone because we agree; that is an unacceptable wait.

Now, as to whether this will all be solved by technology or whether the 14 FTEs are enough, I am going to have Mr. Murphy just comment on that.

Mr. MURPHY. Senator, we have got some lessons learned from what we do at the National Call Center with VBA, and what we found out is a combination of two things: technology in terms of how much call volume we were getting, and the second one was our staffing was not aligned with—we discovered we had our people working Monday through Friday and veterans do not only call Monday through Friday, so we realigned our staffing. We put the mix—we put a few part-time employees in. The new technology we put in place allowed us to identify demand on the part of the veteran, and then we lined up our staffing model to the demand of when the phone calls came.

We are using that same process and technology and putting it in here, the Debt Management Center, so we expect a very quick resolution of this.

Senator BALDWIN. Well, I will be looking forward to a report in August. Thank you.

Senator MORAN. Senator Capito.

Senator CAPITO. Thank you, Mr. Chairman. And thank you all of you, and thank you, Dr. Shulkin, for your service and your leadership.

I wanted to ask a question so I understand your proposed CARE Act. You just alluded to it. Because I think we are all proud of the Choice program, but I think you have initiated the CARE program to sort of supplant this. Am I reading that correctly?

Secretary SHULKIN. Yes. Choice 2.0.

Senator CAPITO. Choice 2.0, which means you would be combining Community Care and Choice?

Secretary SHULKIN. Yes.

Senator CAPITO. The aspect of it that I wanted to ask you about is under the proposed CARE program it is my understanding that the veteran would not be able to access a private provider in their community without explicit permission from a VA clinician who would first assess their needs and then tell them where and when and how they could go. Now, to me, is that another step that is in there or—just give me the rationale for that and how you think that will work better than the system that we have now.

Secretary SHULKIN. Yes. So, first of all, our system that we have now makes the veteran go out to a third party, makes it go out to a TPA and get—

Senator CAPITO. Right. And there are some issues with that.

Secretary SHULKIN. And there are some issues with that. This is returning to a system that is used every day in the private sector, which is a conversation between a patient and a provider. Now, it does not mean that a veteran is going to need to always come in and be evaluated and clinically assessed. If the service is not provided, of course, they go out to Choice. If the service is a convenient service closer to the patient and is easy to get, they will be authorized—that is a new benefit that we will be adding to do that. Sometimes it is simply a phone call or a quick conversation. Other times, it is a clinical assessment.

Senator CAPITO. And you think this will add more efficiencies and get more direct better quality? Obviously, that is the goal.

Secretary SHULKIN. I think this changes it from what we have today, which is a system choice based on administrative rules 40 miles, 30 days.

Senator CAPITO. Yes. Right.

Secretary SHULKIN. Back to a clinical system of care, which is what healthcare systems should be doing, assessing and providing clinical care based on the needs of their patients.

Senator CAPITO. Okay. Thank you. I would like to know in the budget and also Senator Baldwin mentioned the Jason Simcakoski bill built around the VA's reaction to overprescribing and other issues. Obviously, the VA is a reflection of the general population. There is a huge drug and opioid abuse—and I know it is high in the veteran population. What kind of resources are you putting into this at the VA to try to meet these challenges?

Secretary SHULKIN. Yes. I am going to ask again our CFO what our CARA budget was. I think it is like \$150 million.

Mr. YOW. Actually, sir, it is less than that. The CARA amount for 2018 is \$56 million, and then for the 2019 advanced appropriation it is \$47 million.

Senator CAPITO. So that is coming—the vehicles, the CARA bill that we passed here.

Secretary SHULKIN. Yes.

Mr. YOW. Now, the budget was submitted prior to the \$50 million that came in the omnibus, so that was not included in the budget submission.

Senator CAPITO. So outside of the CARA bill, does the VA have other targeted resources to this?

Secretary SHULKIN. Oh, sure.

Senator CAPITO. Yes. I mean, are you seeing that reflected in your population? I am sure you are.

Secretary SHULKIN. Sure we are. And the VA has been hard at work on this issue since 2010 where we launched our initiatives on opioid safety. And we have seen since then over a 35 percent reduction in the use of opioids throughout the population.

Senator CAPITO. So you have got a concentrated initiative to divert from prescribing opioids to other pain therapies?

Secretary SHULKIN. Yes, other modalities absolutely. And in cases where patients are on opioids, dose reduction and reduction of concomitant use of benzodiazepines.

Senator CAPITO. Right. Okay. Another question I have and Secretary McDonald brought this to our attention. I do not think he

was the first one, but I am wondering where you are on this issue. He mentioned antiquated facilities that are no longer being used but still owned by the VA that is a money drag on you and your inability to either sell or repurpose or—can you give us the status on that? Because in my view—we are talking about tight resources—that could be a good way to free I think some of the VA resources to a more productive delivery of care.

Secretary SHULKIN. Yes. We agree with that. Yesterday, I put out a press release saying I am moving forward on exactly that issue. We have identified 1,100 facilities that are either vacant or underutilized. I announced that in the next 2 years I will deal with those 1,100 facilities, starting with 142 facilities right now that I am proceeding with disposal or essentially destruction of those buildings so that we no longer are paying for maintaining—you know, vacant buildings.

Senator CAPITO. Right. Good. Well, I am certainly supportive of that initiative.

And just last, I would like to thank the VA for the relocation of the community-based outpatient clinic in Lewisburg, West Virginia, to Ronceverte where there were some workplace issues. It is a beautiful facility. We cut the ribbon on it just several weeks ago, and I know it will enjoy a lot—I mean, the veterans in that area are very, very pleased, and I thank you for that.

Secretary SHULKIN. Sure. Good. Thank you.

Senator CAPITO. Thank you.

Senator MORAN. Senator Udall.

Senator UDALL. Thank you, Chairman Moran.

Secretary Shulkin, thank you very much for joining us today, and I look forward to continued cooperation, making improvements, and addressing ongoing challenges facing the VA.

In March of this year I sent you a letter expressing my concerns regarding staffing shortages across the VA medical system, including several facilities in New Mexico. In April, you responded and said that the VA had addressed this issue by increasing pay for several positions. Can you give me an update whether or not you are seeing positive results from these pay increases?

Secretary SHULKIN. There is mixed news on this. We have 24 vacancies still, physician vacancies I am talking about. The six in emergency medicine we have made offers and have acceptances. We are still looking for a director of emergency medicine. In some of the other areas, even though we have done market salary surveys and made adjustments, we are still challenged to find healthcare professionals, like many parts of the country that have shortages. And in New Mexico we still continue to see shortages.

So, we are making some progress, but I think we are still concerned that we are going to be able to do this as quickly as we all want to do it.

Senator UDALL. Yes. Thank you for that. And thank you for your effort there.

In the same letter, I asked you to address the severe shortage of mental health practitioners within the VA and specifically in New Mexico. You responded that in New Mexico a staffing shortage and broken air-conditioning unit were to blame for reduced capacity, substance abuse, trauma, and rehabilitation residents. Can you

update me whether the full-time staff positions were filled by the end of May?

Secretary SHULKIN. Yes. I know that we fixed the air-conditioner. That certainly is done. And the full-time people are now on board so that we are able to get that corrected as well.

Senator UDALL. And besides pay increases, what measures is the VA taking to increase training, scholarships, residences, and other options that could help address these chronic personnel shortages especially in the rural areas of our State and across the Nation?

