THE FISCAL YEAR 2014 BUDGET FOR VETERANS AFFAIRS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED THIRTEENTH CONGRESS

FIRST SESSION

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APRIL 15, 2013

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C O N T E N T S

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APRIL 15, 2013

SENATORS

WITNESSES

APPENDIX

THE FISCAL YEAR 2014 BUDGET FOR VETERANS AFFAIRS

MONDAY, APRIL 15, 2013

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

The Committee met, pursuant to notice, at 2:30 p.m., in room 418, Russell Senate Office Building, Hon. Bernard Sanders presiding.

Present: Senators Sanders, Rockefeller, Tester, Begich, Blumenthal, Hirono, Burr, Isakson, Johanns, Moran and Boozman.

OPENING STATEMENT OF HON. BERNARD SANDERS, CHAIRMAN, U.S. SENATOR FROM VERMONT

Chairman SANDERS. OK. We have got a lot of work, so let's get the hearing underway.

And I want to welcome everyone to this afternoon's hearing on the fiscal year 2014 budget and the fiscal year 2015 advanced appropriations request for the Department of Veterans Affairs.

Earlier this year, as I think we will all recall, we heard from nearly all of the veterans service organizations. These groups shared with us their priorities which reflect the needs of the men and women who have served our country. I want to thank all of the service organizations not only for the important testimony but for the great work they do every single day, protecting the interests of America's veterans.

If there is anything that many of us have learned in recent years, it is that the real cost of war is far, far greater than simply paying for the tanks and guns and planes and the manpower to fight those wars. I believe that we now understand more fully than we have in the past that soldiers who come home from war are often very different people than when they went.

We now understand that the cost of war includes significant care not only for those who lost their legs and their arms and their eyesight but for those who came home with what we now call the invisible wounds of war. Most recently, this includes the hundreds of thousands of brave soldiers who returned from Iraq and Afghanistan with Traumatic Brain Injury and Post Traumatic Stress Disorder.

So, while this $152 billion budget we discuss today is a complicated document with a whole lot of numbers, it all comes down to how the people of our country, through their government, honor their commitments to those who have sacrificed so much and to the spouses and children who have often also sacrificed.

In their testimonies, the VSOs discussed many of the important and positive things that the VA does, which sometimes we over-look, but let me talk a little bit about what the VSOs discussed.

In terms of health care, in a nation with over 45 million people lacking any health insurance and at a time when the cost of health care in this country is far higher than any other country on earth, the VA is recognized by many as providing excellent quality health care in a cost-effective way to those who have served our Nation. Like every other health care organization, the VA can do better—and it must do better—but most will agree that the VA has come a very long way in the last 20 to 30 years in terms of health care.

In terms of another important issue—homelessness. At a time when too many Americans and people in my own State of Vermont are sleeping out in the streets or in their cars, the VA has under-taken an aggressive and successful effort to significantly reduce the number of homeless veterans in our country. Since 2009, there has been a 17 percent decline in veterans homelessness despite the tough economy. That is the good news. The bad news is that there were still more than 62,000 homeless veterans in January 2012.

The VA must sustain its positive efforts in combating veterans homelessness. Progress is being made; more must be done.

Through its world-class research program, the VA is making sig-nificant advances in health care not only for veterans but for the entire country. That progress must continue.

The VSOs, while praising the VA in many areas, also highlighted the significant challenges and problems that continue to confront veterans of all generations, and I agree with many of their con-cerns. Among many other issues, they spoke of the obligation to ad-dress the tragic number of servicemember and veteran suicides. This is a horrendous tragedy. It is a tough issue. We have got to address it.

Further, the need to accelerate the transformation of the com-pensation claims system in order to deal with the unacceptably long delays that we are now seeing and the huge backlog in cases—if there is any issue that I think veterans and the veterans commu-nity are concerned about, it is that issue, and I share that concern.

While the VA is now processing far more claims than ever before, the movement to a paperless and efficient system must be com-pleted on schedule. I know we will be discussing that issue during this hearing.

Further, the responsibility to make smart investments in infra-structure and information technology systems to ensure that the VA can continue to provide the care and benefits veterans have earned is a major issue. This means—and this, again, is a huge issue which this Committee will delve into—a significant improve-ment in the relationship between the VA and the Department of Defense. We may be dealing with two separate agencies, but we are dealing with one human being who goes through the DOD into the VA.

I believe that this year's budget request, especially within the overall budget restraints facing Congress, again reflects a strong commitment by this Administration to provide veterans and their families with the care and benefits they deserve.

This year's total budget request is $152.7 billion—$86.1 billion for mandatory entitlements and $66.5 billion for the discretionary account. This is a 10.2 percent increase over last year's enacted amount.

While the VA budget presented by the Administration is a strong one, and I applaud the President for that, I remain deeply disappointed that the White House included in their budget request the so-called chained CPI. Switching to a chained CPI would mean major cuts in Social Security and the benefits that disabled veterans receive. Veterans who started receiving VA disability benefits at age 30 would have their benefits reduced by $1,425 at age 45, $2,341 at age 55 and over $3,000 a year at age 65—tens of thousands of dollars within their lifetime. This, to my mind, is unconscionable, and I will do all that I can to prevent these cuts from taking place.

When it comes to the issue of funding for suicide prevention, the budget is literally a matter of life or death. Ensuring timely access to high quality mental health care is critical for our veterans and their loved ones. To that end, I am pleased to see the President's budget recommendation calls for a 7.2 percent increase in funding for mental health.

At our last hearing, when we discussed the issue of mental health and suicide, Dr. Petzel testified that the VA is on track to hire the 1,600 mental health clinicians called for in the President's Executive Order by the deadline of June 30. As I noted at that hearing, I remain concerned that the VA has hired just 47 clinicians in the 2 months prior to that hearing. I understand VA must ensure that they are hiring high-quality clinicians, but VA must pick up the pace of hiring if it intends to meet its goal of 1,600 new clinicians by the end of June of this year.

When hiring these clinicians, the VA must recognize that individual veterans respond differently to different treatments and not all veterans respond well to traditional therapies. I appreciated Senator Boozman at our last hearing raising the important issue of over-medicating veterans seeking mental health treatment. I share that concern, as I believe do many Americans.

I also know that many veterans respond positively to complementary and alternative medicine. As the name indicates, such treatments—which include therapies such as acupuncture, guided imagery, meditation, chiropractic care and yoga—can be provided in conjunction with traditional care or as stand-alone care. I commend the VA's top leadership for embracing these therapies but worry that that interest has not penetrated all levels of the VA health care system. VA must do a better job to make sure that these therapies are available to all interested veterans.

In terms of the claims backlog, the fact that nearly 70 percent of claims are pending longer than 125 days is completely unacceptable as is the fact that it took, on average, 287 days to complete a compensation rating claim in 2012.

The inability to provide compensation benefits in a timely manner tarnishes VA's reputation among the very population it serves. I never want a veteran's negative experience with the claims system to prevent him or her from seeking mental health care or help in battling homelessness.

Mr. Secretary, I see your testimony reiterates VA's goal of eliminating the claims backlog by 2015. VA has set ambitious goals, put forward a plan and has been working hard to transform the system.

I think we can all agree that the VA took too long to start transforming itself from a paper-based to electronic system. Clearly, that effort should have begun a decade ago, or longer, and not just 4 years ago. Yet, despite these facts, one must certainly understand how it is difficult for the average person to believe VA is making progress when we continue to see the unacceptably long wait times faced by veterans and their survivors in obtaining benefits.

VA must do a better job of showing not only the Congress but also veterans and their survivors about how VA plans to accomplish their ambitious goals. And I look forward to working with you to establish benchmarks which will allow us to see the progress, or lack of progress, that VA is making in this vitally important area.

VA must be able to construct, repair, or lease the physical infrastructure necessary to provide the high-quality care that veterans deserve. Yet, for the fourth year in a row the President's request has been out of touch with the realities on the ground. Adequate funding to maintain VA's aging infrastructure must be a critical part of the discussion on providing quality health care.

Further, the fiscal year 2014 budget request includes another 13 major medical facility leases but does not include funding for the full cost of authorizing these leases despite the challenges Congress is still working to surmount. This is an issue I would like to address later today.

Last, let me repeat; the importance of information technology cannot be understated as VA seeks to deliver the care and benefits that our veterans deserve in a more efficient and effective way. I think the bottom line is there must, must, must be much better cooperation between the DOD and the VA.

So let me conclude my remarks by thanking the Secretary and his staff for being with us today. The issues that we are going over are of enormous importance to millions of veterans and the American people. I look forward to a very productive hearing.

Senator Burr.

STATEMENT OF HON. RICHARD BURR, RANKING MEMBER, U.S. SENATOR FROM NORTH CAROLINA

Senator BURR. Good afternoon, Mr. Chairman, and Secretary Shinseki, welcome. And to your team, welcome.

Mr. Chairman, thank you for that very thorough opening statement.

As the Chairman indicated, we will be discussing the President's budget request for the Department of Veterans Affairs for fiscal year 2014.

As I have said at past budget hearings, it's important that we provide adequate funding for the VA so that all veterans receive the benefits and care that they have earned and deserve. Yet, along with that funding we must conduct vigorous oversight to make sure programs which benefit veterans are working properly and lead to better outcomes for veterans, their families, and their survivors.

Yet, in looking over the budget request, the lack of consistent predictions and a lack of transparency lead me to question if VA's stewardship of the taxpayers' money is leading to better outcomes.

First, VA has been consistently inconsistent with its workload projections. These changing projections mask whether they have the backlog situation under control.

Second, the unclear accounting practices in the IT budget make it difficult for us to conduct the necessary oversight into these programs.

Regarding claims processing, we all know that the backlog and delays have gotten worse over the past 4 years even though VA has hired more staff, spent millions on IT solutions, and rolled out dozens of initiatives. Today, we will again hear VA assure that despite these trends this situation will be completely under control by 2015; but in my view, this budget provides one more reason to seriously question those assurances.

For starters, the budget reflects that in 2013 and 2014 VA will receive 2.6 million claims and decide 2.5 million. But in the VA's strategic plan for eliminating the backlog, which was sent to Congress less than 3 months ago, VA projected output of 2.8 million claims during those years. That means VA has already lowered its productivity expectations by 12 percent.

As for receipts, the backlog plan estimated that VA would take in 2.7 million claims this year and next year combined, but VA acknowledged it could receive as many as 774,000 additional claims as a result of recent laws. Despite that caution, the budget shows that VA will have even lower receipts in those years than the backlog plan estimated.

The budget also reflects that incoming claims will continue to exceed output during this year and next year, which means that the number of pending claims will continue to grow. In fact, VA now projects that it will have an inventory of roughly 960,000 claims at the end of 2014—about 100,000 more than are pending today.

Compare that with VA's backlog plan, which predicted that the decisions would outpace claims receipts next year, and, as a result, the level of claims would drop to less than 800,000.

Finally, the budget projects that no more than 40 percent of claims will be pending long enough this year and in 2014 to be considered backlogged even though 70 percent of claims are currently backlogged. On the other hand, VA's strategic plan showed a backlog of 68 percent this year and 57 percent next year, just 3 months ago.

Even if VA has updated these estimates based on more recent data, it is difficult to understand how all of these projects could change so dramatically in less than 12 weeks. These fluctuating predictions, together with a history of missed milestones and deteriorating performance, make it extremely difficult to believe that VA has the backlog situation under control.

As I said earlier, another area of concern for me is the ambiguity of the IT projects that are becoming the backbone of operations at VA medical centers and VA regional offices.

Currently, VA has several IT projects that are vital to providing benefits and services to our Nation's veterans. In the President's

request, the Office of Information Technology, or OIT, requested roughly $3.7 billion, a $360 million increase over last year.

There are three areas of concern within the IT budget I believe are worth highlighting.

First, OIT requested $252 million for the IPO for development activities of the iEHR and VLER. How much of this money will be spent on a new strategy of quick wins versus the two initial operating capabilities at two sites in 2014 is a question.

Second, according to the budget justifications, the 2014 allocation for VBMS development is roughly $33 million, which would be a $71 million decrease from fiscal year 2012. However, we are being told that there is another $155 million for VBMS in this budget. Is this additional funding coming from VBA's budget?

Finally, in my questions from last year's budget hearing, I asked about the cost of the new patient scheduling system. VA's response stated that they planned to have a Life Cycle Cost Estimate completed by January 2013.

As of today, this life cycle cost analysis has yet to be received by my office. Since the 2014 budget request has a $30 million allocation for the development of a new scheduling package, I wonder if the life cycle cost analysis has now been completed. [See below for answer.]

This unclear nature of the IT budget stands in the way of Congress's ability to conduct effective oversight into these programs to make sure they are working properly and, more importantly, meeting their milestones. Unfortunately, these inconsistent projections and lack of transparency are becoming the standard operating procedure at VA, which is even more troubling when it is our Nation's veterans that stand to lose the most.

Mr. Chairman, I thank you, and I look forward to spending some time with our panel today.

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. RICHARD BURR FROM OFFICE OF INFORMATION AND TECHNOLOGY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Response: As a follow up to our prior correspondence to Senators Burr and Murray on September 12, 2102, VA provides the following update to its scheduling procurement efforts:

VA will procure a scheduling solution in two phases. In the first phase, currently ongoing, VA is running a risk-reduction contest under the America Competes Act calling for scheduling application submissions. The purpose of this contest will be to reduce procurement and deployment risk. VA will offer up to three prizes for scheduling packages that demonstrate their compatibility with the Open Source version of VA's electronic health record, VistA. Contest submissions are due in June, and VA is scheduled to announce winners in September.

The second phase will include the actual procurement of a scheduling solution. As this risk-reduction activity proceeds, VA will continue working with the Department of Defense and the Interagency Program Office to determine joint requirements and a master development and acquisition plan. The master development and acquisition plan will be based upon an evaluation of contestant responses for proposed functionality and compliance with iEHR architecture.

May 2013

Chairman SANDERS. Senator Burr, thank you very much.
Senator Rockefeller.

STATEMENT OF HON. JOHN D. ROCKEFELLER IV,
U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. Thank you, Mr. Chairman; and I welcome General Shinseki and his staff, as we all do.

I just want to recount to my colleagues that I spent a very, very long time last week talking with General Shinseki about how one takes a 220,000-person agency and gets it to be responsive on all kinds of different issues, many of which have been mentioned today and some more of which I will mention.

The General actually has done a lot of work on management over the course of his life, and training, and he described how he broke the 220,000 down into blocks and then blocks within blocks, all of them to be held accountable, all evaluating themselves, and being evaluated.

The reason I say this is because I really do not know of any job which has such a human poignancy in its work and yet has complexity and bulk at the level that the VA has.

I think you are a superb General of that VA, and I just want to say that. We talked about claims and all the rest of it. I mean, you are really working at it, and I believe that.

Does that give veterans enough comfort? No. But everything in life is a process and the process is either pushed from above or it is not.

As you and I discussed, General, a number of years ago, all of a sudden the VA, medically, went from sort of a not really very, very good place to a really good place. And we both, at the same time, said Ken Kizer.

Ken Kizer had been sitting here on that row for years. I knew his position. I had no idea until he left the effect that he had, which lasts today.

I don't want Johnny Isakson, who is my dear friend, to be mad at me if I say something nice about the President, but I am really struck, Mr. Chairman, by the specificity and directness of the budget increases which the President—with the entire rest of the world claiming every nickel that he doesn't have in this government— what he has done to make your mission more amenable to your leadership, though not in all fields and not with all problems. But he has given a vote of confidence, and more importantly than that, he has spoken very strongly to the veterans.

I do not usually say things like that at hearings, but I just wanted to in this case.

A 10.2 increase percent is huge, you know. We throw those numbers around and soon forget them, but this will not be forgotten.

Nevertheless, I am also very concerned about the persistent problems that have been addressed by the two speakers prior to me— the needs of the rapidly growing veterans community to the backlog in veterans' claims. I am actually not sure whether it is 600,000, or at one point, I heard it was 800,000. In one sense, it does not make any difference. It is too many.

And, yes, you are attacking that crisis. You are bringing in more mental health clinicians. You are meant to have 1,600; I think you have over 1,200. People all over the country—hospitals—are screaming and yelling because you are taking some of their best

people. I say, well done. But the importance of that, as Chairman Sanders indicated, is so incredibly important.

Mental health care is so needed and so recently, powerfully, on the minds of all of us. I think Americans in general, American families, and even Senators as policymakers are capable of seeing those kinds of things.

There is no quick fix for health care, mental health care, claims, or anything else. There is the need for a persistent driving agenda—when the Secretary and his team come to work every day, determined as you are, sir, to make a difference as best you can.

I am disturbed by the fact that this very promising DOD/VA joint effort on IT and other things, which was quite vibrant 7 or 8 years ago, has now kind of been called off. So I want to ask why and what price do we pay, and what can be done?

I would just say to my friends on this Committee that we are very, very lucky to serve here. I've been on here every year that I've been in the Senate, which some may think is 1 or 2 but actually is 28 years. And it is a proud, proud service.