Secretary SHULKIN. Yes. You know, we continue to be challenged with this. We do know that several of our programs that we use are effective. Educational debt reduction, which you will see in the 2018 budget we have asked for additional funds for, that is a very effective tool to attract health care professionals. But the truth is that there is a shortage right now of trained healthcare professionals, and we are looking for ways to attract people to the VA. So, one of the thoughts that we have is to work with you to expand our graduate medical education program in the VA, and in exchange for expansion have a payback service in the VA particularly to underserved areas. The Department of Defense does this quite effectively. The Public Health Service does this quite effectively. We think it is a model we should be looking at.

Senator UDALL. Yes. And basically, your model there is many of these new doctors that come out medical school have big debts, and so in exchange for helping them with their debt, they then go into underserved areas and many of the places you have not been able to find doctors to—

Secretary SHULKIN. Yes. I think we do that. That is our Educational Debt Reduction Program. And we are talking about actually expanding it to a new idea.

Senator UDALL. Okay.

Secretary SHULKIN. What is happening now is there are more U.S. medical school graduates than there are spots to train them in, so we have a mismatch.

Senator UDALL. Yes.

Secretary SHULKIN. VA under the Choice Act, actually you helped expand the number of residency programs.

Senator UDALL. Right.

Secretary SHULKIN. We would like to go further this time and expand more and use that potentially so that those who train in the residency program would then enter the VA for a specified period of time to practice.

Senator UDALL. Great. Senator Tester and I introduced a bill to expand the Rural Veterans Coordination Pilot Grant Program. Can you just give me an update on the expansion of that program and how it is going?

Secretary SHULKIN. Yes. We are just getting the study results in now. We are in the process of data analysis. We should have that in the next 30 days. We would like to come back and share that with you.

Senator UDALL. Great. Thank you very much.

Secretary SHULKIN. Thank you.

Senator UDALL. I have an additional question for the record on Master Sergeant Jessey Baca and burn pits but I will submit that for the record.

Secretary SHULKIN. Okay. Thank you.

Senator UDALL. And thank you, Mr. Chairman.

Senator MORAN. Thank you, Senator Udall.

Senator Rubio.

Senator RUBIO. Thank you.

Thank you, Dr. Shulkin. Thanks for being here.

My understanding is the President is going to sign the VA accountability bill on Friday?

Secretary SHULKIN. Yes.

Senator RUBIO. I wanted him to do it last Friday. But my sense is that you are prepared to begin to quickly implement the flexibility that it gives you for accountability?

Secretary SHULKIN. Absolutely. And we certainly thank you for your leadership in that. This is something that I think all of us feel is important for moving forward.

Senator RUBIO. Yes. The one thing I would note is that we had tremendous bipartisan support on it.

Secretary SHULKIN. Yes.

Senator RUBIO. The people came together. Senator Tester, Senator Moran were part of that as well.

Secretary SHULKIN. Yes.

Senator RUBIO. And it just troubles me—and again, it does not matter. I did not have to put my name in it—but how little coverage it got. And I bet you if we had fought over it a little bit, they might have talked about it. It is important when good things happen at the agency or here in Congress that people mention it, particularly in this case because there has been so much negativity over the last three or four years about the VA system and that every opportunity we can to catch people doing things right, that we point to that as well.

And the great thing about accountability is it is not really a punitive measure. It is designed in many ways to reward the people who are doing things the right way. It is not fair to a good employee to be saddled with the consequences of someone who is not doing a good job—

Secretary SHULKIN. Yes. We have actually seen a fair amount of coverage on it. It may not have come to your attention, but—

Senator RUBIO. Maybe it is the stations I watch.

Secretary SHULKIN. Exactly. But it is exactly the points I make, Senator. I believe this is going to help us improve morale. It is going to help us improve recruitment because people want to work alongside people that share their values. And the vast majority of people who work in the VA are dedicated people who are there for the right reason.

Senator RUBIO. Yes. So one of the things that concerns me, and I think these numbers are right; I am pretty sure they are. We have a little under 1,000 nursing home beds in Florida for long-term.

Secretary SHULKIN. Yes.

Senator RUBIO. And I think if you take the number of veterans and extrapolate that out to the general population understanding,

we would love for people to age in place. We want as many as possible to be home with their loved ones, and then we know there are instances in which that is no longer possible. Either the family can no longer sustain it or the patient actually would not benefit from it. How are we planning for that, the baby boomer, surge that will ultimately impact veterans, particularly of the Vietnam era? How are we planning for that moving forward? Obviously, Florida is a place where—I mean, this is not very well-known, but we have a lot of retirees. Many of them served in the military obviously. And so how are we planning for that need in the years to come?

Secretary SHULKIN. Yes.

Senator RUBIO. And by the way, when I say nursing home and long-term care facilities, we say in many instances that is someone who is a senior, but unfortunately, in some cases with concussive brain injuries and the like, it may come much sooner than anticipated. So, what is our plan moving forward on that?

Secretary SHULKIN. Yes. Well, first of all, Florida, as you know, is one of our fastest-growing States in terms of veterans and retired veterans, so we are doing several things. First of all, I made the decision about 2 months ago to eliminate the Federal requirements on the States for building State nursing homes or State facilities with Federal money. So, what we used to do is we used to give out grants to the State—and Florida was actually the case example for us—where we would tell them exactly how they had to build these things. And it was costing them 40 percent more than the States could do it if we would just get out of the way.

And so we have now changed that to allow Florida and all other States to rely upon their own regulations so they are able to build with the same amount of money, 40 percent more beds for residents, so I think that is going to start helping. And there are two of these facilities under construction in Florida right now.

Secondly, we do believe with the use of technology and home health technology that we can keep more people at home than ever before because we can provide services that previously had to be in institutions in the home.

And third, we do believe in the extended use of caregivers where people want to remain in their homes and not go and seek institutional care. But, as you said, we are going to have to continue to expand capacity, and that is why we are working with States, we are working with nonprofit organizations, and the VA itself is also building community living centers.

Senator RUBIO. And then one of the things we have learned in the sort of, you know, stay-at-home model is there are needs from time to time for someone to be able to go to a daytime facility while the caregiver works or what have you. Do these centers have the flexibility to provide that service, or is it—basically, it is up to the State to design based on State regulation?

Secretary SHULKIN. Yes, that is what we have said. It is now up to the State.

Senator RUBIO. So you are providing the money, and then they are building it as if it were any facility operating in the State.

Secretary SHULKIN. Exactly. Yes.

Senator RUBIO. Under their guidelines?

Secretary SHULKIN. Yes, and I was on a call with all the State directors yesterday going over this, and States have different philosophies about this. I happen to think that partial-day programs and the type of adult daycare that you are talking about may not be a great—

Senator RUBIO. I am sorry. When you extrapolate the long-term need with the dollars in the budget, do we have sufficient funding in that program to keep pace with what we think will be the need in the years to come?

Secretary SHULKIN. Well, the States think that the Federal Government should be helping more. I have told them that this is important to us, that we will maintain our funding commitments to it, that we will certainly look and advocate for more dollars but that the Federal budgets are under considerable, you know, stress. And we are going to have to look for all sorts of sources of funding to meet the needs.

Senator RUBIO. I think the right answer to those questions is always yes, is it not? Yes, we need more money. But I understand your perspective.

Secretary SHULKIN. Yes.

Senator RUBIO. The States want the Federal share to be higher.

Secretary SHULKIN. Sure.

Senator RUBIO. Got it. Thank you.

Senator MORAN. Let me ask Dr. Alaigh a question. This subcommittee held a hearing on April the 27th on veteran suicide, more specifically, veteran suicide prevention. Dr. Clancy and Dr. Kudler were the VHA lead witnesses. We spent a lot of time talking about the OIG report, which was in February of 2016, and that report was highly critical of the operations of the veterans' service line. At our hearing, which was more than a year after the report, we learned that none of the seven IG recommendations for action were closed.

And then, can you, Dr. Alaigh, bring us up to date on the status of those important recommendations. My understanding is that six of the seven now have been completed, have been closed. Will you proactively pursue number six, which is not closed?

And then, since then, the IG produced a second report on the crisis line, March of this year. It has 16 recommendations for the VHA. Are you aggressively pursuing tackling those recommendations? And what will you do to keep us informed of your progress?

Dr. ALAIGH. Thank you, Mr. Chairman. Nice meeting you and talking to you. And thank you for raising this issue because, as you know, suicide prevention is our number-one clinical priority. Many times, we say that, you know, we take care of our veterans, but this is a time that if we do not take care of our veterans, we are going to lose them, so there is nothing more important for us than to take care of this.

As far as the initial IG recommendations, the seven, we have closed six and a seventh one is being closed by June 30 because that was related to a new contract award for our rollover contract, so we just wanted to make sure, based on the IG recommendations, that the performance, the quality measures, the operational measures were all consistent with our own program. And so for that, we had to go into contractual negotiations and modifications so that it

will be signed on June 30, so we would be in compliance with closure of that recommendation by July 1.

Senator MORAN. Doctor, before you answer the second part of my question, would you assure me or is it your belief that compliance with those recommendations has actually improved the responsiveness and the effectiveness of the crisis line?

Dr. ALAIGH. Yes, absolutely, because what we have done is transitioned the suicide prevention crisis line to really a clinical coordination and a clinical crisis solution. So, what we have done is we have added clinical oversight, we have embedded clinicians. We are doing warm transfers when we find a veteran in crisis to a clinician in the medical facility. We have seen rollover rates of 30 percent in the last quarter of the last calendar year now moving to less than 2 percent. Our response rate has improved to about eight seconds. Ninety percent of our calls we respond in less than eight seconds.

So, we have seen operational efficiency, we have seen clinical improvement, and we have been able to tie that whole program together to make it more robust and truly serving our veterans.

Senator MORAN. So, it is not just a matter of meeting the IG recommendations; it is a matter of increasing the opportunities for us to prevent suicide?

Dr. ALAIGH. It is about saving lives for our veterans.

Senator MORAN. And the second part of my question, the March recommendations?

Dr. ALAIGH. Yes, the March recommendations, there were 16 recommendations. We have submitted four for closure. We still have 12 recommendations. A lot of those recommendations are around training and putting standardized processes and policies in place, and those recommendations do require data gathering and analysis and, again, reinforcing that we are meeting our targets. So, it does take time, three to six months to collect that data and report it, but we are on track to close all the recommendations by the end of this calendar year, by December of 2017.

Senator MORAN. The challenge in doing so is not a financial one. It is not a budget issue. It is a matter of timing of getting the reports completed.

Dr. ALAIGH. Right.

Senator MORAN. Thank you for your commitment to that effort. And I would again ask you to keep us informed of your progress.

Dr. ALAIGH. Absolutely.

Senator MORAN. Thank you.

Dr. ALAIGH. Thank you.

Senator MORAN. And now, let me turn to Mr. Walters. Mr. Walters, I understand that my House colleagues reduced major construction account in their mark by \$102 million, which lines up with cutting funding for 2018 for three out of your six major construction cemetery projects. I understand the goal is to provide veterans—your goal is to provide veterans with burial options within 75 miles of their residence. Would this reduction impact your ability to accomplish that goal? And without the funds, would you be able to move forward with those three expansion projects?

Mr. WALTERS. As you mentioned, Mr. Chairman, NCA's goal is to provide 95 percent of the veteran population with reasonable ac-

cess to a burial option in either a national or State Veterans cemetery within 75 miles of where they live. We accomplish that by establishing new national cemeteries and, perhaps more importantly, keeping existing cemeteries open. In fact, our number-one construction priority is to make sure that we have sufficient funds for the timely expansion of existing cemeteries.

The six grave site expansion projects that are included in the budget are at locations that will have at least one type of burial option that will deplete by the year 2020. We requested funds in 2018 to ensure that we had sufficient leeway to address any unanticipated problems that we might encounter during the construction process to ensure that we delivered the grave sites in a timely manner.

The cut of the three expansion projects would place those locations at a much higher risk for a possible interruption of burial service. This is not insignificant. The three cemeteries that were taken out of the request service approximately 1.2 million veterans. That is about 6 percent of the veteran population, so it is something that is of a concern to us.

Regarding your second question, without the requested major construction funding, we would have to significantly reduce the scope of the three projects that were deleted to include the removal of necessary infrastructure repairs and reallocate a large portion of our minor construction budget for stop-gap expansion projects. And this would also require frequent follow-up with additional minor projects to make sure that we do not deplete in the future.

We feel that this is not the most cost-effective or efficient way to address the expansion needs of these three locations at this time.

Senator MORAN. Thank you very much.

Let me turn to Senator Schatz.

Senator SCHATZ. Thank you, Mr. Chairman. Excuse me.

Secretary Shulkin, the Department's request for nonrecurring maintenance is \$1.8 billion, \$700 million over the year 2017. I am happy to see this investment into the program, especially given the current deficiencies. Based on the VA's latest facility condition assessment estimate, what is the total cost of code violations and deficiencies at VA hospitals and clinics across the country?

Secretary SHULKIN. A lot more than that. I think that our total capital deficit across the country is estimated to be somewhere near \$50 billion. A lot of that includes our seismic deficiencies that are of concern to us. Some do include, you know, infrastructure repair. But it is a large capital deficit.

We do think that this NRM program, along with a request that we would make to increase our NRM cap from \$10 million up to \$20 million will make a substantial impact on some of the more severe deficiencies.

Senator SCHATZ. I am a little concerned about the lack of investment into other capital accounts, major and minor construction accounts. And I want to be reassured here that, as you know, your capital expenditures reflect your long-term programmatic priorities where they should. And because you have this reduction in the major and minor construction accounts, I want to be reassured that this is not reflective or predictive of your view as to where services

are going to be provided, in other words, at VA facilities or not at VA facilities but rather, due to fiscal constraints, you just had to make tough choices. I want to know that this is not a reflecting sort of view of the political winds here in terms of privatizing services. I want to know what your thinking was here in reducing these accounts.

Secretary SHULKIN. Yes. You know, the way I would say it is that our thinking is that we were not doing this very well. And so with the fiasco in construction in Denver, we made several changes. One was to get the Corps involved, and secondly, to cut back on our appetite for having such big construction projects and look for alternative ways to continue to have new facilities for our veterans and to be able to provide state-of-the-art facilities for them.

So, it absolutely is not a philosophy towards privatization. This is a philosophy that we have to do business differently. We have to do it smarter. I believe the future is going to involve several things when it comes to facilities. One is we are going to have to build different types of facilities. The days of building big bed towers are over. Where most care is delivered is in ambulatory settings, and we are going to have to construct different types of facilities. So, most of our facilities were built more than 50 years ago, and we need the newer, modern-type design.