You know, in West Virginia we have so many veterans; every State does. The work is powerful in its poignancy.

I commend you for the work to be done, and I have more questions I want to ask.

Thank you, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Rockefeller.

Senator Johanns.

STATEMENT OF HON. MIKE JOHANNS, U.S. SENATOR FROM NEVADA

Senator JOHANNS. Mr. Chairman, thank you and thank you for calling this hearing on this budget request.

Mr. Secretary, it is good to see you again. One of the things that I appreciate, and I know the other Members certainly do also, is your willingness to stop by our offices and talk to us about the issues that are of concern to us.

I also want to indicate, as a former department head, I understand the complexities of putting together a budget that meets the priorities of the President of the United States. I also understand the challenges in trying to touch all of the bases.

There are many challenges facing the VA. The Chairman and the Ranking Member went through those. I will not take up time this afternoon and go through them item-by-item myself.

There are a couple of things that I did want to mention. The first one is one that I appreciate a great deal. As you know, for some period of time, a number of us have been working on a VA cemetery in the Omaha area. I do want to thank you for including that in the fiscal year 2014 budget request.

There are about 112,000 veterans and their families who currently do not have a VA cemetery within 75 miles that will be very positively impacted. I did not want the start of this hearing to go by without me saying how much I appreciate that.

In addition, I also wanted to mention on a more concerning note, though, is the issue of facilities. As I mentioned, I have gone through these budget efforts, where you are trying to put together the necessary funds and get it passed through OMB, et cetera, and

one of the things that always tends to slip is the capital improvements. It is just the reality of what we deal with. You have real human beings with real human needs that you need to find funding for.

I think about the facility in Omaha, but I do not want this to be just about that facility because I know there are problems all over the country where we are dealing with 1950s-era buildings. Recently, in the Omaha VA they closed the operating suite for much needed repairs. I am sure there are stories that could be told about that kind of thing all across the country.

So, as we go through the hearing this afternoon, I would like to spend a little bit of time on facility needs around the country and how you think we are doing in addressing that because I do believe it is an important issue and, again, I recognize it is an issue that I would suspect slips as the budget gets put together.

With that, I do want to thank you for being here and look forward to your testimony.

Thank you, Mr. Chairman.

Chairman SANDERS. Well, thank you, Senator Johanns.

Senator Tester.

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

Senator TESTER. Yes, thank you, Mr. Chairman.

I want to thank each and every one of you for being here today. I have had a chance to work with, I think, every one of you pretty closely, and I appreciate that.

A special thanks to the Secretary—thank you, General. Thank you for being here and thank you for the work you do.

You have been saddled with a tough job, and you have received some criticism. I just want to say some of it has been pretty unfair criticism, and I think you have done a great job considering the conditions that you are faced with in this position. I appreciate your leadership, and I appreciate your service to the country very much.

Now I will be the first to tell you—and you know this—I do not agree with everything you have done, and there is plenty to improve upon. Yet, I think we have made great strides under your leadership, working with some incredibly complex issues—the cost of war, the men and women coming back from Iraq and now Afghanistan, and the injuries, both seen and unseen, that you have to deal with and your staff has to deal with and everybody on the ground has to deal with.

I can tell you that I have been on this Committee for 6 years and in this Senate for 6 years. I have had numerous meetings around the State of Montana, and I have found one—one—person that does not like VA health care. The rest of them love it. So I just want to say thank you for your work.

This is a $152.7 billion budget. It is a fair chunk of change that invests significantly in our veterans, and we need to make sure that we spend it as effectively as possible. That is our job, and it is your job. We need to proceed in a way that honors our military folks' service, and one that also makes the most sense for the taxpayers as we go forward.

This is an important discussion, whether we are talking mental health or local partnerships or vet vans or Vet Centers or vet cemeteries or homelessness or education. There are plenty of issues to talk about. How we make this budget work for our veterans is going to be critically important.

I want to thank you for being here, and I look forward to the discussion today, Mr. Chairman.

Chairman SANDERS. Thank you very much, Senator Tester.

Now, Senator Isakson.

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

Senator ISAKSON. Thank you, Mr. Chairman.

So, as to not disappoint the distinguished Senator from West Virginia, not only do I acknowledge that the President's budget is a 10 percent increase, but it is $7 billion more than this Senate approved in its budget just a month ago. So he has topped us as well, as to what needs to be done.

I will also point out the fact that unlike a lot of appropriations units that we do—whether it is the Department of Energy, the Department of Labor—we are talking about mandatory spending when we talk about veterans. When one of our soldiers comes back from serving overseas, we have a commitment to them that is going to drive how much we spend.

We should never shortchange those benefits, or look at it as an efficiency or a savings. Instead, what we have got to do is make sure we run the Department as efficiently as it can be and find our savings there.

So I commend the President and the Senate, and most of all, I am grateful and thankful to those soldiers who sacrificed and fought for us overseas.

My interest is really in two things: suicide; and the benefit claims backlog. Those two things are terrible, protracted problems that I know you are facing. I acknowledge the compliments that everybody has given you, General Shinseki, because they are well deserved, but those are the two priorities that we have got to focus on if we are ever going to get the VA responding as it should respond to those who have come back from overseas and who have served this country.

So, with that said, I will yield back the balance of my time so we can get to our questions.

Chairman SANDERS. Senator Isakson, thank you very much.

Senator Boozman.

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

Senator BOOZMAN. Thank you, Mr. Chairman.

Likewise, again, I do not have a lengthy statement at all.

It is good to have you here. We appreciate you and appreciate your service, not only to the VA but in so many ways throughout your career, and the team that you have assembled to try to help us get this done.

I think as you hear the mood of the comments so far I think it is important that the public understands that this is not a partisan

issue. This is something that I think both sides are very much committed to helping you here in the Senate and then also spending a lot of time in the House with Congressmen Michaud and Miller. I know that they also are totally dedicated to seeing if we can figure out how to solve some of these very, very difficult problems, as Senator Isakson said—the suicide issue, the benefits, and also just the ongoing.

As was said by our Senator from West Virginia, we can be very proud of the VA system that we have. We are doing a lot of things really, really right.

We have got two VA hospitals in Arkansas that are excellent. That has taken a lot of hard work to get to that outcome. So, again, we appreciate the efforts there.

Clearly, we have to address these other things, but we do have some things that we can celebrate.

Thank you.

Chairman SANDERS. Senator Boozman, thank you very much.

Senator Begich.

STATEMENT OF HON. MARK BEGICH, U.S. SENATOR FROM ALASKA

Senator BEGICH. Mr. Chairman, I really do not have an opening statement. I just want to first thank you for having this hearing.

Thank you, General Shinseki—Secretary Shinseki—for all the work you have done.

First, with Alaska and our rural vets that are moving forward in a relationship with the tribal community on delivery of health care, we really appreciate VA's efforts there. We hope to see, as it moves forward, some good progress.

Second, I know you have put some resources in this budget, which I will be anxious to hear about, regarding disability claims and how we move those forward. We had a hearing, and your staff was—they survived that last hearing, and we appreciate that—but a lot of effort is needed to make sure we move that forward. I know that is one of your priorities.

Last, is the effort that you all are making regarding homeless vets. I know this is one of your top three priorities, within the top three. In Alaska, as you can imagine, homeless veteran issues are even more severe because of climatic conditions and other things that we have to deal with.

So thank you for being here. I look forward to your budget, and I am anxious to hear the testimony.

Thank you, Mr. Chairman.

Chairman SANDERS. OK. It is now my pleasure to welcome VA Secretary Eric Shinseki.

Thank you, General, for joining us today to give your perspective on the President's fiscal year 2014 budget and the fiscal year 2015 advanced appropriations request for the Department of Veterans Affairs. We look forward to hearing your testimony.

Secretary Shinseki is accompanied by Steve Muro, Under Secretary for Memorial Affairs; Allison Hickey, Under Secretary for Benefits; and Dr. Robert Petzel, Under Secretary for Health. We also have Todd Grams, Executive in Charge for the Office of Man-

agement and Chief Financial Officer, and Stephen Warren, Acting Assistant Secretary for the Office of Information and Technology.

Your prepared remarks will be submitted for the record.

Secretary Shinseki, please begin and thanks again for being with us today.

STATEMENT OF HON. ERIC K. SHINSEKI, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY: HON. ROBERT A. PETZEL, M.D., UNDER SECRETARY FOR HEALTH; HON. ALLISON A. HICKEY, UNDER SECRETARY FOR BENEFITS; HON. STEVE L. MURO, UNDER SECRETARY FOR MEMORIAL AFFAIRS; STEPHEN W. WARREN, ACTING ASSISTANT SECRETARY FOR THE OFFICE OF INFORMATION AND TECHNOLOGY; AND W. TODD GRAMS, EXECUTIVE IN CHARGE FOR THE OFFICE OF MANAGEMENT AND CHIEF FINANCIAL OFFICER

Secretary SHINSEKI. Chairman Sanders, Ranking Member Burr, distinguished Members of the Committee, thank you for this opportunity to present the President's 2014 budget and 2015 advanced appropriations requests for VA. We deeply value your partnership and support in providing the resources needed to assure quality care and services for veterans.

Let me also join you, Mr. Chairman, in acknowledging other partners here today—our veteran service organizations, whose insights and support make us much better at our mission of caring for veterans, their families and our survivors.

Mr. Chairman, thank you for accepting my written statement for the record.

The 2014 budget and 2015 advanced appropriations requests demonstrate the President's steadfast commitment to our Nation's veterans. And I thank the members for your resolute commitment as well to veterans and seek your support on these requests.

The latest generation of veterans is enrolling at VA at a higher rate than previous generations. Sixty-two percent of those who deployed in support of operations in Afghanistan and Iraq have used at least one VA benefit or service. VA's requirements are expected to continue growing for years to come. Our plans and resources must be robust enough to care for them all.

The President's 2014 budget for VA, as the Chairman outlined: $152.7 billion—$66.5 billion in discretionary funding and $86.1 billion in mandatory funding, an increase of $2.7 billion in discretionary funding, 4.3 percent above the 2013 level.

This is a strong budget which enables us to continue building momentum for delivering three long-term goals we set for ourselves roughly 4 years ago—increase veterans' access to VA benefits and services, eliminate the disability claims backlog in 2015, and end veterans' homelessness in 2015. These were bold and ambitious goals then. They remain bold and ambitious today because veterans deserve a VA that advocates for them and then finds a way to put resources against its words, against those promises.

Access. Of the roughly 22 million living veterans in the country today, more than 11 million now receive at least 1 benefit or service from VA—an increase of over a million veterans in the last 4 years. We have achieved this by opening new facilities, renovating

others, increasing investments in telehealth and telemedicine, sending mobile clinics and Vet Centers to remote areas where veterans live, and using every means available, including the social media, to connect more veterans to VA. Increasing access is a success story at VA.

The backlog. No question, too many veterans wait too long to receive benefits they deserve. We know this is unacceptable and no one wants to turn this situation around more than this Secretary, Under Secretary Hickey or the folks who come to work at VBA every day, 52 percent of whom are veterans themselves.

We are resolved to eliminate the claims backlog in 2015 when claims will be processed in 125 days or less at a 98 percent accuracy level. Our efforts mandate investments in VBA's people, processes and technology. Not just technology—people, processes and technology.

In terms of people, more than 2,100 claims processors have completed training to improve the quality and productivity of claims decisions. More are being trained, and VBA's new employees now complete more claims per day than their predecessors.

Processes. Use of disability benefits questionnaires, DBQs, online forms for submitting medical evidence, have dropped average processing times of medical exams and improved accuracy.

There are now three lanes for processing claims—an express lane for those that will, predictably, take less time; a special operations lane for unusual cases or those requiring special handling; and a core lane where roughly 60 percent of the claims will go, and that is the remainder.

Technology is critical in ending the backlog. Our paperless processing system, VBMS—Veterans Benefits Management System—will be faster, improve access, drive automation and reduce variance. Thirty regional offices now use VBMS. All 56 will have it by the end of this year.

Homelessness. The last of our three priority goals is to end veterans' homelessness in 2015. Since 2009 we have reduced the estimated number of homeless veterans by more than 17 percent. The latest available estimate from January 2012 is 62,600.

There is more work to be done here, but we have mobilized a national program that reaches into communities all across this country. Prevention of veterans' homelessness is our follow-on main effort. The first phase to be completed by 2015 is the rescue of veterans currently on the street, and at the same time we are building a prevention program to keep others from ending up there.

Mr. Chairman, we are committed to the responsible use of the resources Congress provides.

Again, thank you for this opportunity to appear here today, and we look forward to your questions.

[The prepared statement of Secretary Shinseki follows:]

PREPARED STATEMENT OF HON. ERIC K. SHINSEKI, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Chairman Sanders, Ranking Member Burr, Distinguished Members of the Senate Committee on Veterans' Affairs: Thank you for the opportunity to present the President's 2014 Budget and 2015 advance appropriations requests for the Department of Veterans Affairs (VA). This budget continues the President's historic initiatives and strong budgetary support and will have a positive impact on the lives of Vet-

erans, their families, and survivors. We value the unwavering support of the Congress in providing the resources and legislative authorities needed to care for our Veterans and recognize the sacrifices they have made for our Nation.

The current generation of Veterans will help to grow our middle class and provide a return on the country's investments in them. The President believes in Veterans and their families, believes in providing them the care and benefits they've earned, and knows that by their service, they and their families add strength to our Nation.

Twenty-two million living Americans today have distinguished themselves by their service in uniform. After a decade of war, many Servicemembers are returning and making the transition to Veterans status. The President's 2014 Budget for VA requests $152.7 billion—comprised of $66.5 billion in discretionary funds, including medical care collections, and $86.1 billion in mandatory funds. The discretionary request reflects an increase of $2.7 billion, 4.3 percent above the 2013 level. Our 2014 budget will allow VA to operate the largest integrated healthcare system in the country, with more than 9.0 million Veterans enrolled to receive healthcare; the ninth largest life insurance provider, covering both active duty members as well as enrolled Veterans; an education assistance program serving over 1 million students; a home mortgage service that guarantees over 1.5 million Veterans' home loans with the lowest foreclosure rate in the Nation; and the largest national cemetery system that leads the Nation as a high-performing organization, with projections to inter about 121,000 Veterans and family members in 2014.

<center>PRIORITY GOALS</center>

Over the next few years, more than one million Veterans will leave military service and transition to civilian life. VA must be ready to care for them and their families. Our data shows that the newest of our country's Veterans are relying on VA at unprecedented levels. Through January 31, 2012, of the approximately 1.58 million Veterans who returned from Operations Enduring Freedom, Iraqi Freedom, and New Dawn, at least 62 percent have used some VA benefit or service.

VA's top three priorities—increase access to VA benefits and services; eliminate the disability compensation claims backlog in in 2015; and end Veterans homelessness, also in 2015—anticipate these changes and identify the performance levels required to meet emerging needs. These ambitious goals will take steady focus and determination to see them through. As we enter the critical funding year for VA's priority goals, this 2014 budget builds upon our multi-year effort to position the Department through effective, efficient, and accountable programming and budget execution for delivering claims and homeless priority goals.

<center>STEWARDSHIP OF RESOURCES</center>

Safeguarding the resources—people, money, time—entrusted to us by the Congress, managing them effectively, and deploying them judiciously, is a fundamental duty. Effective stewardship requires an unflagging commitment to use resources efficiently with clear accounting rules and procedures, to safeguard, train, motivate, and hold our workforce accountable, and to assure the effective use of time in serving Veterans on behalf of the American people. Striving for excellence in stewardship of resources is a daily priority. At VA, we are ever attentive to areas in which we need to improve our operations, and are committed to taking swift corrective action to eliminate any financial management practice that does not deliver value for Veterans.

VA's stewardship of resources begins at headquarters. Recognizing the very difficult fiscal constraints facing our country, the 2014 request includes a 5.0 percent reduction in the Departmental Administration budget from the 2013 enacted level. This reduction follows a headquarters freeze in the 2013 President's Budget—a two-year commitment.

Recent audits of the Department's financial statements have certified VA's success in remediating all three of our remaining material weaknesses in financial management, which had been carried forward for over a decade. In terms of internal controls and fiscal integrity, this was a major accomplishment. In the past four years, we have also dramatically reduced the number of significant financial deficiencies from 16 to 1.

At VA, we believe that part of being responsible stewards is shutting down information technology (IT) projects that are no longer performing. Developed by our Office of Information and Technology, the Project Management Accountability System (PMAS) requires IT projects to establish milestones to deliver new functionality to its customers every 6 months. Now entering its third year, PMAS continues to instill accountability and discipline in our IT organization. Through PMAS, the cumulative, on-time delivery of IT functionality since its inception is 82 percent, a rate

unheard of in the industry where, by contrast, the average is 42 percent. By implementing PMAS, we have achieved at least $200 million in cost avoidance by shutting down or improving the management of 15 projects.

Through the effective management of our acquisition resources, VA has achieved savings of over $200 million by participating in Federal strategic sourcing programs and establishing innovative IT acquisition contracts. In 2012, VA led the civilian agencies in contracting with Service-Disabled Veteran-Owned Small Businesses, which, at $3.4 billion, accounted for 19.3 percent of all VA procurement awards. In addition, we have reduced interest penalties for late payments by 19 percent (from $47 to $38 per million) over the past four years.