Secondly, we need to look at private-public partnerships. And thanks to your authorization, we have five pilots that we can do this on. We have announced one in Omaha which took 10 percent of taxpayer dollars compared to what we were going to build, which was a big bed tower.

And third I would say is we need to do our leasing differently. Now, when we do not construct as much—and maybe Hilo is going to be a good example of this—we are looking towards leasing and having the private sector build this for us. We have 27 leases now or 24 leases?

Mr. YOW. Twenty-seven.

Secretary SHULKIN. How many?

Mr. YOW. Twenty-seven.

Secretary SHULKIN. Twenty-seven leases that have not been authorized by Congress yet. So, when things are not working—and it has been difficult for you because of the CBO scoring over a 20-year period of time. It is counted as one big piece of capital. When things are not working, we have to do things differently. So, we are approaching GSA to take over the inventory of our leases and get out of the business of being in the leasing business and let them do that.

I hope that that will be productive and allow us to open up these leases, and we will look at Hilo of course. But this is certainly—we will continue to look at where veterans need new facilities and advanced facilities and continue to advocate for them.

Senator SCHATZ. Thank you. And I will leave this one with you for the record. First of all, thank you for what you are doing in telehealth and telemedicine. I just want to know if there is anything either on the authorizing side—not my side of the shop—but either on the authorizing side or in the next markup that we can

do to help you to expand telehealth and telemedicine and specifically to get telemedicine into veterans' homes.

Secretary SHULKIN. Yes.

Senator SCHATZ. I am very interested in that and where we can be of assistance. I am sure we will be likely to help, so——

Secretary SHULKIN. Well, we have proposed again in technical assistance a legislative fix to allow us to do that, and we would appreciate your support for that.

Senator SCHATZ. Right. We are working on it.

Secretary SHULKIN. Thank you.

Senator SCHATZ. Thank you.

Senator MORAN. Dr. Shulkin, Senator Murkowski is on her way back, which gives me the opportunity, which I had intended to take, regardless of additional questions. But I certainly do not consider these stalling.

On the topic of construction, I had raised three issues with the VA. The Leavenworth VA has, for a long time, had a plan to do a public-private partnership. I would encourage you to take a look at that project. The Johnson County CBOC, that is the suburbs of Kansas City, groundbreaking in March, we do not yet know what kind of services that CBOC is going to provide, if you could help us answer that question.

And then finally, for a long time, going back to my days in the House, there was a DOD VA joint project between McConnell Air Force Base and the Dole VA in Wichita for a new facility that apparently has fallen through the cracks.

It has been a priority on-again, off-again for a long time, and I would appreciate being updated on those three items.

Secretary SHULKIN. Yes. I would be glad to do that.

Senator MORAN. I want to come back and talk about Choice, but let me first turn to the Senator from Alaska.

Senator MURKOWSKI. Thank you, Mr. Chairman. And sorry that I have been popping in and out.

Dr. Shulkin, thank you for being here. I am sorry that I was not able to hear your comments regarding Choice. I will ask you a couple. But before we do that, I want to talk about Wasilla and the Wasilla CBOC and the sad state of affairs. I do not understand why, for 3 years, we have not been able to find a single doctor to permanently support this facility. This is a clinic that should be staffed with two permanent doctors, and we have not been able to keep a single doctor there, and it has been 3 years. And it is not like Wasilla is the end of the road. Wasilla is on the road system. Wasilla is a thriving community.

Becker's Hospital Review rates the Mat-Su Regional Hospital, which is just down the road, as one of the 150 best places to work in health care. The southcentral facility, the clinic there gets rave reviews, has extraordinary professionals. We cannot figure out why we are not able to get a permanent full-time VA physician assigned there.

So, I have to believe that those who are looking at this just think that this is a bad place to be, that the VA is not an employer of choice for potential employees who have a choice. I mean, we have included language in the appropriations bills now for a couple years running. I do not know what to say to either the VA senior

leader who is frustrated. I do not know what to say to our veterans about what the problem is. I just do not get it.

And we have looked at the issues relating to salary and to pay and to benefits and everything else. We cannot get anybody.

Secretary SHULKIN. Yes. Listen, I hope we have a big viewing audience because you made a compelling reason why this is a great place to practice. Of course, you know, I have been up there and I think it is a great place to practice. It is frustrating. I will say that the VA had its recruitment and retention dollars cut in half to pay for the CARA legislation. And that was not helpful to us because we need every tool available to us and every dollar available to us to be able to go out and to recruit physicians.

The last time I was in Alaska, we had three physicians who we brought up there and we lost all three to the private sector. And so it is very competitive, and we are competing directly against really good private institutions that have what seems to be a much greater ability to use recruitment and retention dollars than we have, so we would like to work with you on this.

Senator MURKOWSKI. Well, you know that I am willing to work with you on it, but I am beyond frustrated. I do not know what else we need to do. And again, it makes me think that it is just something systemically within the VA that is chasing good men and women away from these opportunities. And in the meantime, it is our veterans that do not get that level of service.

Secretary SHULKIN. Well, we had a net increase last year of 1,500 physicians. This is one of our priorities. You have given us a new challenge. Listen, I sense your frustration, and it is way too long. And our veterans deserve much better up there. So, let us work on this together. I hope by the next time we sit at a hearing like this, we have filled the position.

Senator MURKOWSKI. I hope we can say that was past tense.

Secretary SHULKIN. Yes.

Senator MURKOWSKI. But I have been thinking that every year now for 3 years.

So, Choice, over the past several years, we have been talking also in these hearings about the Choice program and its shortcomings in the State. You have had an opportunity to visit the State. I think you are familiar with the challenges that the VA faces in delivering health care there. You know we are remote. You know that some of our communities define remote.

I guess, you know, there has been a lot of frustration with how Choice has kind of come about, how it was written quietly behind closed doors, presented at the last minute. Recognizing that there was probably not a—I do not think that there was a transparent process there, recognizing now that we are dealing with Choice 2.0, this major nationwide reform of existing Choice. What do you think? What do you think Alaska's veterans and healthcare providers want to see in Choice 2.0 up in the State? What is achievable? What can we do?

Secretary SHULKIN. Well, first of all, I think Alaska's healthcare system was working well prior to Choice and so—

Senator MURKOWSKI. I think so, too.

Secretary SHULKIN. Yes.

Senator MURKOWSKI. And that has been the frustration.

Secretary SHULKIN. And we heard that loud and clear. There is no question about it. And so because of the national program imposed, I think Alaska took a real hit in its customer service in the step backwards. So, we have been working hard thanks to you and Senator Sullivan who have been making us clear that this has to improve, to change the system back to where it was. And I think that we have gotten pretty close to where we are. We have also signed, as you know, new agreements with the Indian Health Service and the tribal agreements.

And Alaska is unique. There are other parts of the country that are unique. I know Kansas has some challenges in rural areas as well, so what we learned is there is not one model of health care for this country, and every geography needs to have some variation in how they implement this program. And Choice 2.0 allows us for that type of independent geographic customized design for the healthcare system.

Senator MURKOWSKI. Well, and as you point out, we pioneered that. We were doing that in Alaska.

Secretary SHULKIN. Yes.

Senator MURKOWSKI. That is what got the attention of the rest of the country. And you move to that and then you say the only way forward is the way that we design it. You took away—or that flexibility was taken away.

Secretary SHULKIN. Right.