Finally, VA's stewardship achieved savings in several other areas across the Department. The National Cemetery Administration (NCA) assumed responsibility in 2009 for processing First Notices of Death to terminate compensation benefits to deceased Veterans. Since taking on this responsibility, NCA has advised families of the burial benefits available to them, assisted in averting overpayments of some $142 million in benefit payments and, thereby, helped survivors avoid possible collections. In addition, we implemented the use of Medicare pricing methodologies at the Veterans Health Administration (VHA) to pay for fee-basis services, resulting in savings of over $528 million since 2012 without negatively impacting Veteran care and with improved consistency in billing and payment.

TECHNOLOGY

To serve Veterans as well as they have served us, we are working on delivering a 21st century VA that provides medical care, benefits, and services through a digital infrastructure. Technology is integrated with everything we do for Veterans. Our hospitals use information technology to properly and accurately distribute and deliver prescriptions/medications to patients, track lab tests, process MRI and X-ray imaging, coordinate consults, and store medical records. VA IT systems supported over 1,300 VA points of healthcare in 2012: 152 medical centers, 107 domiciliary rehabilitation treatment programs, 821 community-based outpatient clinics, 300 Vet Centers, 6 independent outpatient clinics, 11 mobile outpatient clinics, and 70 mobile Vet Centers. Technology supports Veterans' education and disability claims processing, claims payments, home loans, insurance, and memorial services. Our IT infrastructure consists of telephone lines, data networks, servers, workstations, printers, cell phones, and mobile applications.

No Veteran should have to wait months or years for the benefits that they have earned. We will eliminate the disability claims backlog in 2015; technology is the critical component for achieving our goal. VA is deploying technology solutions to improve access, drive automation, reduce variance, and enable faster and more efficient operations. Building on the resources Congress has provided in recent years to expand our claims processing capacity, the 2014 budget requests $291 million for technology to eliminate the claims backlog? $155 million in Veterans Benefits management System (VBMS) for our new paperless processing system, and $136 million in the Veterans Benefits Administration (VBA) to support a Veterans Claims Intake Program, our new online application system that will allow for the conversion of paper to digital images for our new paperless processing system, the Veterans Benefits Management System (VBMS). Without these resources, VA will be unable to meet its goal to eliminate the disability claims backlog in 2015.

Information Technology

At VA, advances in technology—and the adoption of and reliance on IT in our daily commercial life—have been dramatic. Technology is integral to providing high quality healthcare and benefits. The 2014 budget requests $3.683 billion for IT, an increase of $359 million from the President's 2013 Budget, reflecting the critical role technology plays in VA's daily work in serving and caring for Veterans and their families. Of the total request, $2.2 billion will support the operation and maintenance of our digital infrastructure and $495 million is for IT development modernization and enhancement projects.

The 2014 budget includes $32.8 million for development of VBMS, our new paperless processing system that enables VA to move from its current paper-based process to a digital operating environment that improves access, drives automation, reduces variance, and enables faster, more efficient operations. As we increase claims examiners' use of VBMS version 4.2 to process rating disability claims, our major focus is on system performance, as we tune the system to be responsive and effective. VA will complete the rollout of VBMS in June 2013.

In addition, the 2014 budget includes $120 million for development of the Veterans Relationship Management (VRM) initiative, which enhances Veterans' access to comprehensive VA services and benefits, especially in the delivery of compensa-

tion and pension claims processing. The program gives Veterans secure, personalized access to benefits and information and allows a timely response to their inquiries. Recently, VRM released Veterans Online Application Direct Connect (VDC), which enables Veterans to apply for VBA benefits by answering guided interview questions through the security of the eBenefits portal. Claims filed through eBenefits use VDC to load information and data directly into VBMS.

The Virtual Lifetime Electronic Record (VLER) is an overarching program which aims to share health, benefits, and administrative information, including personnel records and military history records, among DOD, VA, SSA, private healthcare providers, and other Federal, State and local government partners. eBenefits is already reaching 2 million Veterans and Servicemembers and 1 million active users with BlueButton. The 2014 budget requests $15.4 million for VLER to develop and support these functions as well as the Warrior Support Veterans Tracking Application; the Disability Benefits Questionnaires; a VA/DOD joint health information sharing project known as Bidirectional Health Information Exchange; and a storage interface known as Clinical Data Repository/Health Data Repository. All of these efforts are designed to enable the sharing of health, military personnel and personal information among VA, other Federal agencies, Veteran Service Organizations and private health care providers to expedite the award and processing of disability claims and other services such as education, training and job placement.

<center>ELIMINATING THE CLAIMS BACKLOG</center>

Too many Veterans wait too long to receive benefits they have earned. This is unacceptable. Today's claims backlog is the result of several factors, including: increased demand; over a decade of war with many Veterans returning with more severe, complex injuries; decisions on Agent Orange, Gulf War, and combat PTSD presumptions; and, successful outreach to Veterans informing them of their benefits. These facts, in no way, diminish the urgency that we all feel at VA to fix this problem which has been decades in the making. VA remains focused on eliminating the disability claims backlog in 2015 and processing all claims within 125 days at a 98-percent accuracy level.

To deliver this goal, the Veterans Benefits Administration (VBA) is implementing a comprehensive transformation plan based on more than 40 targeted initiatives to boost productivity by over the next several years However, as VBA transforms its people, processes, and technologies, its claims demand is expected to exceed on million annually. From 2010 through 2012, for the first time in its history, VBA processed more than one million claims in three consecutive years. In 2013, VBA expects to receive another million claims and similar levels of demand are anticipated in 2014. This is driven by successful outreach, claims growth not previously captured in VBA's baseline, and new requirements. Included are mandatory Servicemember participation in VOW/VEI benefits briefings and an expected increase upon successful completion of a transition assistance program, revamped by the President as Transition: Goals, Plan, Success (GPS). As more than one million troops leave service over the next 5 years, we expect our claims workload to continue to rise. In addition, VBA is experiencing an unprecedented workload growth arising from the number and complexity of medical conditions in Veterans' compensation claims. The average number of claimed conditions for our recently separated Servicemembers is now in the 12 to 16 range—roughly 5 times the number of disabilities claimed by Veterans of earlier eras. While the increase in compensation applications presents challenges, it is also an indication that we are being successful in our efforts to expand access to VA benefits.

Investments in transformation of our people, processes, and technologies are already paying off in terms of improved performance. For example:

• *People:* More than 2,100 claims processors have completed Challenge Training, which improves the quality and productivity of VBA compensation claims decision-makers. As a result of Challenge Training, VBA's new employees complete more claims per day than their predecessors—with a 30 percent increase in accuracy.

VBA's new standardized organizational model incorporates a case-management approach to claims processing that organizes its workforce into cross-functional teams that work together on one of three segmented lanes: express, special operations, or core. Claims that predictably can take less time will flow through an express lane (30 percent); those taking more time or requiring special handling will flow through a special operations lane (10 percent); and the rest of the claims flow through the core lane (60 percent). Initially planned for deployment throughout 2013, VBA accelerated the implementation of the new organizational model by nine months due to early indications of its positive impact on performance.

VBA instituted Quality Review Teams (QRTs) in 2012 to improve employee training and accuracy while decreasing rework time. QRTs focus on improving performance on the most common sources of error in the claims processing cycle. Today, for example, QRTs are focused on the process by which proper physical examinations are ordered; incorrect or insufficient exams previously accounted for 30 percent of VBA's error rate. As a result of this focus, VBA has seen a 23 percent improvement in this area.

- *Process:* Disability Benefits Questionnaires (DBQs) are online forms used by non-VA physicians to submit medical evidence. Use of DBQs has improved timeliness and accuracy of VHA-provided exams—average processing time improved by 6 days from June 2011 to October 2012 (from 32 to 26 days).

Fully developed claims (FDCs) are critical to reducing "wait time" and "rework." FDCs include all DOD service medical and personnel records, including entrance and exit exams, applicable DBQs, any private medical records, and a fully completed claim form. Today, VBA receives 4.5 percent of claims in fully developed form and completes them in 117 days, while a regular claim takes 262 days to process. Fulfilling the Veterans Claims Assistance Act, to search for potential evidence, is the greatest portion of the current 262-day process. The Veterans Benefit Act of 2003 allows Veterans up to 365 days, from the date of VA notice for additional information or evidence, to provide documentation. Of the 262 days to complete a regular claim, approximately145 days are spent waiting for potential evidence to qualify the application as a fully developed claim.

VBA built new decision-support tools to make our employees more efficient and their decisions more consistent and accurate. Rules-based calculators provide suggested evaluations for certain conditions using objective data and rules-based functionality. The Evaluation Builder uses a series of check boxes that are associated with the Veteran's symptoms to help determine the proper diagnostic code of over 800 codes, as well as the appropriate level of compensation based on the Veteran's symptoms.

- *Technology:* The centerpiece of VBA's transformation plan is VBMS—a new paperless electronic claims processing system that employs rules-based technology to improve decision speed and accuracy. For our Veterans, VBMS will mean faster, higher-quality, and more consistent decisions on claims. Our strategy includes active stakeholder participation (Veterans Service Officers, State Departments of Veterans Affairs, County Veterans Service Officers, and Department of Defense) to provide digital electronic files and claims pre-scanned through online claims submission via the eBenefits Web portal.

- VBA recently established the Veterans Claims Intake Program (VCIP). This program will streamline processes for receiving records and data into VBMS and other VBA systems. Scanning operations and the transfer of Veteran data into VBMS are primary intake capabilities that are managed by VCIP. As VBMS is deployed to additional regional offices, document scanning becomes increasingly important as the main mechanism for transitioning from paper-based claim folders to the new electronic environment.

There are other ways that VA is working to eliminate the claims backlog. VHA has implemented multiple initiatives to expedite timely and efficient delivery of medical evidence needed to process a disability claim by VBA. As a result, timeliness improved by nearly one-third, from an average of 38 days in January 2011 to 26 days in October 2012. Recently, VA launched Acceptable Clinical Evidence (ACE), an initiative that allows clinicians to review existing medical evidence and determine whether they can use that evidence to complete a DBQ without requiring the Veteran to report for an in-person examination. This initiative was developed by both VHA and VBA in a joint effort to provide a Veteran-centric approach for disability examinations. Use of the ACE process opens the possibility of doing assessments without an in-person examination when there is sufficient information in the record.

Another way to eliminate the claims backlog is by working closely with the DOD. The Integrated Disability Evaluation System (IDES) is a collaborative system to make disability evaluations seamless, simple, fast and fair. If the Servicemember is found medically unfit for duty, the IDES gives them a proposed VA disability rating before they leave the service. These ratings are normally based on VA examinations that are conducted using required IDES examination templates. In FY 2012, IDES participants were notified of VA benefit entitlement in an average of 54 days after discharge. This reflects an improvement from 67 days in May 2012 to 49 days in September 2012.

The Benefits Delivery at Discharge (BDD) and Quick Start programs are two other collaborations for Servicemembers to file claims for service-connected disabilities. This can be done from 180 to 60 days prior to separation or retirement. BDD

claims are accepted at every VA Regional Office and at intake sites on military installations in the U.S., and at two intake site locations overseas. In 2012, BDD received more than 30,300 claims and completed 24,944—a 14% increase over 2011's productivity (21,657). During this same period of time Quick Start decreased their rating inventory by over 44 percent.

<div align="center">EXPANDING ACCESS TO BENEFITS AND SERVICES</div>

VA remains committed to ensuring that Veterans are not only aware of the benefits and services that they are entitled to, but that they are able to access them. We are improving access to VA services by opening new or improved facilities closer to where Veterans live. Since 2009, we have added 57 community-based outpatient clinics (CBOCs), for a total of 840 CBOCs through 2013, and increased the number of mobile outpatient clinics and mobile Vet Centers, serving rural Veterans, to 81. Last August, we opened a state-of-the-art medical center in Las Vegas, the first new VAMC in 17 years. The 2014 medical care budget request includes $799 million to open new and renovated healthcare facilities and includes the authorization request for 28 new and replacement medical leases to increase Veteran access to services.

Today, access is much more than the ability to walk into a VA medical facility; it also includes technology, and programs, as well as, facilities. Expanding access includes taking the facility to the Veteran—be it virtually through telehealth, by sending Mobile Vet Centers to rural areas where services are scarce, or by using social media sites like Facebook, Twitter, and YouTube to connect Veterans to VA benefits and facilities. Telehealth is a major breakthrough in healthcare delivery in 21st century medicine, and is particularly important for Veterans who live in rural and remote areas. The 2014 budget requests $460 million for telehealth, an increase of $388 million, or 542 percent, since 2009.

As more Veterans access our healthcare services, we recognize their unique needs and the needs of their families—many have been affected by multiple, lengthy deployments. VA provides a comprehensive system of high-quality mental health treatment and services to Veterans. We are using many tools to recruit and retain our large mental healthcare workforce to better serve Veterans by providing enhanced services, expanded access, longer clinic hours, and increased telemental health capabilities. In response to increased demand over the last four years, VA has enhanced its capacity to deliver needed mental health services and to improve the system of care so that Veterans can more readily access them. Since 2006, the number of Veterans receiving specialized mental health treatment has risen each year, from over 927,000 to more than 1.3 million in 2012, partly due to proactive screening. Outpatient visits have increased from 14 million in 2009 to over 17 million in 2012. VA believes that mental healthcare must constantly evolve and improve as new knowledge becomes available through research.

The 2014 budget includes $168.5 million for the Veterans Relationship Management (VRM) initiative, which is fundamentally transforming Veterans' access to VA benefits and services by empowering VA clients with new self-service tools. VA has already made major strides under this initiative. Most recently, in November 2012, VRM added new features to eBenefits, a Web application that allows Veterans to access their VA benefits and submit some claims online. Veterans can now enroll in and manage their insurance policies, select reserve retirement benefits, and browse the Veterans Benefits Handbook from the eBenefits Website. With the help of Google mapping services, the update also enables Veterans to find VA representatives in their area and where they are located. Since its inception in 2009, eBenefits has added more than 45 features allowing Veterans easier, quicker, and more convenient access to their VA benefits and personal information.

VBA has aggressively promoted eBenefits and the ease of enrolling into the system. We currently have over 2.5 million registered eBenefits users. Users can check the status of claims or appeals, review VA payment history, obtain military documents, and perform numerous other benefit actions through eBenefits. The Stakeholder Enterprise Portal (SEP) is a secure Web-based access point for VA's business partners. This electronic portal provides the ability for VSOs and other external VA business partners to represent Veterans quickly and efficiently.

VA also continues to increase access to burial services for Veterans and their families through the largest expansion of its national cemetery system since the Civil War. At present, approximately 90 percent of the Veteran population—about 20 million Veterans—has access to a burial option in a national, state, or tribal Veterans cemetery within 75 miles of their homes. In 2004, only 75 percent of Veterans had such access. This dramatic increase is the result of a comprehensive strategic planning process that results in the most efficient use of resources to reach the greatest number of Veterans.

ENDING VETERAN HOMELESSNESS

The last of our three priority goals is to end homelessness among Veterans in 2015. Since 2009, we have reduced the estimated number of homeless Veterans by more than 17 percent. The January 2012 Point-In-Time estimate, the latest available, is 62,619. We have also created a National Homeless Veterans Registry to track our known homeless and at-risk populations closely to ensure resources end up where they are needed. In 2012, over 240,000 homeless or at-risk Veterans accessed benefits or services through VA and 96,681 homeless or at-risk Veterans were assessed by VHA's homeless programs. Over 31,000 homeless and at-risk Veterans and their families obtained permanent housing through VA specialized homeless programs.

In the 2014 budget, VA is requesting $1.393 billion for programs to assist homeless Veterans, through programs such as Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH), Grant and Per Diem, Homeless Registry, and Health Care for Homeless Veterans. This represents an increase of $41 million, or 3 percent over the 2013 enacted level. This budget will support our long-range plan to end Veteran homelessness by emphasizing rescue and prevention—rescue for those who are homeless today, and prevention for those at risk of homelessness.

Our prevention strategy includes close partnerships with some 150 community non-profits through the Supportive Services for Veteran Families (SSVF) program; SSVF grants promote housing stability among homeless and at-risk Veterans and their families. The grants can have an immediate impact, helping lift Veterans out of homelessness or providing aid in emergency situations that put Veterans and their families at risk of homelessness. In 2012, we awarded $100 million in Supportive Service grants to help Veterans and families avoid life on the streets. We are currently reviewing proposals for the $300 million in grants we will distribute later this year. In 2012, SSVF resources directly helped approximately 21,000 Veterans and over 35,000 household members, including nearly 9,000 children. This year's grants will help up to 70,000 Veterans and family members avoid homelessness. The 2014 budget includes $300 million for SSVF.

To increase homeless Veterans' access to benefits, care, and services, VA established the National Call Center for Homeless Veterans (NCCHV). The NCCHV provides homeless Veterans and Veterans at-risk for homelessness free, 24/7 access to trained counselors. The call center is intended to assist homeless Veterans and their families, VA medical centers, Federal, state and local partners, community agencies, service providers, and others in the community. Family members and non-VA providers who call on behalf of homeless Veterans are provided with information on VA homeless programs and services. In 2012, the National Call Center for Homeless Veterans received 80,558 calls (123 percent increase) and the center made 50,608 referrals to VA medical centers (133 percent increase).

VA's Homeless Patient Aligned Care Teams (H-PACTs) program provides a coordinated "medical home" specifically tailored to the needs of homeless Veterans. The program integrates clinical care with delivery of social services and enhanced access and community coordination. Implementation of this model is expected to address health disparity and equity issues facing the homeless population. Expected program outcomes include reduced emergency department use and hospitalizations, improved chronic disease management, and improved "housing readiness" with fewer Veterans returning to homelessness once housed.

During 2012, 119,878 unique homeless Veterans were served by the Health Care for Homeless Veterans Program (HCHV), an increase of more than 21 percent from 2011. At more than 135 sites, HCHV offers outreach, exams, treatment, referrals, and case management to Veterans who are homeless and dealing with mental health issues, including substance use. Initially serving as a mechanism to contract with providers for community-based residential treatment for homeless Veterans, many HCHV programs now serve as the hub for myriad housing and other services that provide VA with a way to outreach and assist homeless Veterans by offering them entry to VA medical care.

VA's Homeless Veterans Apprenticeship Program was established in 2012—a 1-year paid employment training program for Veterans who are homeless or at risk of homelessness. This program created paid employment positions as Cemetery Caretakers at five of our 131 national cemeteries. The initial class of 21 homeless Veterans is simultaneously enrolled in VHA's Homeless Veterans Supported Employment program. Apprentices who successfully complete 12 months of competency-based training will be offered permanent full-time employment at a national cemetery. Successful participants will receive a Certificate of Competency which can also be used to support employment applications in the private sector.

Another avenue of assistance is through Veterans Treatment Courts, which were developed to avoid unnecessary incarceration of Veterans who have developed mental health problems. The goal of Veterans Treatment Courts is to divert those with mental health issues and homelessness from the traditional justice system and to give them treatment and tools for rehabilitation and readjustment. While each Veterans Treatment Court is part of the local community's justice system, they form close working partnerships with VA and Veterans' organizations. As of early 2012 there are 88 Courts.

The Veterans Justice Outreach (VJO) program exists to connect these justice-involved Veterans with the treatment and other services that can help prevent homelessness and facilitate recovery, whether or not they live in a community that has a Veterans Treatment Court. Each VA Medical Center has at least one designated justice outreach specialist who functions as a link between VA, Veterans, and the local justice system. Although VA cannot treat Veterans while they are incarcerated, these specialists provide outreach, assessment and linkage to VA and community treatment, and other services to both incarcerated Veterans and justice-involved Veterans who have not been incarcerated.

MULTI-YEAR PLAN FOR MEDICAL CARE BUDGET

Under the Veterans Health Care Budget Reform and Transparency Act of 2009, which we are grateful to Congress for passing; VA submits its medical care budget that includes an advance appropriations request in each budget submission. The legislation requires VA to plan its medical care budget using a multi-year approach. This policy ensures that VA requirements are reviewed and updated based on the most recent data available and actual program experience.

The 2014 budget request for VA medical care appropriations is $54.6 billion, an increase of 3.7 percent over the 2013 enacted level of $52.7 billion. The request is an increase of $157.5 million above the enacted 2014 advance appropriations level. Based on updated 2014 estimates largely derived from the Enrollee Health Care Projection Model, the requested amount would allow VA to increase funding in programs to eliminate Veteran homelessness; continue implementation of the Caregivers and Veterans Omnibus Health Services Act; fulfill multiple responsibilities under the Affordable Care Act; provide for activation requirements for new or replacement medical facilities; and invest in strategic initiatives to improve the quality and accessibility of VA healthcare programs. Our multi-year budget plan assumes that VHA will carry over negligible unobligated balances from 2013 into 2014—consistent with the 2013 budget submitted to Congress.

The 2015 request for medical care advance appropriations is $55.6 billion, an increase of $1.1 billion, or 1.9 percent, over the 2014 budget request. Medical care funding levels for 2015, including funding for activations, non-recurring maintenance, and initiatives, will be revisited during the 2015 budget process, and could be revised to reflect updated information on known funding requirements and unobligated balances.

MEDICAL CARE PROGRAM

The 2014 budget of $57.7 billion, including collections, provides for healthcare services to treat over 6.5 million unique patients, an increase of 1.3 percent over the 2013 estimate. Of those unique patients, 4.5 million Veterans are in Priority Groups 1–6, an increase of more than 71,000 or 1.6 percent. Additionally, VA anticipates treating over 674,000 Veterans from the conflicts in Iraq and Afghanistan, an increase of over 67,000 patients, or 11.1 percent, over the 2013 level. VA also provides medical care to non-Veterans through programs such the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) and the Spina Bifida Health Care Program; this population is expected to increase by over 17,000 patients, 2.6 percent, during the same time period.

The 2014 budget proposes to extend the Administration's current policy to freeze Veterans' pharmacy co-payments at the 2012 rates, until January 2015. Under this policy, which will be implemented in a future rulemaking, co-payments will continue at $8 for Veterans in Priority Groups 2 through 6 and at $9 for Priority Groups 7 through 8.

The 2014 budget requests $47 million to provide healthcare for Veterans who were potentially exposed to contaminated drinking water at Camp Lejeune as required by the Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012, enacted last August. Since VA began implementation of the law and in January 2013, 1,400 Veterans have contacted us concerning Camp Lejeune. Of these, roughly 1,100 were already enrolled in VA healthcare. Veterans who are eligible for care under the Camp Lejeune authority, regardless of current enrollment sta-

tus with VA, will not be charged a co-payment for healthcare related to the 15 illnesses or conditions recognized, nor will a third-party insurance company be billed for these services. In 2015, VA expects to start treating family members as authorized under the law and has included $25 million for this purpose within the 2015 advance appropriations request. VA continues a robust outreach campaign to these Veterans and family members while we press forward with implementing this complex new law.

Mental Healthcare and Suicide Prevention

At VA, we have the opportunity and the responsibility to anticipate the needs of returning Veterans. Mental healthcare at VA is a system of comprehensive treatments and services to meet the individual mental health needs of Veterans. VA is expanding mental health programs and is integrating mental health services with primary and specialty care to provide better coordinated care for our Veteran patients. Our 2014 budget provides nearly $7.0 billion for mental healthcare, an increase of $469 million, or 7.2 percent, over 2013. Since 2009, VA has increased funding for mental health services by 56.9 percent. VA provided mental health services to 1,391,523 patients in 2012, 58,000 more than in 2011.

To serve the growing number of Veterans seeking mental healthcare, VA has deployed significant resources and is increasing the number of staff in support of mental health services. Consistent with the President's August 31, 2012 Executive Order, VHA is on target to complete the goal of hiring 1,600 additional mental health clinical providers and 300 administrative support staff by June 30, 2013 to meet the growing demand for mental health services. In addition, as part of VA's efforts to implement the Caregivers and Veterans Omnibus Health Services Act of 2010, VA has hired over 100 Peer Specialists in recent months, and is hiring and training nearly 700 more. Additionally, VA has awarded a contract to the Depression and Bipolar Support Alliance to provide certification training for Peer Specialists. This peer staff is expected to be hired by December 31, 2013, and will work as members of mental health teams.

In addition to hiring more mental health workers, VA is developing electronic tools to help VA clinicians manage the mental health needs of their patients. Clinical Reminders give clinicians timely information about patient health maintenance schedules, and the High-Risk Mental Health National Reminder and Flag system allows VA clinicians to flag patients who are at-risk for suicide. When an at-risk patient does not keep an appointment, Clinical Reminders prompt the clinician to follow-up with the Veteran.

Since its inception in 2007, the Veterans Crisis Line in Canandaigua, New York, has answered over 725,000 calls and responded to more than 80,000 chats and 5,000 texts from Veterans in need. In the most serious calls, approximately 26,000 men and women have been rescued from a suicide in progress because of our intervention—the equivalent of two Army divisions.

We recently completed a 2012 VA suicide data report, a result of the most comprehensive review of Veteran suicide rates ever undertaken by VA. We are working hard to understand this issue—and VA and DOD have jointly funded a $100 million suicide research project. We will be better informed about suicides, but while research is ongoing, we are taking immediate action and are not waiting 10 years for final study outcomes. These actions include Veterans Chat on the Veterans Crisis Line, local Suicide Prevention Coordinators' for counseling and services, and availability of VA/DOD Suicide Outreach resources.

The Affordable Care Act

The Affordable Care Act (ACA) expands access to coverage, reins in health care costs, and improves the Nation's health care delivery system. The Act has important implications for VA. Beginning in 2014, many uninsured Americans, including Veterans, will have access to quality, affordable health insurance choices through Health Insurance Marketplaces, also known as Exchanges, and may be eligible for premium tax credits and cost-sharing reductions to make coverage more affordable. The 2014 budget requests $85 million within the Medical Care request and $3.4 million within the Information Technology request to fulfill multiple responsibilities as a provider of Minimum Essential Coverage under the Affordable Care Act, including: (1) providing outreach and communication on ACA to Veterans related to VA health care; (2) reporting to Treasury on individuals who are enrolled in the VA healthcare system; and (3) providing a written statement to each enrolled Veteran about their coverage by January 2015.

Medical Care in Rural Areas

VA remains committed to the delivery of medical care in rural areas of our country. For that reason, in 2012, we obligated $248 million to support the efforts of the

Office of Rural Health to improve access and quality of care for enrolled Veterans who live in rural areas. Some 3.4 million Veterans enrolled in the VA healthcare system live in rural or highly rural areas of the country; this represents about 41 percent of all enrolled Veterans. For that reason, VA will continue to emphasize rural health in our budget planning, including addressing the needs of American Indian and Alaska Native (AI/AN) Veterans.

VA is committed to expanding access to the full range of VA programs to eligible AI/AN Veterans. Last year, VA signed a Memorandum of Agreement with the Indian Health Service (IHS), through which VA will reimburse IHS for direct care services provided to eligible American Indian and Alaska Native Veterans. While the national agreement applies only to VA and IHS, it will inform agreements negotiated between the VA and tribal health programs.

This follows the agreement already in place between VA and IHS whereby nearly 250,000 patients served by IHS have utilized a prescription program that allows IHS pharmacies to use VA's Consolidated Mail Outpatient Pharmacy (CMOP) to process and mail prescription refills for IHS patients. By accessing the service, IHS patients can now have their prescriptions mailed to them, in many cases eliminating the need to pick them up at an IHS pharmacy.

Women Veterans Medical Care

Changing demographics are also driving change at VA. Today, we have over 2.2 million women Veterans in our country; they are the fastest growing segment of our Veterans' population. Since 2009, the number of women Veterans enrolled in VA healthcare increased by almost 22 percent, to 591,500. However, by 2022—less than a decade from now—their number is projected to spike to almost 2.5 million, and an estimated 900,000 will be enrolled in VA healthcare.

The 2014 budget requests $422 million, an increase of 134 percent since 2009, for gender-specific medical care for women Veterans. Since 2009, we have invested $25.5 million in improvements to women Veterans' clinics and opened 19 new ones. Today, nearly 50 percent of our facilities have comprehensive women's clinics, and every VA healthcare system has designated women's health primary care providers, and has a women Veteran's program manager on staff.

In 2012, VA awarded 32 grants totaling $2 million to VA facilities for projects that will improve emergency healthcare services for women Veterans, expand women's health education programs for VA staff, and offer telehealth programs to female Veterans in rural areas. These new projects will improve access and quality of critical healthcare services for women. This is the largest number of one-year grants VA has ever awarded for enhancing women's health services.

MEDICAL RESEARCH

Medical Research is being supported with $586 million in direct appropriations in 2014, with an additional $1.3 billion in funding support from VA's medical care program and through Federal and non-Federal grants. VA Research and Development will support 2,224 projects during 2014.

Projects funded in 2014 will be focused on supporting development of New Models of Care, identifying or developing new treatments for Gulf War Veterans, improving social reintegration following Traumatic Brain Injury, reducing suicide, evaluating the effectiveness of complementary and alternative medicine, developing blood tests to assist in the diagnosis of Post Traumatic Stress Disorder and mild Traumatic Brain Injury, and advancing genomic medicine.

The 2014 budget continues support for the Million Veteran Program (MVP), an unprecedented research program that advances the promises of genomic science. The MVP will establish a database, used only by authorized researchers in a secure manner, to conduct health and wellness studies to determine which genetic variations are associated with particular health issues—potentially helping the health of America's Veterans and the general public. MVP recently enrolled its 100,000th volunteer research participant, and by the end of 2013, the goal is to enroll at least 150,000 participants in the program.

VETERANS BENEFITS ADMINISTRATION

The 2014 budget request of $2.455 billion for VBA, an increase of $294 million in discretionary funds from the 2013 enacted level, is vital to the transformation strategy that drives our performance improvements focused most squarely on the backlog.

Virtually all 860,000 claims in the VBA inventory, including the 600,000 claims that have been at VA for over 125 days and are considered backlogged, exist only in paper. Our transition to VBMS and electronic claims processing is a massive and

crucial phase in VBA transformation. VA awarded two VCIP contracts in 2012 to provide document conversion services that will populate the electronic claims folder, or eFolder, in VBMS with images and data extracted from paper and other source material. Without VCIP, we cannot populate the eFolder on which the VBMS system relies. The 2014 request for $136 million for our scanning services contracts will ensure that we remain on track to reach this key goal. In addition, the budget request includes $4.9 million for help desk support for Veterans using the Veterans On-Line Application/eBenefits system.

VBA projects a beneficiary caseload of 4.6 million in 2014, with more than $70 billion in compensation and pension benefits obligations. We expect to process 1.2 million compensation claims in 2014, and we are pursuing improvements that will enable us to meet the emerging needs of Veterans and their families.

Veterans Employment

Under the leadership of President Obama, VA, DOD, the Department of Labor, and the entire Federal Government have made Veterans employment one of their highest priorities. In August 2011, the President announced his comprehensive plan to address this issue and to ensure that all of America's Veterans have the support they need and deserve when they leave the military, look for a job, and enter the civilian workforce. He created a new DOD/VA Employment Initiative Task Force that would develop a new training and services delivery model to help strengthen the transition of our Veteran Servicemembers from military to civilian life. VA has worked closely with other partners in the Task Force to identify its responsibilities and ensure delivery of the President's vision. On November 21, 2012, the effective date of the VOW Act, VA began deployment of the enhanced VA benefits briefings under the revised Transition Assistance Program (TAP), called Transition GPS (Goals, Plans, Success). VA will also provide training for the optional Technical Training Track Curriculum and participate in the Capstone event, which will ensure that separating Servicemembers have the opportunity to verify that they have met Career Readiness Standards and are steered to the resources and benefits available to them as Veterans. Accordingly, the 2014 budget requests $104 million to support the implementation of Transition GPS and meet VA's responsibilities under the VOW Act and the President's Veterans Employment Initiative.

Veterans Job Corps

In his State of the Union address in 2012, President Obama called for a new *Veterans Job Corps* initiative to help our returning Veterans find pathways to civilian employment. The 2014 budget includes $1 billion in mandatory funding to develop a *Veterans Job Corps* conservation program that will put up to 20,000 Veterans back to work over the next five years protecting and rebuilding America. Jobs will include park maintenance projects, patrolling public lands, rehabilitating natural and recreational areas, and administrative, technical, and law enforcement-related activities. Additionally, Veterans will help make a significant dent in the deferred maintenance of our Federal, State, local, and tribal lands including jobs that will repair and rehabilitate trails, roads, levees, recreation facilities and other assets. The program will serve all Veterans, but will have a particular focus on post-9/11 Veterans.

Post-9/11 and other Education Programs

Since 2009, VA has provided over $25 billion in Post-9/11 GI Bill benefits to cover the education and training of more than 893,000 Servicemembers, Veterans, family members, and survivors. We are now working with Student Veterans of America to track graduation and training completion rates.

The Post-9/11 GI Bill continues to be a focus of VBA transformation as it implements the Long-Term Solution (LTS). At the end of February we had approximately 60,000 education claims pending, 70 percent lower than the total claims pending the same time last year. The average days to process Post-9/11 GI Bill supplemental claims has decreased by 17 days, from 23 days in September 2012 to 6 days in February 2013. The average time to process initial Post-9/11 GI Bill original education benefit claims in February was 24 days.

NATIONAL CEMETERY ADMINISTRATION

The 2014 budget includes $250 million in operations and maintenance funding for the National Cemetery Administration (NCA). As we move forward into the next fiscal year, NCA projects our workload numbers will continue to increase. For 2014, we anticipate conducting approximately 121,000 interments of Veterans or their family members, maintaining and providing perpetual care for approximately 3.4 million gravesites. NCA will also maintain 9,000 developed acres and process approximately 345,000 headstone and marker applications.