Senator MURKOWSKI. So, again, you know that there is a lot of frustration up north because we have challenges. We are a place that is born and bred to meet challenges with great ingenuity and some enthusiasm. But when we are told basically that this is how it will be done, we know best in Washington, D.C., we are not interested in hearing that. We have been told we are unique so many times we just do not even listen to it anymore. We know we are. We know that we need flexibility. And my hope is that there is an understanding to allow within Alaska the opportunity to define the solutions, as we did pretty well before, and if we can do that, our veterans I think will be in a better place.

Secretary SHULKIN. Yes.

Senator MURKOWSKI. Mr. Chairman, thank you for letting me air-drop in at the end. I appreciate it.

Senator MORAN. Well, I was glad you were here. I was fearful I was going to run out of the opportunity to ask questions.

Mr. Secretary, let me try to bring this hearing to a conclusion with just a bit more conversation about Choice. First of all, I would indicate that what Senator Collins talked about, her ARCH circumstance in Maine is the same circumstance in Kansas.

Secretary SHULKIN. Yes.

Senator MORAN. We are one of those four pilot programs who have been utilizing Community Care. No longer is it eligible. Secondly, in just a more broad conversation about where I think we are, a reason—I guess not the—I suppose this is the reason I suggested to you that you withdraw your mandate that Choice go away, which was the fear that in the absence of Choice, we will have an absence of third-party providers, third-party administrators.

Secretary SHULKIN. Administrators, yes.

Senator MORAN. And so you were in my view wise enough to withdraw that, but it has been replaced with something that yet does not solve the problem of keeping the third-party administrators in place. I do not know what the timeframe is that they will continue or can continue to operate, but I know, based upon what you said, they are losing money.

Secretary SHULKIN. Yes.

Senator MORAN. And there is at least a rumor that they are in the process of notifying their employees that their employment may come to an end. And so, you know, primarily what we are here about is veterans, so I am not here on behalf of the third-party administrators, but in their absence, I do not know how we have a Choice program that works for veterans.

Your response to the Senator from North Dakota about community-based care was we are going to pursue this in long-term reauthorization of Choice. I am interested in that. I am for that, and I am part of the effort to make sure that Choice is reauthorized in the long term, but I am worried that we are not going to have anything in place; we will be starting from scratch and Choice will disappear.

Secretary SHULKIN. Well, I think we all agree if we act quickly—and I want to be part of the solution. I know you do, too. I truly thank you for raising this to the type of urgency to resolve this as it deserves. And you were the first one to reach out and say that this needs to be resolved.

We need to do this quickly because I do not want to see the third-party administrators take their networks down. But more importantly, and I know you agree with this, we do not want to see veterans at all impacted by our inability to manage budgets. This is not the veterans' fault. This is the fact that we have financial systems that are very difficult to maneuver and to get correct in these last couple months of the budget year. I believe we have two ways to approach this, and I am willing to work with you on either way, as long as we can work on it quickly, because, inevitably, I think we all agree it needs to be done, so we might as well do it sooner rather than later so that we do not have unintended consequences.

Senator MORAN. Well, is there a way in the interim that you can return to providing more guidance to your VISNs to continue using Choice beyond

Secretary SHULKIN. Well. Beyond the statutory? I do not feel comfortable asking them to return to a Choice-first policy because I now have less than \$800 million of unobligated funds in that account. And I can do the math that that will not make it till October 31, so I am trying to be responsible and make sure that we do not get to a point where we just have to stop the Choice program. That would be even worse than where we are now.

Senator MORAN. I think you testified today that the date is now August the 7th?

Secretary SHULKIN. Yes.

Senator MORAN. And I think the last time we talked, it was August the 15th?

Secretary SHULKIN. August 7, August 15, I wish I could be that precise that it mattered. I mean, it is mid-August.

Senator MORAN. So there is not some new factor, some——

Secretary SHULKIN. No. No, no, no.

Senator MORAN. It is still in the same ballpark.

Secretary SHULKIN. In fact, extending it so that I did not mean to shorten it on you.

Senator MORAN. Should be going?

Secretary SHULKIN. It probably is actually longer than when we had talked about.

But, you know, it does not reach till October 31–September 30 and so we do need to do something different.

Senator MORAN. So what is missing in getting this resolved? When you and I say I want to work with you and you say you want to work with me, what is not happening that moves this process to a quick resolution?

Secretary SHULKIN. Yes. I would say to you that if you and your colleagues have a preferred path to go down, we would like to work with you on that.

Senator MORAN. And you have had that conversation with the leadership of the authorizing committee?

Secretary SHULKIN. Yes, I have.

Senator MORAN. Okay. And is there something that we could assure ourselves that if we go down that path that the administration, OMB, the White House would say we support that effort?

Secretary SHULKIN. Yes, we are in discussions with OMB. I had breakfast with the chairman of the authorizing committee this morning, and he is certainly supportive of resolving this. And we are in discussions with OMB and the administration making sure that they understand where our discussions are. I think all of us, all the way up to the President, want to see this resolved.

Senator MORAN. But the administration has not chosen one of those options or another one that we have not talked about?

Secretary SHULKIN. No.

Senator MORAN. Okay. Mr. Secretary, it is always my practice to give you or any of your team the opportunity to tell us anything that we did not ask you or did not talk about or you want to modify or correct to improve my understanding.

Secretary SHULKIN. I think we are all ready to go home.

Senator MORAN. You know, you indicated this could be a long hearing with the two of us having a conversation.

Secretary SHULKIN. Yes.

Senator MORAN. I think almost every member of the subcommittee was here. It demonstrates the importance of the Department of Veterans Affairs to our constituents and to our country, and it indicates a significant interest in your success in leading the Department of Veterans Affairs. We want you to succeed and we want to help you accomplish that.

Secretary SHULKIN. The only thing I would like to add besides thanking you for those last comments is that one thing that I think that veterans across the country appreciate and certainly we do at VA is the bipartisan nature in which issues with veterans are approached. And we know increasingly how difficult that is in the environment, but when it comes to VA, we have seen you act in a singular fashion in veterans' interests, and we hope and believe that is really important to continue.

Senator MORAN. In my time in Congress, those arenas in which that bipartisanship still exists and works well has diminished. There used to be a larger array of areas.

Secretary SHULKIN. Yes.

Senator MORAN. We certainly would not want to lose that in this setting.

Secretary SHULKIN. Thank you.

Senator MORAN. Again, I appreciate you being here, and I again look forward to working with you on issues of concern for our veterans and our country.

ADDITIONAL COMMITTEE QUESTIONS

I would ask that members of the subcommittee who have any questions for the record, they should turn them into subcommittee staff no later than June the 28th.

QUESTIONS SUBMITTED BY SENATOR MITCH MCCONNELL

Question. I welcomed our recent discussion regarding the status of the new Louisville VA Medical Center, and I look forward to another update in the near future. In the meantime, can you please provide an updated timeline for the design, construction, and completion of the facility? This project was announced in 2006, and Kentucky's veterans have had to wait for too long to begin receiving care at this new facility.

Answer. Design of the replacement Robley Rex VA Medical Center (VAMC) in Louisville, Kentucky, is ongoing. As outlined in the final Environmental Impact Statement (EIS) for the replacement VAMC project, VA identified the Brownsboro Road site as the preferred alternative for the project. VA has not changed the preferred alternative site at this time. The Record of Decision (ROD), which is the final step of the EIS process, is undergoing VA's review. Once the ROD is finalized, VA will then move forward with completion of the design, which is projected for 2018. VA construction of the replacement facility is dependent on funding availability, and will be decided in future budget submissions.