Review of National Cemeteries

For the first time in the 150-year history of national cemeteries, NCA has completed a self-initiated, comprehensive review of the entire inventory of 3.2 million headstones and markers within the 131 national cemeteries and 33 Soldiers' Lots it maintains. The information gained was invaluable in validating current operations and ensuring a sustainment plan is in place to enhance our management practices. The review was part of NCA's ongoing effort to ensure the full and accurate accounting of remains interred in VA national cemeteries. Families of those buried in our national shrines can be assured their loved ones will continue to be cared for into perpetuity.

Veterans Employment

NCA continues to maintain its commitment to hiring Veterans. Currently, Veterans comprise over 74 percent of its workforce. Since 2009, NCA has hired over 400 returning Iraq and Afghanistan Veterans. In addition, 82 percent of contracts in 2012 were awarded to Veteran-owned and service-disabled Veteran-owned small businesses. NCA's committed, Veteran-centric workforce is the main reason it is able to provide a world-class level of customer service. NCA received the highest score—94 out of 100 possible—in the 2010 American Customer Satisfaction Index (ACSI) sponsored by the University of Michigan. This was the fourth time NCA participated and the fourth time it received the top rating in the Nation.

Partnerships

NCA continues to leverage its partnerships to increase service for Veterans and their families. As a complement to the national cemetery system, NCA administers the Veterans Cemetery Grant Service (VCGS). There are currently 88 operational state and tribal cemeteries in 43 states, Guam, and Saipan, with 6 more under construction. Since 1978, VCGS has awarded grants totaling more than $500 million to establish, expand, or improve Veterans' cemeteries. In 2012, these cemeteries conducted over 31,000 burials for Veterans and family members.

NCA works closely with funeral directors and private cemeteries, two significant stakeholder groups, who assist with the coordination of committal services and interments. Funeral directors may also help families in applying for headstones, markers, and other memorial benefits. NCA partners with private cemeteries by furnishing headstones and markers for Veterans' gravesites in these private cemeteries. In January of this year, NCA announced the availability of a new online funeral directors resource kit that may be used by funeral directors nationwide when helping Veterans and their families make burial arrangements in VA national cemeteries.

CAPITAL INFRASTRUCTURE

A total of $1.1 billion is requested in 2014 for VA's major and minor construction programs. The capital asset budget reflects VA's commitment to provide safe, secure, sustainable, and accessible facilities for Veterans. The request also reflects the current fiscal climate and the great challenges VA faces in order to close the gap between our current status and the needs identified in our Strategic Capital Investment Planning (SCIP) process.

Major Construction

The major construction request in 2014 is $342 million for one medical facility project and three National Cemeteries. The request will fund the completion of a mental health building in Seattle, Washington, to replace the existing, seismically deficient building. It will also increase access to Veteran burial services by providing a National Cemetery in Central East Florida; Omaha, Nebraska; and Tallahassee, Florida.

The 2014 budget includes $5 million for NCA for advance planning activities. VA is in the process of establishing two additional national cemeteries in Western New York and Southern Colorado, according to the burial access policies included in the 2011 budget. These two new cemeteries, along with the three requested in 2014, will increase access to 550,000 Veterans. NCA has obligated approximately $16 million to acquire land in 2012 and 2013 for the planned new national cemeteries in Central East Florida; Tallahassee, Florida; and Omaha, Nebraska.

Minor Construction

In 2014, the minor construction request is $715 million, an increase of 17.8 percent from the 2013 enacted level. It would provide for constructing, renovating, expanding and improving VA facilities, including planning, assessment of needs, gravesite expansions, site acquisition, and disposition. VA is placing a funding pri-

ority on minor construction projects in 2014 for two reasons. First, our aging infrastructure requires a focus on maintenance and repair of existing facilities. Second, the minor construction program can be implemented more quickly than the long-term major construction program to enhance Veterans' services.

In light of the difficult fiscal outlook for our Nation, it's time to carefully consider VA's footprint and our real property portfolio. In 2012, VA spent approximately $23 million to maintain unneeded buildings. Achieving significant reduction in unneeded space is a priority for the Administration and VA. To support this priority, the President has proposed a Civilian Property Realignment Act (CPRA), which would allow agencies like VA to address the competing stakeholder interests, funding issues, and red tape that slows down or prevents the Federal Government from disposing of real estate. If enacted by Congress, this process would give VA more flexibility to dispose of property and improve the management of its inventory.

LEGISLATION

Besides presenting VA's resource requirements to meet our commitment to the Nation's Veterans, the President's Budget also requests legislative action that we believe will benefit Veterans. There are many worthwhile proposals for your consideration, but let me highlight a few. For improvements to Veterans healthcare, our budget includes a measure to allow VA to provide Veterans with alternatives to long-stay nursing homes, and enhance VA's ability to provide transportation services to assist Veterans with accessing VA healthcare services. Our legislative proposasl also request that Congress make numerous improvements to VA's critical homelessness programs, including allowing an increased focus on homeless Veterans with special needs, including women, those with minor dependents, the chronically mentally ill, and the terminally ill.

We also are putting forward proposals aimed squarely at the disability claims backlog—such as establishing standard claims application forms—that are reasonable and thoughtful changes that go hand-in-hand with the ongoing transformation and modernization of our disability claims system. We are offering reforms to our Specially Adaptive Housing program that will remove rules that in some circumstances can arbitrarily limit the benefit. The budget's legislative proposals also include ideas for expanding and improving services in our national cemeteries.

Finally, this budget includes provisions that will benefit Veterans and taxpayers by allowing for efficiencies and cost savings in VA's operations—for example, we are forwarding a proposal that would require that private health plans treat VA as a 'participating provider'—preventing those plans from limiting payments or excluding coverage for Veterans' non-service-connected conditions. VA merits having this status, and the additional revenue will fund medical care for Veterans. We are also requesting spending flexibility so that we can more effectively partner with other Federal agencies, including DOD, in pursuit of collaborations that will benefit Veterans and Servicemembers and deliver healthcare more efficiently.

SUMMARY

Veterans stand ready to help rebuild the American middle class and return every dollar invested in them by strengthening our Nation. And we, at VA, will continue to implement the President's vision of a 21st century VA, worthy of those who, by their service and sacrifice, have kept our Nation free. Thanks to the President's leadership and the solid support of Congress, we have made huge strides in our journey to provide all generations of Veterans the best possible care and benefits through improved technology that they earned through their selfless service. We are committed to continue that journey, even as the numbers of Veterans using VA services increase in the coming years, through the responsible use of the resources provided in the 2014 budget and 2015 advance appropriations requests. Again, thank you for the opportunity to appear before you today and for your steadfast support of our Nation's Veterans.

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RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. BERNARD SANDERS TO HON. ERIC K. SHINSEKI, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

BENEFITS AND BURIAL PROGRAMS

Question 1. Provide the current performance standards for employees involved with the processing of claims.

Response. Please see attached documents, "Q1—PMC RVSR Performance Plan," "Q1—PMC VSR Performance Plan," "Q1—RVSR Standard," and "Q1—VSR Standard."

[The referenced files, due to their volume, are not being reproduced here.]

The current performance standards for Veterans Service Representatives (VSR) and Rating Veterans Service Representatives (RVSR) are attached. The performance standards are based on the employee's General Schedule grade level. VSRs and RVSRs are evaluated based on quality of work, productivity, customer service, workload management, cooperation, and organizational support. Claims processors are awarded credit for actions taken to process a claim.

Question 2. Provide the job titles, grade level and number of FTE assigned to each of the services and organizations within the Veterans Benefits Administration as of April 1, 2011 and April 1, 2013.

Response. Please see attachment entitled "VBA-SVAC-PHQ2FTElist"

[The referenced file, due to its volume, is not being reproduced here.]

For the purposes of this response, the spreadsheet reflects Full-time Equivalent (FTE) rather than individual employees. One FTE is the equivalent of one employee working full time. For example, an employee who is scheduled for 80 hours per pay period is considered 1 FTE, an employee scheduled for 40 hours per pay period is considered .5 FTE, an employee scheduled for 20 hours is considered .25 FTE, and so on. It is also important to note that if an office has and is authorized 10 FTE, there could theoretically be 20 half time employees to meet the 10 FTE limit. In this example, when examining performance output or budget authorizations, it would be misleading to note the office has 20 employees since it may be assumed the office has 20 full time employees. This accounts for why whole numbers are not shown in the spreadsheet.

Question 3. Provide the number of FTE at each VA regional office, separated by job tittle and grade as of April 1, 2011 and April 1, 2013.

Response. Please see attachment entitled "VBA-SVAC-PHQ3FTElist"

[The referenced file, due to its volume, is not being reproduced here.]

For the purposes of this response, the spreadsheet reflects Full-time Equivalent (FTE) rather than individual employees. One FTE is the equivalent of one employee working full time. For example, an employee who is scheduled for 80 hours per pay period is considered 1 FTE, an employee scheduled for 40 hours per pay period is considered .5 FTE, an employee scheduled for 20 hours per pay period is considered .25 FTE, and so on. It is also important to note that if an office has and is authorized 10 FTE, there could theoretically be 20 half time employees to meet the 10 FTE limit. In this example, when examining performance output or budget authorizations, it would be misleading to note the office has 20 employees since it may be assumed the office has 20 full time employees. This accounts for why whole numbers are not shown in the spreadsheet.

Question 4. Provide the methodology utilized to allocate personnel and resources to the regional offices.

Response. Veterans Benefits Administration's (VBA) Resource Allocation Model (RAM) is a systematic approach to distributing field resources each fiscal year. The RAM uses a weighted model to assign compensation and pension FTE resources based on regional office (RO) workload in rating receipts, rating inventory, non-rating receipts, and appeals receipts. VBA leaders use the model as a guide, making some adjustments for special circumstances or missions performed by individual ROs. Special missions include the Appeals Management Center, the Records Management Center, Day-One Brokering Centers, IDES processing sites, Benefits Delivery at Discharge sites, Quick Start processing locations, national call centers, fiduciary hubs, pension management centers, etc. Similar workload-based models are used for each VBA business line.

Non-payroll and travel resources are allocated to each RO based on business need. RO need is driven by the number of FTE, benefits programs administered by the RO, and other factors that are unique to each RO, such as geographic location and jurisdiction, facility characteristics, security needs, and workload.

VBA's Office of Field Operations works with the Area Offices and ROs to determine resource needs.

Question 5. As of 2009, VA started updating the VA Schedule for Rating Disabilities yet this budget request includes little information about the status or resources necessary to complete this effort.

a. Provide an itemized list of funding expended in FY 2012 on the rating schedule modernization.

Response. The Department of Veterans Affairs (VA) is in the process of updating the VA Schedule for Rating Disabilities (VASRD). As part of this process, members of Compensation Service, Regulations Staff hosted multiple public forums to gather scientific evidence regarding disabling conditions and their impact on the average

impairment of earnings capacity. These public forums have also been used as a platform to solicit public input regarding these deliberations. In addition, during these forums, working groups were formed to support the ongoing review process. For fiscal year (FY) 2012, the non-payroll expenditures for the VASRD modernization project totaled $366,139. The table below shows a breakdown:

Event	Date	Expenses
VASRD FORUM—NYC	October 11-20	$84,626
VASRD Forum—NYC	January 17-26	$52,688
Travel	FY 2012	$27,467
Medical consultation contract	FY 2012	$201,358
TOTAL		$366,139

The medical consultation contract provided subject matter expertise to assist with medical content relevant to rating disabilities, consult on policy issues and revisions to the disability benefits questionnaires, and various other responsibilities.

b. Provide an itemized list of funding expended in FY 2013 on the rating schedule modernization?

Response. So far in FY 2013, an event focused on mental health disorders was held on May 1 and 2, with expenses totaling $4,300, and a meeting focused on skin diseases was held from March 28 through April 5, with expenses totaling $2,000.

VA plans to fund additional VASRD modernization project conferences this year. These conferences are needed for the body systems still pending final review and revision, which include the musculoskeletal system and mental disorders. The purpose of these work group conferences is to intensify the review process and to expedite research, development, and deliberations within these sections of the VASRD. The diverse work group includes medical doctors, psychologists, attorneys, Veterans Service Organization representatives, and VA adjudicators. The benefit of these conferences is the generation of more ideas and energizing of the collaborative process which is at the heart of the VASRD review. Each conference will require participants to travel, with estimated costs of $12,000 to $15,000.

VBA medical officers responsible for drafting the VASRD regulations will also meet with subject matter experts (SME) to obtain clinical expertise and opinions useful in revising the VASRD regulations. The estimated cost for FY 2013 is $15,000.

c. Provide an itemized list of the requested funding in FY 2014 for the rating schedule modernization? Also, include the number of FTE assigned to or supporting this modernization effort.

VBA Response: It is anticipated that conferences, travel, and outside consultation will be completed in FY 2013. In FY 2014, it is expected that the remaining work will be accomplished by VA without travel or outside consultation. VA has $15,000 in funding in FY 2014 to support any unforeseen travel or conferences. There are currently 5 FTE assigned to the VASRD modernization project.

d. Provide the Project Management Plan, the VASRD Update Operating Plan and project schedule for the rating schedule modernization.

Response. VA is currently expanding the Project Management Plan (PMP) to include a specific addendum that will include milestones, deliverables, and the designation of a sub-program manager who is dedicated to managing any earnings loss and validation studies VA undertakes. VA is currently exploring the option of engaging in research partnerships to conduct more than one earnings loss study at a time to increase our research capacity. A copy of the updated PMP and operating plan as well as the project schedule will be provided when completed.

e. Provide an itemized list of any funding requested to support IT solutions to modernize the rating schedule.

Response. The VASRD modernization project did not require any IT solutions.

f. Does the FY 2014 request include any funding to support updates that will need to be made to IT solutions, including VBMS, disability benefit questionnaires, rules based calculators, or other initiatives based on current VASRD? How much funding does VA anticipate these updates will require upon publication of final rules for the various body systems?

Response. The FY 2014 request does not include funding changes to IT systems related to the VASRD modernization project, as Veterans Benefits Management System (VBMS) enhancements will incorporate any VASRD changes. VBMS will continue to be enhanced and additional system capabilities will be released in 3 future generations of VBMS that will be deployed over the next 2 years.

VA/DOD COLLABORATION

Question 6. According to the FY 2014 budget request, IDES now operates at 139 military treatment facilities worldwide and is available to all servicemembers who are referred to Medical Evaluation Boards. The FY 2014 budget request also noted over 30,000 new referrals in 2012.

a. Provide the amount of funding spent in FY 2012 (both mandatory and discretionary) and how many VA employees were dedicated to the IDES process.

Response. During FY 2012, VA's Office of Planning and Policy (OPP) spent approximately $1,074,539, consisting of $467,081 for a program management support contract, $577,458 in salary for 5 full-time equivalent employees (FTE), and $30,000 in travel costs.

During FY 2012, the Veterans Benefits Administration (VBA) spent approximately $54.8 million for salaries and general operating expenses for 490 FTE dedicated to disability claims processing in the Integrated Disability Evaluation System (IDES) process. Compensation staff and Vocational Rehabilitation and Employment Counselors are included in this count. Veterans filing claims through the IDES sites are captured in the nationwide Veteran caseload count and total compensation benefit obligations; therefore, mandatory funding cannot be separated for this program.

The FY 2012 IDES Supplemental Budget distributed to the operational field sites supporting IDES was $24.4 million. Staffs located at the VA medical centers (VAMC) are not solely dedicated to the IDES process.

b. Provide the amount of funding spent in FY 2013 (both mandatory and discretionary) and how many VA employees were dedicated to the IDES process.

Response. During FY 2013, OPP spent approximately $1,336,630 which is comprised of $570,630 for a program management support contract, $741,000 in salary for 5 FTE, and $25,000 in travel costs.

During FY 2013, VBA estimates it will spend approximately $63 million for salaries and general operating expenses to support 580 FTE dedicated to disability claims processing in the IDES process.

The FY 2013 IDES Supplemental budget was $21.6 million. These funds were distributed to the VAMCs in support of IDES. Staffs located at the VAMCs are not solely dedicated to the IDES process.

c. Provide the amount of funding requested in FY 2014 (both mandatory and discretionary) and how many VA employees will be dedicated to the IDES process.

Response. During FY 2014, OPP estimates it will spend $1,057,458, which is comprised of $450,000 for a program management support contract, $577,458 in salary for 5 FTE, and $30,000 in travel costs.

During FY 2014, VBA estimates it will spend approximately $63.6 million for salaries and general operating expenses to support 580 FTE dedicated to disability claims processing in the IDES process.

For FY 2014, the IDES Supplemental budget request is $18.6 million. Staff located at the VAMCs are not solely dedicated to the IDES process.

d. What is the methodology used to predict workload for this joint program? Has DOD provided information on the anticipated number of referrals that VA can expect the program to receive in FY 2013 and FY14?

Response. The IDES workload is based solely on the number of referrals made by the Military Services; therefore, IDES workload projections are made by DOD. We defer to DOD to explain the methodology used in workload predication. VA has requested a 5 year projection from DOD, and DOD is working on that request. The anticipated number of referrals for FY 2013 is 32,000 and for FY 2014 is 32,000.

e. How many referrals has the program received in FY 2013 and how many are anticipated for FY14.

Response. For FY 2013, 19,841 referrals have been received as of May 12, 2013, and the anticipated number of referrals for FY 2014 is 32,000.

f. For each of the 139 military treatment facilities operating IDES, provide performance metrics to include enrollment, outcomes, VA exam utilization rate, timeliness, referred and total conditions, and timeliness for case processing by stage.

Response. VA is at 116 sites throughout the United States and Puerto Rico. The remaining 23 sites are overseas locations. The attached spreadsheet shows the performance metrics for enrollment, referred and total conditions, and timeliness for case processing by stage. IDES outcomes are determined by the Military Services Physical Evaluation Boards. VBA defers to DOD to provide definitive IDES outcome metrics and the exam utilization rate, which is based on the outcome metrics.

g. How many contract disability examinations were used to support IDES in FY 2012 and FY 2013 and at which IDES locations?

Response. In FY 2012, 11,616 VBA contract examinations were completed in support of IDES. In FY 2013 (through May 15, 2013), 7,426 VBA contract examinations

have been completed in support of IDES. The attached spreadsheet provides a breakdown by location of the contract disability examinations completed so far in FY13.

The Veterans Health Administration (VHA), similar to VBA, has a contract—the Disability Examination Management (DEM) Contract, which is used by the VAMCs to supplement Compensation & Pension (C&P) examination services. No IDES exams were conducted using the DEM Contract in FY 2012. However, 1,116 IDES exams were conducted using this contract in FY 2013 through March 2013. Of these, 661 exams were conducted to directly support IDES locations as described below. The remaining examinations were conducted by VAMCs Nation-wide in support of the IDES Reserve Component Exams Closest to Home initiative.

IDES Location	Number of Exams
West Point	44
Ft. Bragg/Pope AFB/Camp Lejeune	4
Ft. Riley/Ft. Leavenworth/McConnell AFB/Whiteman	32
Ft. Hood	571
Ft. Bliss	1
Mountain Home AFB	9
Total	661

Question 7. VA's Office of VA/DOD Collaboration is responsible for "coordinating the implementation of the integrated disability evaluation system (IDES) and streamlining the disability evaluation process through continual process improvements."

a. What process improvements were made in FY 2013 to streamline the process?

Response. VA has made the following process improvements in streamlining the disability evaluation process:

• *Entry of Physical Evaluation Board (PEB) Decisions in the Veterans Tracking Application (VTA)*—IDES cases that have completed Secretarial Review are missing Disposition and Combat Condition data in VTA. Consistent entry of timely PEB decision information into VTA will improve Benefits Notification process timeliness (Implemented).

• *Ensure cases are "Ready to Rate" before reaching the Disability Rating Activity Site (DRAS)*—Current IDES case processing requires certain military information and/or documentation which ensure cases are ready to rate before forwarding them to the DRAS. At times, some of the required information and/or documentation were missing. DOD has provided 15 DOD personnel to perform DOD administrative procedures in development teams to assist in increasing the ready to rate inventory (Implemented).

• *Disability Benefits Questionnaire (DBQs)*—Currently DBQ's are used in processing regular disability claims. VA's move to DBQ's will increase the efficiency of the DRAS operations, assist in reducing the current IDES backlog, reduce the percentage of insufficient medical exams, and provide raters with needed clinical information to effectively complete disability ratings.

Other identified initiatives in development are as follows:

One Rating—Current IDES case processing procedures require the DRAS to prepare a rating decision for a case at two separate points in time—Proposed Rating and Benefits Notification. Resources expended to complete final rating could be devoted to proposed ratings which will enable timely Benefit Notification and additional resources (information technology changes will have to be made in the claims processing system, potential implementation in FY 2014).

b. What is the status of electronic case file transfer capabilities within IDES?

Response. Partial IDES case files, minus Service Treatment Records (STRs), are already being shared electronically between DOD and VA using DOD's Safe Access File Exchange (SAFE) system. Moreover, DOD and VA have successfully tested a new system for electronically sharing IDES case files-to include portions of STRs and other non-medical case forms-using the Electronic Case File Transfer (eCFT) system, exchanging more than 3,000 case files since the pilot began in September 2012. The eCFT pilot was designed to demonstrate the ability of the Departments to jointly develop and electronically share files that execute various portions of the IDES process.

In January 2013, VA identified additional requirements to establish interoperability between eCFT and VA IT via a data-exchange service. These will satisfy VA's needs to (1) retain electronic copies of case files for legal purposes, and (2) maintain

the ability to track documents entered into case files on a per member, per document basis. Once these requirements are met, eCFT will replace SAFE.

To this end, VA and DOD are working together to provide an automated file transfer capability that physically moves the files from eCFT to VA systems (i.e., the Veterans' Benefits Management System or VBMS) by way of VA's Virtual Lifetime Electronic Record Data Access Service (VLER DAS).

MEDICAL PROGRAMS

Budget Request Assumptions

Question 8. The President's budget request includes an increase of 15.4 percent for mental health care since 2012, which is a 7.2 percent increase since last year's enacted level. Please explain how VA arrived at this number. Specifically, did VA take into account an anticipated increase in enrollment and use of behavioral health services that may result from the return of troops from Afghanistan and the downsizing of the force?

Response. The Veterans Health Administration (VHA) places a high priority on ensuring that all enrolled Veterans have access to needed mental health services. The VA Enrollee Health Care Projection Model (Model), with input from VHA's Office of Mental Health Services, projected an increase in the utilization of mental health services by taking into account several techniques to forecast Veteran enrollee needs for VA mental health services. These techniques include incorporating the latest scientific evidence about effective mental health interventions, data analysis of Veteran demographics, access to care data, and trends in service utilization projections. The Model projects future demand for mental health services and accounts for the impact of enrollee age, gender, morbidity, the unique utilization patterns of specific cohorts such as Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND), events such as the return of troops from Afghanistan, and the downsizing of the force.

Question 9. Given that VA saw an increase of nearly 150,000 patients between 2010 and 2011, when the impact of the health insurance coverage requirement in the Affordable Care Act coupled with the drawdown of troops in Afghanistan was less of a factor, what led VA to estimate that only 100,000 new patients will come into VA between 2014 and 2015?

Response. The year-to-year enrollment and patient projections presented in the President's budget submission represent the net change in projected enrollment and patients over the prior fiscal year. VA recognizes that the additional options available under the Affordable Care Act (ACA) may lead some Veterans to choose non-VA providers while other Veterans may enroll with VA for the first time in order to satisfy the requirement to have minimum essential coverage. The VA Enrollee Health Care Projection Model (EHCPM) accounts for many factors affecting enrollment, such as the drawdown of troops in Afghanistan, mortality, change in demographic mix, morbidity, reliance on the VA health care system, and economic conditions. These factors will affect the net enrollment and patient growth differently each fiscal year. The extent to which ACA will impact VA will be closely monitored on an ongoing basis.

Question 10. How did VA determine that an increase of 5.4 percent over the FY 2013 level for medical services was sufficient? To what extent does this increase allow for an expansion of health care treatment options beyond what VA is currently providing?

Response. VA's medical care budget is based on an actuarial model (the Enrollee Health Care Projection Model) that reflects health care trends within VA and also considers health care trends in the broader health care industry. The estimate is informed by understanding the demographic changes in the enrolled Veteran population, which is a key factor for projecting future demand for health care services. VA's budget also includes several initiatives for expanding services to Veterans such as addressing Veteran homelessness and new models of care, which include Patient Aligned Care Teams (PACT), Women's Health, Special Care Team Based Models, and Connected Health. VA's program offices are actively engaged to ensure that the actuarial model reflects continued evolution of VA's health care delivery system and reflects VA's vision for personalized, proactive, Veteran-centric health care.

Complementary and Alternative Medicine

Question 11. How has VA included complementary and alternative medicine (CAM) specialists into its health care delivery model? Are clinicians who provide these services integrated into VA's Patient Aligned Care Teams?

Response. As VHA does not have occupational codes that would allow the hiring of CAM providers, almost all CAM delivered within VHA is done by providers with

allopathic training who have an interest in CAM. Eighty-nine percent of VA facilities offer at least one form of CAM, and these therapies are integrated into traditional VA care. CAM is primarily used for the management of chronic pain and mental health disorders and for the promotion of general health and well-being. The principles of patient activation and self-management embodied by many CAM activities are very consistent with VA's health care delivery model which advocates for proactive, personalized, and patient-driven care. The issue of chronic disease management, including management of mental health disorders and chronic pain, as well as the promotion of healthy lifestyle and behavior modification are a key part of the management of Veterans in PACTs. While the clinicians who deliver CAM services within VA are not physically part of the PACTs, many of the services they provide are ones that would be accessed through PACTs. The providers who deliver CAM would be considered part of the PACTs' resources.

Question 12. What are individual medical centers doing to promote CAM therapies among their patients, including those seeking treatment for behavioral health and pain management?

Response. The main reason cited by individual medical centers for offering CAM therapies was to promote wellness, as an adjunct to chronic disease management, and because they believed it was consistent with patient preferences. The strategies of facilities regarding CAM are variable. Some facilities offer CAM services such as Yoga and Tai Chi, which may be accessed directly by Veterans, as well as other services which may be accessed via referral from a primary care provider or offered by a treating specialist as part of a comprehensive plan of care. According to a 2011 VHA Survey of Complementary and Alternative Medicine conducted by VHA's Healthcare Analysis and Information Group, the conditions most commonly treated with CAM in VA are mental health disorders and chronic pain. Within mental health, CAM therapies such as meditation, biofeedback, and guided imagery, while not a substitute for conventional therapies, are seen as potentially useful adjuncts to care. The potential benefits of CAM therapies as adjuncts to allopathic care are a consistent theme within VA.

For the past 13 months, VHA Primary Care Services and the Office of Patient Centered Care and Cultural Transformation have hosted a monthly Integrative Medicine Community of Practice conference call. This call has served as a forum to spread information and education on Integrative Health and CAM and on the ways CAM is being used within VA as well as to create dialog on issues of policy and implementation.

Question 13. Would CAM therapies be more readily available to veterans if clinicians could be hired solely to practice these therapies?

Response. The lack of allopathic providers with training and expertise in CAM does pose a barrier to being able to offer CAM services, as does the lack of CAM providers. Further education of our allopathic providers regarding the evidence and integration of these practices, as well as the ability to hire CAM providers, would likely enhance VA's ability to provide CAM services. In 2005, the Institute of Medicine published its national report on CAM, and one of the key recommendations was that "health profession schools should incorporate sufficient information about CAM into the standard curriculum at the undergraduate, graduate, and postgraduate levels to enable licensed professionals to competently advise their patients about CAM." The scope of Integrative Health and CAM is vast, including whole systems of medicine and a diverse group of practices and products. As with conventional approaches, those that are best trained and most qualified should be the ones providing the services, which would also make these services more readily available.

Medical Care Collections

Question 14. How does VA plan to ensure it meets its budget projection of collecting nearly $3.1 billion for Fiscal Year 2014?

Response. The Medical Care Collections budget can be broken out into three segments: Medical Care Collection Fund (MCCF) collections, other collections (including parking fees, enhanced-use revenue, compensation work therapy, compensation and living expenses and makes up $65 million of the FY 2014 budget), and collections tied to legislative proposals. The MCCF collections portion accounts for $2.870 billion of the $3.064 billion budget. VA's plans to ensure that FY 2014 MCCF budget projections are met through the following:

• *Consolidated Patient Accounting Centers (CPAC):* In FY 2012, VA completed the transition of revenue collection activities from individual VA medical centers to seven industry-best-practice CPACs. This transition was done one year earlier than required under Public Law 110–387. Most critically, CPACs have demonstrated success based on standardized business practices, enhanced employee training and

greater accountability for results. In order to ensure MCCF collection targets are met in FY 2014, VA will continue to focus on improving efficiencies using the CPAC model in areas related to people, process and technology.

• *Payer Relations Activities:* VHA continues to aggressively pursue strategies to effectively manage relationships with third-party payers. In order to ensure that MCCF collection targets are met in FY 2014, VA plans to provide comprehensive training to payer relations staff located in each CPAC, implement enhanced denials management capabilities and deploy tools to monitor payments versus agreement terms and conditions.

• *Electronic Business Initiatives:* In an effort to leverage the health care industry's migration to national standard electronic data exchanges under the Health Insurance Portability and Accountability Act and to comply with other legal requirements, VHA has put in place electronic business initiatives to add efficiencies to the billing and collections processes. In order to meet FY 2014 MCCF collection targets, VHA will continue to enhance this capability through expanded utilization of Electronic Data Interchange tools related to insurance verification, electronic billing and electronic payments.

Question 15. To what extent would VA be unable to meet its projected collections level if the legislation the Department proposed on this topic does not become law?

Response. VA has submitted two legislative proposals in the FY 2014 President's Budget that 1) allow for VA to release of patient information to bill health plans for non-service-connected care relating to drug abuse, alcoholism, or alcohol abuse and 2) require health plans to treat VA as a participating provider, whether or not an agreement is in place with the health plan. These two proposals account for $129 million of the $3.064 billion FY 2014 budget (4%). VA does not anticipate being able to achieve this target without these proposals becoming law.

Affordable Care Act

Question 16. Veterans enrolled in VA health care are not eligible for tax credits established by the Affordable Care Act to assist individuals in paying for health care coverage through the Exchange. What is VA doing to inform veterans of this and how is VA working with the IRS to determine which veterans will be ineligible for the tax credit?

Response. VA has developed a plan to inform, educate, and engage Veterans, eligible beneficiaries, and other stakeholders about ACA. This plan includes a set of key messages that have been incorporated into communications materials addressed to Veterans and other beneficiaries. One of these key messages is that enrollment in VA health care programs meets the ACA minimum essential coverage (MEC) requirement. VA and the Internal Revenue Service (IRS) collaborated to draft a special provision for Veterans. Under an IRS final rule, individuals who are enrolled in specified VA health care programs identified as MEC will not be eligible to receive premium tax credits (with respect to that individual) to purchase coverage through the Health Insurance Marketplace.

VA will inform enrollees that individuals enrolled in specified VA health care programs (i.e., Veterans health care program, VA Civilian Health and Medical Program (CHAMPVA), and Spina Bifida health care benefits program) are not eligible for a tax credit to purchase additional health insurance coverage. Family members of enrolled Veterans who are not enrolled in specified VA health care programs may still be eligible for a tax credit (if they otherwise meet the applicable eligibility criteria) to purchase health insurance coverage through the Health Insurance Marketplace (formerly known as Health Insurance Exchanges). Similar information will also appear in documents such as fact sheets, frequently asked questions, and language for VA social media sites accessible to both enrolled and non-enrolled Veterans and other beneficiaries.

Question 17. Please provide a justification for the amount the President requested for compliance with the Affordable Care Act.

Response. VA has prepared for health reform by examining the key provisions of the law, identifying the implications for Veterans and VA, and conducting analyses to estimate the potential impact of the law on VA. The Fiscal Year 2014 President's Budget submission reflects the estimated cost impacts due to the current assumption that VA will experience a modest net enrollment increase as a result of ACA. VA's Fiscal Year 2014 budget request included $85 million for the care of the estimated 66,000 new Veterans that VA estimates may choose VA for their health care under ACA. VA believes that some Veterans may enroll with VA to satisfy the requirement to have MEC, and other Veterans may disenroll in order to take advantage of the premium tax credit. VA believes that those most likely to enroll or disenroll are those Veterans who will have low reliance on VA health care. In addition, the Fiscal Year 2014 VA Information Technology budget includes $3.4 million

to build functionality needed to deliver statements to enrolled Veterans and beneficiaries enrolled in CHAMPVA and Spina Bifida who maintain MEC through VA. This funding will also go toward building the tool to identify and report on individuals who are enrolled in VA health programs identified as MEC.

Question 18. What is VA doing to address the expected increase in demand for primary care services that will be the result of expanded insurance coverage under the Affordable Care Act?

Response. Since the Affordable Care Act's enactment, VA has been proactive in working to understand the law's impact on Veterans, other beneficiaries, and VA's health care system, and in preparing for implementation of the law. VA will continue to provide eligible Veterans with high quality, comprehensive health care they have earned through their service. VA is preparing for ACA implementation with a focus on providing personalized, Veteran-centric health care. Ongoing efforts include, for example, developing data tools and coordinating directly with other Federal agencies, including the Department of Health and Human Services.

Question 19. The President's Budget requests an additional $19 million for the HHS Inspector General for new oversight efforts, including efforts related to the ACA. Do you anticipate VA's Office of Inspector General will require any additional funds specific to ACA-related activities?

Response. Until VA more clearly understands the impact of ACA on its programs and operations, it is not possible to determine what OIG efforts will be required. Additional funds may be needed when VA is able to provide the OIG with detailed plans on ACA's impact.