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

Answer. VA is enhancing facilities, training healthcare staff, and improving access to services to meet the current and future healthcare needs of women Veterans. More than 400,000 women Veterans are currently enrolled in the VA healthcare system.

We understand that women Veterans have unique health needs. Women Veterans can receive primary care, specialty care, and preventive care, such as breast and cervical cancer screenings. They can also get prenatal and maternity care, prescription coverage, mental healthcare, home healthcare, and geriatric and extended care, as well as medical equipment and prosthetics coverage.

Subject to the availability of funding and future budget submissions, it is anticipated that the new Louisville VAMC replacement hospital will include a Women's Health Clinic with four Patient Aligned Care Teams (PACT). The clinic is planned to include a dedicated reception and waiting area, gynecology examination rooms with private restrooms, general examination rooms, TeleHealth examination rooms, PharmD consultation/examination, behavioral health consultation, nutritional consultation, a phlebotomy laboratory, a procedure room with a private restroom, and an imaging suite. The imaging suite is planned to include equipment needed for women's healthcare including Ultrasound, Bone Densitometry, and Mammography. In addition, the Women's Health Clinic is planned to have dedicated support space for all assigned staff. For cases in which a woman Veteran would like to see a provider not assigned specifically to the Women's Health Clinic, all other PACT modules are expected to include gynecology examination rooms with private restrooms.

Question. To assist the VA as it continues with reform efforts to improve and expedite care for our nation's veterans, Congress recently passed and the President signed into law the Department of Veterans Affairs Accountability and Whistle-

blower Protection Act of 2017. This bill authorizes the creation of a new Office of Accountability and Whistleblower Protection and provides new authority for additional accountability measures. Will you please provide a timeline of the VA's plans to implement these new authorities to ensure that veterans receive the quality care they deserve and bad actors are held accountable?

Answer. The Department is working to satisfy the requirements of Public Law 115-41, the "Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017" signed into law in June 2017.

OFFICE OF ACCOUNTABILITY AND WHISTLEBLOWER PROTECTION (OAWP)

On May 25, 2017, following an Executive Order signed by President Trump, OAWP was established. By June 12, 2017, employees of the former Office of Accountability Review were realigned to OAWP.

OAWP is headed by a politically-appointed Executive Director, who is working on establishing OAWP, commensurate with the law.

OAWP has also developed a website: <https://www.va.gov/accountability>. Whistleblowers may also now make a disclosure to OAWP by email at vacoaccountabilityteam@va.gov; fax at 202-495-5601; and toll-free hotline at 866-429-6669.

Other key actions for implementing the authorities are as follows:

On or around July 6, 2017, the Secretary issued VA policies implementing the accountability authorities provided under the Act, including 38 United States Code (U.S.C.) § 713, as amended, 38 U.S.C. § 714, and the revised timelines and procedures for Title 38 employees provided for under the Act. VA has and continues to provide training to managers and senior executives on the accountability authorities and the implementing policies.

The other accountability measures as outlined in Title II of the Act are under review and will be implemented.

Question. Mental health issues remain a significant challenge for many veterans. What programs are in place to assist and support veterans suffering from mental health issues, particularly as they may relate to suicide prevention? Are there any additional authorities that the VA needs from Congress in order to provide effective treatment and care to veterans suffering from mental health issues?

Answer. The VA Fact Sheet below provides information regarding many of VA's mental health services.

MEDICATION-ASSISTED TREATMENT FOR OPIOID USE DISORDERS

Question. As you may be aware, the opioid and heroin epidemics have hit Kentucky particularly hard and continue to be a challenge for many veterans. What programs have been implemented by the VA to treat substance use disorders, and particularly opioid abuse, by veterans? What programs have been most effective in providing successful treatment to veterans?

Answer. The Veterans Health Administration (VHA) has responded to growing demand for opioid use disorder treatment by increasing access to Medication-Assisted Treatment (MAT). MAT includes counseling or psychotherapy; close patient monitoring; and medication using buprenorphine/naloxone, methadone (administered through an Opioid Treatment Program), or extended-release injectable naltrexone. Buprenorphine/naloxone and extended-release injectable naltrexone are on the VHA National formulary. These are available at VHA facilities and through non-VA purchased care options in the community. Methadone is administered and dispensed through 32 VHA Opioid Treatment Programs across the Nation and through non-VA purchased care options at many facilities.

VHA has been expanding access to MAT for patients with opioid use disorders. In the year ending in the second quarter of fiscal year (FY) 2016, VA treated 23,117 patients with MAT, up from 19,333 patients in the year ending in the fourth quarter of fiscal year 2014, a 20-percent increase in patients treated in just 1 and a half years. This expansion is the result of a comprehensive and integrated approach. The Buprenorphine in VA Initiative provides clinician education through monthly webinars, newsletters, a SharePoint site with educational resources, individual consultations, and a national community of practice supported by an e-mail group. The Psychotropic Drug Safety Initiative (PDSI) combines use of informatics tools and a national quality improvement collaborative to improve the evidence-based use of psychotropic medications. One of the PDSI program's many impacts has been significantly increased rates of using opioid agonist therapy among Veterans with Opioid Use Disorder. In addition, VA Pharmacy's Academic Detailing service is de-

veloping an Opioid Use Disorder campaign using informatics tools and individual provider support to increase Veteran access to MAT.

VHA offers several medication assisted treatments for opioid use disorder. Opioid Agonist Treatment includes prescription of methadone or buprenorphine delivered either in a licensed clinic or office-based setting, as well as injectable depot naltrexone.

OPIOID SAFETY

VA has implemented a number of programs to address the epidemic of opioid related adverse events.

1. The VA's Opioid Safety Initiative (OSI) was implemented nation-wide in August 2013, and is producing the intended results. The basis for OSI is to make the totality of opioid use visible at all levels in the organization. OSI includes key clinical indicators, such as the number of VA pharmacy users who have been dispensed an opioid, the number of VA pharmacy users receiving long-term opioids who also receive a urine drug screen, the number of VA pharmacy users receiving an opioid and a benzodiazepine (which puts them at a higher risk of adverse events) and the average morphine equivalent daily dose of opioids. Overall, VA has seen a 30-percent reduction in the number of Veterans who have received opioids for greater than or equal to 90 days.

2. VA deployed two state-of-the art tools to help providers manage risk for Veterans receiving opioids. These tools are available now to all staff in VA facilities.

The Opioid Therapy Risk Report (OTTR) is a national dashboard to help primary care teams manage Veteran patients on long term opioid therapy. It includes information about the dosages of opioids and other sedative medications, significant medical problems that could contribute to an adverse reaction, and monitoring data to aid in the review and management of complex patients.

The Stratification Tool for Opioid Risk Mitigation (STORM) was designed to identify higher risk patients receiving opioid prescriptions for proactive care management and review. STORM incorporates predictive models to estimate the risk that a patient with an opioid prescription will experience a suicide-related event or overdose, respiratory depression event, or an accident or fall. STORM generates a nightly-updated report, including: current risk estimates, a list of clinical and prescription risk factors, a tailored checklist of recommended risk mitigation strategies, and information for care coordination. STORM can also provide risk estimates for any VHA patient considering opioid therapy, estimating their risk of adverse events if they were to initiate a low, medium, or high dose trial of opioid medication. These estimates can help guide risk-benefit discussions and shared decisionmaking regarding pain management plans.