Homeless Veterans

Question 20. As we pass the halfway point in the Secretary's five-year plan to end homelessness among veterans, is any program realignment necessary to ensure that there are no unsheltered homeless veterans by the end of 2015?

Response. VA's successes thus far in reducing Veteran homelessness is in part due to ongoing program evaluation and realignment in two areas: services and resource investments. Finishing the job of ending Veteran homelessness and ensuring there are no unsheltered homeless Veterans on our streets will require continued realignment of program resources and continued investment in Veteran-centric permanent housing and health programs, including the widespread adoption of evidence-based best practices, such as Housing First and critical time intervention case management services.

Already, VA has realigned its programs and instituted a number of Veteran-centric program innovations and transformations based on a guiding principle: the solution to homelessness is permanent housing with wrap-around supportive services. This commitment to permanent supportive housing is best captured by VA's adherence to a Housing First model. Housing First is an evidence-based approach that focuses on helping individuals and families access and sustain permanent housing as quickly as possible while providing the necessary health care and other supports to help sustain permanent housing and improving the Veteran's quality of life. VA's service delivery system has become more accessible, community-based, and Veteran-centric, with a focus on meeting Veterans where they are and helping them to move forward to improve their health and housing stability. Resources focused on rapid engagement and placement in permanent housing need to continue to grow to ensure there are no unsheltered Veterans on the street. VA has demonstrated its commitment to properly realigning program services and program investments through the Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH) Program, Supportive Services for Veteran Families (SSVF) Program, and the ongoing transformation of the Grant and Per Diem (GPD) Program.

The HUD-VASH Program is concrete evidence of VA's efforts to realign program services to successfully end Veteran homelessness. The HUD-VASH Program is jointly administered by HUD and VA to provide permanent supportive housing for eligible homeless Veterans. Veterans in the HUD-VASH Program receive a HUD-provided Section 8 Housing Choice voucher and VA-provided case management services. Since 2008, a total of 48,385 vouchers have been awarded, and 42,557 formerly homeless Veterans are currently in homes because of HUD-VASH. VA's ongoing commitment to the HUD-VASH Program is in keeping with its efforts to realign program services under a Housing First permanent supportive housing model.

The SSVF Program is further evidence of VA's ongoing efforts to realign program services and investments to end Veteran homelessness. Although still a relatively new program, it is already clear that the SSVF Program has been an enormous success. The SSVF Program provides grants to private non-profit organizations and consumer cooperatives to help Veteran families rapidly exit homelessness or to assist Veterans at-risk of homelessness. The SSVF Program is unique in that it can

serve both the Veteran and his or her family member(s) and continues VA's efforts to realign services under a Housing First permanent supportive housing model. In fiscal year (FY) 2012, during the SSVF Program's first full year of operations, SSVF surpassed expectations, serving approximately 21,500 Veterans and a total of over 35,000 persons. Of those served, 40 percent were at-risk for homelessness and seeking prevention services while the remaining 60 percent were provided rapid re-housing services to transition from homelessness into permanent housing. At the end of FY 2012, VA awarded 151 SSVF grants in 49 states and the District of Columbia for operations in FY 2013. In recognition that this community-based resource needed to be more geographically available to all communities assisting Veterans and their families, VA recently announced an FY 2013 SSVF Notice of Funding Availability (NOFA) for an additional $300 million to further grow this program.

Additionally, VA's recent efforts to transform the GPD Program provides further evidence of VA's commitment to the realignment of program services and investments. As VA advances its realignment efforts focused on a community-based, Veteran-centric permanent supportive housing, VA expects that the demand for transitional housing will be less intense. In recognition of the decreased demand for transitional housing, the GPD Program is already working with a new model utilizing the principles of Housing First and focused on facilitating permanent supportive housing, GPD Transition in Place (TIP). In FY 2012, VA awarded approximately $28.4 million in grants to provide capital funding for transitional housing projects. Thirty-one of the funded projects were GPD TIP, which will provide time-limited wrap-around supportive services to homeless Veterans housed in apartment style housing, in which the services transition but the Veteran remains in the housing. GPD TIP provides an opportunity to realign traditional transitional housing services with VA's preferred permanent supportive housing model.

To increase and enhance efforts at housing unsheltered homeless, VA is working with community-based agencies to realign efforts at targeting vulnerable unsheltered homeless Veterans. For example, some local VA medical centers have started partnering with local homeless Continuums of Care (CoC) to conduct local "Registry Weeks." A Registry Week is a concept used to develop an accurate registry of the needs of individuals/Veterans who are permanently, or frequently, living on the street. Volunteers are recruited and trained to reach out to unsheltered homeless individuals and survey them in an effort to collect valuable information that will help connect them to the appropriate housing and services. Those identified as the most vulnerable (physical and behavioral health conditions that are serious) are prioritized for available permanent housing and support. Local VA medical centers have also teamed with local homeless CoCs and other local community-based organizations to evaluate and realign system processes through Rapid Results Boot Camps. A Rapid Results Boot Camp is a full-day event designed to train service providers who are already helping homeless Veterans in their communities to learn new and more efficient ways to house Veterans and provide them with the services they need. Teams of representatives from VA, public housing authorities, local governments, and other agencies who work with homeless Veterans attend and participate in the Boot Camps. Boot Camps help communities to improve their processes in order to decrease the amount of time it takes a homeless Veteran to leave the streets and enter into permanent housing.

VA has had significant and measurable success in VA's Plan to End Veteran Homelessness. Based on HUD's Point in Time (PIT) Count, from 2009 to 2012, the number of Veterans experiencing homelessness on a single night in January has decreased 17.2 percent (from 75,609 to 62,619). Furthermore, these reductions in Veteran homelessness took place in a challenging economic period.

In conclusion, VA has made significant and measurable success in ending Veteran homelessness. VA must continue to focus its efforts on housing unsheltered homeless Veterans. The key to success is a continued and increased investment in the HUD-VASH and SSVF Programs, continued focus on the principles of Housing First, and effective and ongoing realignment of program services and resources nationally and at the local level.

Question 21. While homelessness is generally an urban phenomenon, it is important to recognize that homelessness also occurs in rural areas, albeit generally in the form of overcrowding or substandard housing. What specific actions is VA taking to ensure that the housing needs of rural veterans are also being met?

Response. VA has taken decisive action to eliminate Veteran homelessness in both urban and rural areas. VA's ongoing prevention, transitional housing, and permanent supportive housing programs provide wide-ranging services in rural areas. VA realizes the importance of reaching the rural homeless Veteran population. Rural homeless persons are often referred to as the "hidden homeless" as many of these individuals reside in the woods, campgrounds, abandoned farm buildings, and build-

ings not intended for human habitation. Much of the rural at-risk homeless population reside in substandard housing or are doubled up in temporary housing arrangements. Additionally, rural community-based homeless service providers often lack adequate capacity and infrastructure to address rural homelessness.

The SSVF Program provides grant funding for private non-profit organizations and consumer cooperatives to assist Veterans and their families with preventive supportive services. Of those grants awarded in FY 2011 for operations conducted in FY 2012, approximately 5 percent of the SSVF grants serve Veteran families in rural areas exclusively while an additional 32 percent of grants serve a mix of rural and urban areas. In FY 2012, VA awarded funding for operations in FY 2013. Approximately 10 percent of the community agency grantees provide services exclusively in rural areas. Additionally, over 45 percent of these grantees included a rural component in their services. VA is expanding access to services both by increasing available resources and by specifically targeting rural areas. In the past year, VA has increased funding available through its SSVF grant program from $100 million to $300 million. Additionally, the FY 2013 SSVF NOFA lists "Veteran families located in a rural area" as one of the target populations for SSVF funding.

Community agencies funded under VA's Homeless Providers GPD Program provide transitional housing for Veterans who are homeless. In FY 2012, 16.8 percent of those GPD Programs were in rural areas. As of April 2013, 26.6 percent of those GPD Programs indicated that they provided transitional housing for Veterans in rural areas.

VA's HUD-VASH Program offers homeless Veterans permanent housing opportunities through Section 8 vouchers, linked with wrap-around VA case management services. Vouchers are distributed through Public Housing Authorities in both urban and rural areas. From FY 2008 to FY 2012, HUD allocated approximately 11 percent of the approximately 48,000 HUD-VASH vouchers to rural areas, awarding a total of 5,260 vouchers to rural areas. VA expects HUD to announce the allocation of an additional 10,000 vouchers for FY 2013 and expects a similar proportion of these additional vouchers to serve rural areas.

Finally, VA understands that the rural homeless Veteran population has pressing and unique needs. To that end, VA continues to explore the potential use of video-teleconferencing and related technologies in the care of rural homeless Veterans. Connecting people through technology can reduce costly and inconvenient travel and prevent isolation for remote staff and Veterans.

Question 22. The FY 2014 budget request notes that over 3,000 veterans were enrolled in H-PACTS in 2012 and that enrollment was associated with greater health outcomes. Please provide more specific data on what type of outcomes improved and how care improved.

Response. The Homeless Patient Aligned Care Team (H-PACT) initiative is a pilot program that provides integrated homeless program support and primary care to homeless Veterans. Teams integrate a housing agenda with providing care for the ongoing and evolving medical, mental health, and substance abuse needs of homeless Veterans coming into the system. The goal is to create a "medical home" tailored to the needs of homeless Veterans that reduces unnecessary trips to the emergency department for care; assists in addressing chronic medical, mental health, and substance abuse treatment needs; and integrates homeless program staff to expedite housing placement and reduce recidivism. Enrollment in the H-PACT program has consistently been associated with high volume use of primary care, mental health, and specialty care outpatient services. Homeless Veterans enrolled in H-PACT have shown reductions in inpatient hospitalizations and emergency department visits. While national data is not available on H-PACT program clinical performance, published site-specific data (Providence VA Medical Center (VAMC): American Journal of Public Health 2010, American Journal of Public Heath 2013 (publication forthcoming)) has demonstrated improvements in chronic disease (diabetes, hypertension, hyperlipidemia) monitoring and management, as well as accelerated placement in permanent housing among Veterans enrolled in the H-PACT program.

Through September 2012, approximately 3,549 Veterans were enrolled in an H-PACT program. Of those enrolled, approximately 40.6 percent have shown a reduction in emergency department use and a 32.3 percent reduction in inpatient hospitalizations. Data from the Providence VAMC has shown 80.7 percent of homeless Veterans enrolled in an H-PACT program moved into transitional or permanent supportive housing within 6 months and demonstrated significant improvements in blood pressure and cholesterol management.

The H-PACT model has already shown considerable promise with preliminary data from early May 2013 showing 5,691 enrolled H-PACT patients nationwide. H-PACT sites average approximately 350 new patients each month with an 86 percent retention rate. Based on the positive patient outcomes and the excellent perform-

ance of H-PACTs, VA is considering further resource realignment to fund additional H-PACT sites in FY 2014.

Question 23. CRRCs are critical to ending homelessness among veterans. The FY 2014 budget request states that "based on demonstrated positive contribution to the community, additional CRRC investment is anticipated in FY 2013 and FY 2014." Please describe the level of additional investment anticipated in each fiscal year, and the locations that may be considered for placement of additional CRRCs.

Response. Community Resource and Referral Centers (CRRC) are collaborative, multi-agency, multi-disciplinary programs that provide "one-stop shopping" access to housing, health care, job development programs, and other VA and non-VA benefits. In FY 2013, an additional 13 medical centers across the country were awarded funding to establish CRRCs. Two of these sites will become operational in FY 2014. The total funding for 28 of 30 CRRCs in FY 2013 will amount to approximately $23 million. All 28 sites will continue operations in FY 2014 along with two new sites that will activate in FY 2014. At an estimated annual cost of $1 million per site, the total estimated FY 2014 cost is $30 million. CRRC costs include lease, staffing costs, and supply costs.

Although specific locations for future CRRCs have not been determined, additional sites for CRRCs may be selected as the budget allows in FY 2014. VA medical centers will be encouraged to apply for the placement of a CRRC upon announcement of a Request for Proposals. In the event funding is available, potential future sites will be chosen through selection criteria including: documentation of need, homeless Veteran population, services offered, support from the local VA medical center, and community support.

Veterans Canteen Service

Question 24. What is VA doing to ensure that everyone who is eligible to make purchases in person at Veterans Canteen Service (VCS) retail locations can do so via the VCS online exchange store?

Response. Working with internal/external stakeholders, Veterans Canteen Service (VCS) has placed special emphasis on outreach initiatives to eligible patrons communicating the benefits of VCS services. VCS' Online Exchange Catalog validates eligible patrons through VA's enrolled Veterans and active employee database.

Additional initiatives include:

• VA's Health Benefits Office Veterans Benefit Handbook includes VCS Online Exchange Catalog Program and 1–800 Special Order Program information. Since February 2013, approximately 1.5 million copies have been mailed to Veterans. The Veteran Identification Card (VIC) will include information about VCS shopping benefits, and Veterans will be able to directly access the VCS Web site from the Health Benefits Web site.

• eBenefits will host a promotional graphic with the VCS Online Exchange Catalog Program on its homepage carousel. This will take place in September 2013.

• Veterans Integrated Service Network (VISN) Newsletters and booklets include the VCS Online Shopping program. VISN newsletters are electronically sent to Veterans and VA employees. As an incentive, VCS provides coupons placed in newsletters and in some Community Living Centers' (CLC) booklets to be used at the retail stores.

• VCS conducts sale events at community-based outpatient clinics (CBOC) on a scheduled basis. These operations do not have traditional retail/food operations. VCS flyers and Exchange Catalogs are offered to patrons informing them of online shopping benefits and opportunities with VCS.

• VCS uses "eBlasts" (e-mail) to send information periodically to patrons about new VCS programs and online shopping benefits. The list includes 97,000 VA employees and 2,000 Veterans. VCS ran a promotion through July 2013 to sign up Veterans to the eBlast program. VCS accumulated 6,870 new e-mail addresses to include in our national eBlast promotions schedule. Veterans that signed up for the promotion were also registered into a drawing to win prizes for their participation. Winners were notified and visited the VCS Patriot Store to claim their prize. In addition, VCS has increased the e-mail list for VA employees from 97,000 to 101,368 since June 2013.

Question 25. The FY 2014 budget details an anticipated increase of 50 FTE for the Veterans Canteen Service (VCS). Please describe how VCS plans to use these FTE, and where VA anticipates that they will be located.

Response. Veterans Canteen service (VCS) will open 30 PatriotBrew Coffee Shops as well as eight food/retail combo operations located in CBOCs and VBA sites. Additional full-time employees (FTE) will be secured to operate and maintain services at these locations.

Question 26. How is VCS working to improve the profitability of underperforming locations?

Response. VCS has initiated a "deep-dive" assessment of the underperforming operations. This will include analysis of current business models for small, class 4/5 operations; business metrics assessment (gross margins, retail turns, personnel cost increase, FTE/productivity goals, supply chain, retail turns, retail/food/vending promotions, overhead costs, leadership skill sets and core competencies, etc.) to ascertain cause/effect correlations involving successful/unsuccessful operating canteens; and the development of aspirational goals and/or new business models to facilitate improved sales and earnings for these operations. This assessment and supporting action plans were completed in July 2013. Financial reports for August 2013 indicate that 70 percent of the targeted canteens showed improvement in operating income and other metrics. Monthly financial results are addressed directly with targeted operations to ascertain progress toward defined aspirational goals.

Question 27. Is VA considering any expansion of the healthy vending initiative?

Response. VCS currently provides healthy vending machines at 10 percent of VA medical centers. These units offer a variety of organic, gluten free, and healthy food/beverage options. VCS expects to increase the presence of healthy vending machines by 60 percent by the end of fiscal year 2013. This will include VA medical centers, CBOCs, and Veterans Benefits Administration locations.

In 2012, VCS increased the assortment of healthy vending snack options across the country. The assortment includes low fat and low calorie selections. These additions produced a 25-percent sales increase over the previous selections and have been well received by customers. This fiscal year, VCS will double its healthy choice options available from existing food and snack machines to include freshly prepared salads, sandwiches, fruits, and vegetables as well as organic and gluten free products.

Miscellaneous

Question 28. Given that VA generally pays for non-VA care at the Medicare rate, does VA have plans to reduce reimbursement rates, since Medicare is subject to a 2 percent cut and has reduced repayment rates by that percentage?

Response. If the services are under contract, VA will continue to honor the contractual reimbursement rate. Likewise, for services that VA reimburses under the applicable Medicare Fee Schedule when there is no contract, VA payments would continue to reflect Medicare Fee Schedule rates, as only Medicare final payment amounts—not Medicare Fee Schedule rates—are affected by the sequester.

Question 29. Please provide documentation to illustrate the mental health staffing model that VA uses to determine the target number of mental health staff at each facility.