3. VA has implemented the Opioid Overdose Education and Naloxone Program. As of March, 2016, VA had dispensed over 70,000 naloxone kits to Veterans.
4. VA has implemented the Psychotropic Drug Safety Initiative to foster quality improvement efforts for mental health prescribing. PDSI includes efforts to increase access to pharmacological treatments for substance use disorder, and reduce prescribing of benzodiazepines.

Question. The Army is in the process of replacing the Ireland Army Community Hospital (IACH) at Fort Knox with a new facility. Will you please provide an update on the VA's plans to replace the Fort Knox VA facility currently located at the IACH, and what are the VA's plans to ensure area veterans see no disruption in care currently provided at this facility?

Answer. The VA Community Based Outpatient Clinic located at Fort Knox, Kentucky, is responding to the Army's Plan to build a new healthcare facility that will replace the existing Ireland Army Community Clinic. Currently, VA occupies space, via a sharing agreement, within the existing Ireland Army Community Clinic. The new project will consist of a site that is 4.1 acres in area adjacent to the new Army health facility. The project is planned to be an 18,134 gross square feet facility, and offer primary care and mental health services to Veterans in the Fort Knox area.

VA's current project schedule anticipates the design build "Request for Proposal" to be solidified by August 2017, with a construction contract to be awarded by December 2017.

The project was awarded to the Army Corps of Engineers in order to coordinate both projects and ensure seamless transition from the existing site to the new site

of care. In collaboration with the Department of Defense (DoD)/IACH to support care process transformation, the services have 1 year to move the clinics prior to DoD's readiness for demolition of the existing IACH. VA foresees no disruption in care at Fort Knox VA Clinic.

Question. Your recent announcement regarding the VA's decision to transition to the same Electronic Health Record system used by the Department of Defense (DoD)—referred to as MHS GENESIS—was welcome news to many veterans. Can you please provide a timeframe for proceeding with this transition, and how will you ensure that veterans' health records are protected during the process?

Answer. The Electronic Health Record (EHR) modernization effort is anticipated to take several years to be fully complete, and will continue to be an evolving process as technology advances are made to provide seamless care for Veterans. VA is in the midst of focused negotiations to finalize a contract.

NOW	Secretary signs D&F directing use of the Cerner EHR in support of seamless care with DoD.
NEAR	VA to solidify its EHR capabilities requirements in coordination with DoD to promote adherence to a single common system.
FUTURE	VA will transition to a state-of-the-market EHR solution with the appropriate governance and change management mechanisms firmly in place.

Safeguarding Veterans' personal information will remain of paramount importance as VA plans for a multi-year transition effort. Once an EHR contract is in place and an implementation approach is established, we will have more information to share.

QUESTIONS SUBMITTED BY SENATOR BRIAN SCHATZ

MEDICAID

Question. The President's budget assumes hundreds of billions of cuts to Medicaid. According to a recent study released last month by Families USA and Vote Vets, about 1.75 million veterans have Medicaid as a source of health coverage, and about 340,000 veterans receive coverage through the ACA's Medicaid expansion.

Has the VA forecasted what a cut of this magnitude to Medicaid would do to VA's utilization rates or costs?

Answer. Although we are closely monitoring policy discussions, the impact on utilization and costs is unclear until more information is known about the final version of the healthcare reform bill and how the states may react to changes in Federal policy.

Question. Secretary Shulkin, you are a clinician with years of experience running healthcare systems. In your view, do you believe that significant cuts to Medicaid will have an impact on the number of veterans seeking and relying on care through the VA's healthcare system?

Answer. The Department of Veterans Affairs' (VA) primary concern for Veterans healthcare is that Veterans retain access to quality healthcare throughout the country, along with financial support for that care where needed. VA would be concerned about any policy changes that negatively affect health insurance coverage for Veterans, including those currently reliant upon Medicaid for their healthcare. These Veterans, typically those with a relatively lower income, may have few if any other means to pay for their care if they lose Medicaid coverage.

Question. Does the fiscal year 18 budget request assume any new costs due to an increase in veterans coming to the VA system because of cuts to Medicaid?

Answer. The fiscal year (FY) 2018 budget request was based upon current policies. Since changes to Medicaid have not been implemented, the fiscal year 2018 budget did not include costs due to pending healthcare reform proposals.

ELECTRONIC HEALTH RECORDS

Question. You recently announced that VA would move to purchase the same electronic health record as DoD. If done right, implementing an electronic health record has the potential to be transformational. However, your current platform, Vista, is an integral part of almost everything VHA does—including telehealth. In short, this is more than just an EHR procurement; it's a culture change which will impact current work patterns and management.

Leaving the technical requirements aside, what are you doing to engage with clinicians and other healthcare workers now to ensure you have buy-in by the end of this process?

Answer. The current Electronic Health Record (EHR) modernization effort is anticipated to take several years to be fully complete, and will continue to be an evolving process as technology advances are made. The input from multi-disciplinary clinical teams from VA will be central to how VA implements the new EHR system. We are standing up an inter-agency Governance board to maintain a single common EHR solution between VA and the Department of Defense (DoD) to drive VA's requirements for implementation and to work jointly with DoD to keep the two agencies in sync for seamless care.

VA's longstanding history in field-based IT innovation will be leveraged and clinicians and healthcare workers have already begun engaging at various levels with the modernization effort. Development, technical, and clinical staff with experience in VistA/CPRS and other clinical applications will be central to the EHR modernization effort. VA encourages and recognizes the need for employee engagement and support as we prepare for this substantial organizational change.

Question. How are you engaging with DoD to ensure that you can leverage their expertise in acquisition and learn from their experiences?

Answer. VA and DoD are committed to partnering in this effort and understand that the mutual success of this venture is dependent on the close coordination and communication between the two Departments. To that end, DoD is making available current and former senior acquisition, testing, and project management experts who were instrumental in the beginning phases of DoD's own transformation to assist VA with contracting and initial implementation. This will allow VA to capitalize on the experience and expertise of individuals who supported previous modernization and EHR implementation efforts, including adopting DoD's best practices and lessons learned through the requirements and acquisition phase.

Moving forward, VA has established a dedicated Program Executive Office (PEO), which will be staffed with VA's most knowledgeable technical and functional subject matter experts in contracting, health IT, and business innovation. The newly established PEO will be led by the former DoD EHR Program Manager who successfully led the acquisition of the DoD EHR solution and related services. Hence, the lessons learned from DoD's past efforts will be applied throughout the various stages of the VA acquisition and implementation processes.

Question. To what extent, if any, will Vista remain in use at the VA and how will that impact telehealth platforms that tie information back to Vista?

Answer. The new EHR system will bring needed modern functionality and infrastructure integrated into a single experience with fewer products. This will help simplify healthcare delivery for both Veterans and clinical providers. The EHR will be designed to accommodate the aspects of healthcare delivery that are high priority or unique to VA, while bringing industry best practices to improve VA care. As VA plans for a multi-year transition effort, VA will continue to use existing clinical systems and identify which of the existing associated applications and which VistA modules, in addition to all the clinical ones, will be replaced. The impact of telehealth as it relates to EHR modernization is still being determined. Once an EHR contract is in place and an implementation approach is established, we will have more information to share.

Question. On the budgetary side, clearly your decision was made after the fiscal year 2018 budget was developed. When do you expect to know overall costs and schedule?

Answer. VA is in the midst of focused negotiations to finalize a contract. Though the contract negotiations will likely take 3–6 months, PEO EHRM should be able to offer an anticipated budget request in September to support funding requirements and alignment to support the anticipated contract award and related Electronic Health Record deployment schedule and implementation functions. Once an EHR contract is in place and an implementation approach is established, we will have more information to share.

Question. Are there specific funds in your fiscal year 18 budget that are currently identified for modernization projects that are now no longer needed—and if so, do you plan to move that funding over to your new acquisition plan in fiscal year 2018?

Answer. As part of the overarching EHR Modernization effort, Veterans Health Administration (VHA) and the Office of Information & Technology subject experts are evaluating modernization efforts that are currently underway with the goal of determining which efforts will continue, be paused, or be cancelled. VA will also be examining our overall contracts portfolio in the coming months to assess capability gaps in support of acquiring and implementing a commercial EHR. Once an EHR

contract is in place and an implementation approach is established, we will have more information to share.

GRANTS FOR THE CONSTRUCTION OF STATE EXTENDED CARE FACILITIES

Question. One of VA's most popular programs with States is the grant program for construction of State extended care facilities. Before a project is eligible to receive a grant the State must provide 35 percent in matching funds. In my home State, we have one project, construction of a new 120 bed facility in Honolulu, which has received matching funds and is currently on the priority one grant list. While I am encouraged that the project made it on the priority one list and is now eligible to receive a grant, it is nevertheless concerning that the amount being requested by the Department for the program falls severely short of what is needed to meet demand. In fact, the VA is only requesting \$90 million for this program, despite having more than \$600 million in priority one grant applications in fiscal year 2017 alone. These are projects that have met the requirements of the program and have State matching funds.

Can you please describe how the budget is developed for this program—especially given that demand is so high, yet the request is barely enough to make a dent in the priority list?

Answer. VA's priority for the Grants for Construction of State Extended Care Facilities is to protect Veterans from those conditions that threaten the lives and safety of residents in existing facilities. In addition to funding, VA also needs different types of strategic partnerships to be able to bring the type of facilities that we need to Veterans, and that means working with local government, with academic affiliates, other Federal agencies, and private sector partnerships.

VA establishes a priority list of applications for State home grants each fiscal year. First priority is provided to feasible applications where States have provided sufficient State funds so that the project may proceed upon award of the grant. The first priority is further prioritized as follows: (1) Remedies for life/safety deficiencies; (2) States that have not previously applied for a construction grant for a nursing home; (3) Great need for beds in a State; (4) Renovation other than (1); (5) Significant need for beds in a State; and (6) Limited need for beds in a State. After VA receives the annual appropriation for the State Home Construction Grant program, projects are funded in the order of priority ranking on the list until Federal funds are spent.

TELEHEALTH

Question. Earlier this year, this Subcommittee held a hearing on VA's telehealth program. As I mentioned at that hearing, VA has long been a leader in leveraging telehealth technology to provide better access to veterans. In fact, this is an area where I believe the Department far exceeds what is happening in the private sector.

Given VA's past successes, how is the Department looking to expand telehealth and remote patient monitoring in fiscal year 2018?

Answer. VA has multiple telehealth expansion plans that will enhance VA healthcare accessibility and the Veteran's experience including VA Video Connect, which provides secure web-enabled video visits, and regional telehealth clinical resource hubs offering telehealth providers to fill temporary or longer term service gaps for primary care, mental health, and specialty care services.

With its new Home Telehealth (HT) technology contracts in 2017, Veterans have even greater flexibility for innovative HT solutions to include tablets, mobile monitoring applications, and video—to add to the already established HT solutions like hub devices, interactive voice response, and web-enabled browser technologies. With these additional solutions for case management, VA plans to expand HT to Veterans who are more tech-savvy and looking for more flexible and portable options. Additionally, these tools will be used to expand the Low Acuity/Low Intensity monitoring program that offers another level of case management for Veterans who need less assistance than currently provided by HT, but more coaching, guidance, and monitoring than a mobile self-management application would provide.

Question. What, if any, help do you need from Congress to bring telehealth into veterans homes?

Answer. On August 3, 2017, the Secretary announced VA is beginning to implement nationally VA Video Connect, a software solution that facilitates the delivery of real time video communications on personal computers and mobile technologies (phones, tablets). This new technology will enable VA to more easily deliver services at locations most convenient for Veterans, be it in their homes or any other secure location where they have their mobile technology. VA still needs to establish the unambiguous authority for providers to deliver VA clinical services to Veterans irre-

spective of the provider or Veteran's locations. Considering the critical priority assigned to this need and its direct relation to expanding clinical services, VA has pursued all known avenues to establish this authority. VA expects to issue a notice of proposed rule-making in the fall of 2017. Depending on public comments, VA expects to have a final, legally effective rule in early fiscal year 2018.

While VA is using its existing authority to amend its regulations in consideration of telehealth, it still believes that a clear statement in statute of Federal Supremacy by Congress would be the ultimate protection for providers and could expand VA's authority to deliver comprehensive Telehealth services to Veterans in any location. Currently, VA providers delivering telehealth across State lines have no clear protection from the enforcement of State laws that require local licensure or limit the practice of telehealth. VA needs legislation that explicitly authorizes VA providers to care for Veterans using telehealth irrespective of the location of the provider or Veteran.

HILO CBOC

Question. The VA Pacific Island Health Care System has proposed a new one-stop-shop style CBOC for Hilo. As I mentioned at the hearing, the project has been in the VA's SCIP pipeline for years despite the fact that the existing CBOC in Hilo has to move because it is in a tsunami risk area. The VA has leased a temporary space in an industrial part of Hilo that it is building out and plans to move into next year, but veterans tell me that it is hard to get to, and too many of them will not utilize this space once the VA moves there.

What is the status of the VAPIHCS's proposed one-stop-shop CBOC for Hilo and when does the VA expect to fund this project?

Answer. Fiscal year 2018 was the first year that the Hilo CBOC minor construction project was submitted and scored through the Strategic Capital Investment Planning (SCIP) process. Prior to this, the project was listed as a potential out year project in the facility's long-range plan. Out year projects are not considered for funding request purposes. While the proposed CBOC is a valid requirement, the project was not approved for funding in 2018. Due to limited resources, VA had to prioritize projects. This included emphasizing VA's non-recurring maintenance program over other construction programs, including minor construction. The majority of VA's fiscal year 2018 minor request is directed towards completing the backlog of previously-started minor construction projects. VA requested funding for only six new minor projects in the fiscal year 2018 budget. VA plans to consider the Hilo CBOC project in future budget years.

Question. To what extent does the SCIP process consider the impact on access to care for veterans that would utilize a new project as compared to the status quo when it is prioritizing proposals?

Answer. SCIP business cases for new capital investments are submitted for prioritization, and must address how a project will meet an identified performance gap(s), including deficiencies in access, space, utilization, and condition. Potential alternatives to meeting needs include leasing, new construction, renovation, contracting out, and purchasing an existing facility. If a performance gap exists, status quo is not a viable option. If there is no performance gap identified, then status quo would be an acceptable course of action. Minor gaps may be met by maintaining the status quo, and supplementing by other available means.

SUBCOMMITTEE RECESS

Senator MORAN. This hearing is now adjourned.

[Whereupon, at 4:29 p.m., Wednesday, June 21, this hearing is concluded and the subcommittee was recessed, the reconvene subject to the call of the Chair.]