Response. VA has developed and is implementing staffing guidance for general outpatient mental health programs per 1,000 Veterans using mental health services. VA does not yet have a staffing model that determines the target number of mental health staff for the whole facility. VA has previously developed a staffing model for the Residential Rehabilitation Programs that is based on the number of beds in the program. The general outpatient mental health model's clinical staffing ratio is as follows:

Employee Category	FTEE for Mental Health (MH) Team Panel Size of 1,000
Total MH Clinician: Licensed Independent Providers (LIP)	5.1–5.5
Admin. Clerical Support	0.5–1
Non-LIPs	1
Total FTEE	6.6–7.5

The "Total MH Clinician" full-time equivalent employee (FTEE) refers primarily to LIPs (e.g., psychiatrists, psychologists, social workers, nurse practitioners, physician assistants, clinical nurse specialists, licensed marriage and family therapists, and licensed professional mental health counselors) and certain Doctors of Pharmacy (Pharm.D.) with residency and board certification in psychiatric pharmacy while the non-LIPs refer to providers such as Registered Nurses (RN), addiction therapists, and peer support staff. The "Admin. Clerical Support" is the administrative and/or clerical FTEE needed to support the mental health providers on the team. In sum, at the Residential Rehabilitation Program, each team of approxi-

mately 6.6–7.5 FTEE will be responsible for the mental health care of 1,000 Veterans.

Under Section 729 of the National Defense Authorization Act for Fiscal Year 2013, VA is currently developing guidance to determine the staffing level required for specialty mental health outpatient programs per 1,000 Veterans. Finally, VA will develop guidance for acute inpatient programs. Actual staffing at facilities will be based on the types of programs available at the facilities and adjusted for local factors such as use of telemental health programs and non-VA contracts.

Question 30. To the extent that there has been a study completed within the last few years on the nutritional content of food available at VA medical centers, please provide a brief summary of the study's findings as well as a copy of the report.

Response. The automated version of the nutrient analysis data of VA medical center diets began in FY 2002 for Veteran patients. The total calories, fat, cholesterol, and sodium are decreasing. The sodium content of meals has decreased by 1500 milligrams since FY 2002 with the average FY 2012 content at approximately 3100 milligrams of sodium per day. VA medical centers offer modified diets to meet the needs of inpatient Veterans, including Diabetic/Carbohydrate Controlled, Renal, and others that are specific to our patient population. In 2010, VHA's Nutrition and Food Services published VHA Directive 2010–007, Healthy Diet Guidelines, to improve the Regular Diet offered in all VA medical centers: www.va.gov/vhapublications/ViewPublication.asp?pub—ID=2167.

Subsequent to the release of VHA Directive 2010–007, Healthy Diet Guidelines, the sodium, fat, and cholesterol contents of our meals reached their lowest average since 2002. A copy of the data report is provided as an attachment below.

Nutritional Analysis of Patient Hospital Menus

	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Average Calories	2442	2444	2427	2383	2433	2387	2304	2271
Average Percentage Protein	16.9	17	17.2	17.3	17	17.1	18	18.8
Average Percentage Carbohydrate	49.9	50.3	50.3	49.9	49.8	52.57	51	51.1
Average Percentage Fat	33.3	33.5	32.5	32.7	32.3	32.3	31	30
Average Milligrams Sodium	4293	4167	3911	4068	4003	3688	3250	3165
Average Milligrams Cholesterol	377	369	358	364	386	378	308	361

Question 31. Please provide the amount VA spent on outreach during fiscal year 2012 and the estimate for how much will be spent during fiscal year 2013.

Response. The Office of Public and Intergovernmental Affairs' (OPIA) National Veterans Outreach Office (NVO) spent approximately $600,000.00 on outreach during Fiscal Year 2012. This amount was expended for message development and production of creative material for an integrated advertising campaign. The goal of this campaign was to inform and educate Veterans, their families, and other stakeholders about the health care, benefits and services VA provides and eligibility based on their service.

During FY 2013, OPIA will spend approximately $1,600,000.00 on costs related to a national advertising campaign led by the Ad Council. Ad Council is collaborating with DDB, an award winning advertising agency, to produce the campaign. DDB is providing pro bono advertising services. By working with the Ad Council and DDB, VA is receiving advertising support from a world class advertising agency, which represents approximately $35,000,000.00 worth of savings for the government. These professional services will continue national VA outreach efforts to increase awareness among Veterans and family members regarding the breadth of VA benefits and services available to them and how to access them.

CONSTRUCTION AND LONG RANGE CAPITAL PLAN

Question 32. Please provide a list of priority weights for the major criteria and sub criteria used to inform the FY 2014 Strategic Capital Investment Plan decision plan.

Response. The diagram below shows the major criteria and sub criteria priority weights that were used to inform the FY 2014 Strategic Capital Investment Plan.

Goal | Criteria | Sub-criteria

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

Departmental Initiatives
- Major Initiatives
- Supporting Initiatives
- DoD Collaboration
- Energy Standards

2014 SCIP Decision Criteria

Fixing What We Have
- Reduce Facility Condition Assessment Deficiencies
- Other Gaps (Includes parking and self-defined)

Increasing Access
- Utilization/Workload
- Client (Veteran) Access to Services
- Customer (Internal) Access to Services
- Wait Times
- Support Structures

Right-Sizing Inventory
- Space – New Construction/Renovation/Lease
- Space – Collocation
- Space – Disposal/Reuse
- Space – Telework

Ensure Value of Investment
- Best Value Solution
- Cost Saving Strategies

The decision criteria are Improve Safety and Security, Fixing What We Have; Increasing Access; Right-Sizing Inventory; Ensure Value of Investment; and Departmental Initiatives.

The details of each major criterion are listed below:

• *Improve Safety and Security:* VA is dedicated to ensuring its Clients (Veterans) and Customers (VA Staff) are being served and/or work in a safe and secure environment. Mitigating the destruction and injury caused by natural or manmade disasters (including seismic, hurricane, flooding, blast, etc.); improving compliance with safety and security laws, building codes, and regulations; mitigating threats to persons on a VA facility (physical security), and ensuring VA mission critical buildings are able to provide service in the wake of a catastrophic event, are of paramount importance.

• *Fixing What We Have* (making the most of current infrastructure/extending useful life): VA is committed to managing its buildings in order minimize the extent to which deficiencies in infrastructure (including IT infrastructure) and other areas impact the delivery of benefits and services to Veterans. For infrastructure deficiencies, facility condition assessments (FCA) evaluate the condition of VA buildings. Mitigating other deficiencies (such as functional deficiencies and privacy deficiencies) also has a positive impact on the delivery of benefits and services.

• *Increasing Access:* Serving Veterans is at the core of VA's mission. VA strives to increase access for Veterans by reducing the time and distance a Veteran must travel to receive the best quality services and benefits; providing adequate supporting structures at VA facilities, such as gravesite locators; by increasing our ability to handle workload; and by enabling VA staff to work efficiently.

• *Right-Sizing Inventory:* In order to provide the highest quality service to Veterans at the right time and in the right place, VA is managing its space inventory by reducing excess space, building new space, collocating (VHA, VBA, NCA, and Staff Offices using the vacant or underutilized space of another office), leasing new space, and converting underutilized space of one type to another type, to better suit its mission.

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

• *Departmental Initiatives:* For improved management and performance across the Department, capital projects should contribute to key major (such as eliminating Veterans homelessness; improving Veterans mental health; enable 21st century benefits, etc.) and supporting initiatives (such as educating and empowering minority

and women Veterans; enabling 21st century vocational rehabilitation and employment; expanding Veterans access to burial options in National or State Veterans cemeteries) from the Department's strategic plan, including DOD collaboration and complying with energy standards established in law and Executive Orders.

Question 33. VA has identified over $9 billion in facility condition deficiencies to remediate, and a total of $54–66 billion in facility improvements that have been requested over the next ten years. In light of several successful partnerships to share space with community providers, what type of considerations are being made regarding the use of these means to close this gap with fewer appropriated dollars?

Response. Generally speaking, assets that have significant conditions to remediate are often poor candidates for sharing of space. The risk associated with significant deficiencies must be mitigated prior to engaging with community partners or other Federal agencies to share such space. This mitigation falls on VA and would require appropriated funding.

For assets that have some deficiencies, but are otherwise in usable condition, VA has had success using public-private partnerships. In these cases, VA is able to leverage non-appropriated funds to address the condition deficiencies of certain assets. VA has used its enhanced-use lease (EUL) authority to repurpose and restore unneeded assets, using private funding, in support of housing homeless Veterans and delivering complementary services at local VA medical centers. Since the EUL program was authorized in 1991, VA has awarded 100 projects. These projects include housing (57), special services for Veterans (3), consolidation/improved VA operations (14), energy (4), and mixed-use/community benefit (14). Eight of the 100 projects have been terminated.

VA's current EUL authority, a narrow version to that which existed before expiration on December 31, 2011, only allows re-purposing assets for supportive housing, which limits the type of partnerships and assets that can be pursued. A restoration of VA's full EUL authority, as requested in the FY 2014 President's Budget, would allow additional assets to be considered for re-purposing.

Other VA authorities, such as sharing agreements or joint ventures with DOD have also assisted in meeting some of its condition or space needs. These arrangements, however, generally still require appropriated funding, although they may be shared across agencies. One example of this is the Captain James A. Lovell Federal Health Care Center in North Chicago, Illinois, where VA and DOD operate the center jointly.

Question 34. The budget requests authorization to proceed with 27 major medical facility leases in 18 states. For each, please detail the following:

a. When the existing facility will close, if the request is for a replacement, consolidation, or expansion lease.

b. The number of unique veterans that will not be able to access care, if the request is for a replacement, consolidation, or expansion lease.

c. The effect that pursuing each alternative to lease would have on the patient population or the ability to provide care.

Response. The attached document contains information responsive to questions 34 a–c for each of the 27 major medical facilities requiring Congressional authorization. The attached information was previously transmitted to the Committee on June 4, 2013, and was current at the time of submission.

West Haven, Connecticut
Errera Center Relocation
Replacement and Expansion Lease for West Haven's Errera Center

Summary: Impact on Veterans and the Department of Veterans Affairs (VA) of failure to secure authorization of lease:

VA has created "Errera Centers" to provide intensive support to Mental Health patients and Veterans vulnerable to homelessness. They provide a continuum of care in a single, expanded facility. This lease would support expansion of these vital services through a new facility three times the size of the previous Errera Center and located apart from the parent facility, the West Haven VA medical center.

If Congress cannot enact the authorization for this expanded center, the significant benefit of having these consolidated, focused and expanded services in one dedicated facility to support two of VA's most critical programs, Mental Health and Homeless programs, will be lost.

The community would also lose the benefit of 22 additional VA employees connected with an expanded center.

Veterans currently served at current lease facility (if applicable): *7,182 Veterans*

Detail on adverse impact of failure of authorization:

- *VA is unique in providing Errera Centers to proactively support Mental Health patients and Veterans vulnerable to homelessness. A continuum of care in a single, expanded facility is needed to maximize their care.*
- *By maintaining the current size of the clinic, Mental Health and Homeless programs will be in non-contiguous settings for the Veteran's needs, creating inefficiencies for patients.*
- *By maintaining the current size of the clinic, inefficiencies in staff will remain, creating duplications of functions and services in the Mental Health and Homeless programs.*
- *The current size of the existing Errera Center is 13,445 Net Usable Square Feet (NUSF); the new clinic will be approximately three times this size at 45,000 NUSF to allows for the expansion of the additional services to ensure a true continuum of care for VA's vulnerable patients.*
- *128 employees support the programs at the existing Errera Center; the expansion would increase the number to 150 employees.*
- *Lease expiration is July 31, 2013 without a renewal options.*

Worcester, Massachusetts
Community Based Outpatient Clinic (CBOC) Expansion
Replacement and Expansion Lease for Worcester's CBOC

Summary: Impact on Veterans and Department of Veterans Affairs (VA) of failure to secure authorization of lease:

If Congress cannot enact the authorization for this expanded CBOC, area Veterans will be forced to contend with an outdated and overcrowded clinic. That situation will only get worse with time with increased demand for services.

If Congress cannot pass this routine lease authorization, Veterans will be denied the relief to access problems that would have been provided by a significant increase in clinic space, bringing Mental Health, Specialty Care, Pharmacy, and Prosthetic care closer to them.

The community would also lose the benefit of an additional 37 employees associated with the expansion.

Veterans currently served at current lease facility (if applicable): 6,745 Veterans

Detail on adverse impact of failure of authorization:

- *Veterans will continue to contend with an outdated and overcrowded clinic.*
- *The current size of the existing clinic is 24,693 Net Usable Square Feet (NUSF); the new clinic will be approximately 40,000 NUSF to allow the current services to be appropriately sized to meet the latest design criteria and meet the projected demand.*
- *83 employees support the programs at the existing Worcester CBOC; the expansion would increase the number to 120 employees.*
- *Lease standstill agreement expires on August 12, 2013. A succeeding lease will be procured to continue services in the existing location through 2018.*

Hines, Illinois
Research Lease
New Research Lease for Research Expansion at Hines

Summary: Impact on Veterans and the Department of Veterans Affairs (VA) of failure to secure authorization of lease:

Space constraints and poor conditions for the existing research functions at the Hines VA Medical Center are creating unsafe, overcrowded environments for researchers. If Congress cannot enact the authorization for a new lease for a modern facility, existing space shortages and condition deficiencies will remain, negatively impacting Hines' ability to recruit top Researchers and maintaining the significant level of research grant funding.

Detail on adverse impact of failure of authorization:

- *If the new lease is not authorized, Researchers will continue to be overcrowded in their existing, antiquated space. The building was constructed in 1921 when narrow hallways and lower ceilings were considered ideal. This makes for inefficiencies in staff flow and space utilization.*
- *If the new lease is not authorized, attracting top Researchers will realistically be difficult, resulting in a decrease in grant funding.*
- *The current research environment has condition and safety deficiencies related to mechanical, plumbing and electrical systems, totaling almost $6 million that will be resolved with the new lease.*
- *The new lease will house 175 employees in the Research Office in appropriately sized space, allowing for ample storage and walk-ways to meet life safety concerns.*
- *Current condition deficiencies total $5.1 million*
- *Hines' Research FY2012 grant funding, $18,436,280*

Improved health care access and services if lease authorization approved:

The proposed new lease will house the diverse research programs at the Hines campus, including Basic Laboratory Research and Development, Cooperative Studies, and Health Services Research and Development Center of Excellence. These programs are VA's investment in the advancement of health care for Veterans.

Cape Girardeau, Missouri
Community Based Outpatient Clinic (CBOC) Expansion
Replacement and Expansion Lease for Cape Girardeau's CBOC

Summary: Impact on Veterans and Department of Veterans Affairs (VA) of failure to secure authorization of lease:

If Congress cannot enact the authorization for the expanded CBOC, the existing significantly overcrowded clinic will continue to reside in inefficient space configurations and significant contract fees will continue to be expended for Specialty Care services.

Veterans will lose the benefit of expansions of Primary Care, Mental Health, Women's Health, as well as additional space for Veterans Service Officers and VA's Veterans Benefits Administration. In addition, Specialty Care would be provided to include Substance Abuse Clinic, Radiology, Urology, Oncology, Orthopedics, Rehabilitation Medicine, and general Outpatient Surgery.

The community would lose the benefit of an expected 71 additional employees associated with the clinic.

Veterans currently served at current lease facility (if applicable): *4,977 Veterans*

Detail on adverse impact of failure of authorization:

- *Veterans will continue to be provided with non-VA medical care on a fee basis to the community for Specialty Care services, which is cost prohibitive.*
- *An increase in contracted Specialty Care costs will increase dramatically based on the increased projected demand for Specialty Care.*
- *Veterans will continue to be served in an outdated, inefficient lease, creating overcrowding, resulting in dissatisfied Veterans.*
- *The current size of the clinic is 8,000 Net Usable Square Footage (NUSF); the new clinic will be approximately five times that size at 43,000 NUSF to meet the projected outpatient demands as well as to provide Specialty Care currently contracted with the community.*
- *29 employees support the programs at the existing Cape Girardeau CBOC; the expansion would increase the number to 100 employees.*

Johnson County, Kansas
Community Based Outpatient Clinic (CBOC)

Summary: Impact on Veterans and Department of Veterans Affairs (VA) of failure to secure authorization of lease:

If Congress cannot enact the authorization for this new lease, Veterans will be forced to continue to contend with an overcrowded medical center and face extended driving times to access basic Primary Care and vital Mental Health Care services. This will only worsen as demand for services increases.

Failure to enact this authorization will deny Veterans the relief from access problems that would be provided at this long-planned point of care that would have included comprehensive outpatient services: Primary Care, Mental Health, Audiology and Speech Pathology, Dermatology, Gastroenterology, Endoscopy, Oncology, Chemotherapy, Obstetrics and Gynecology, Ambulatory Surgery, Eye Clinic, Orthopedics, Podiatry, Urology, Substance Abuse, Radiology, Laboratory and Pharmacy.

The community would also lose the benefit of 46 VA employees who would staff the new clinic.

Veterans planned to be served under proposed lease (dependent on lease authorization): *11,327 Veterans*

Detail on adverse impact of failure of authorization:

- *The Veterans will continue to be served at the undersized Kansas City VA Medical Center.*
- *Veterans will continue to have unsatisfactory access for Primary Care and Mental Health, having to drive longer than 30 to 60 minutes across town to reach the medical center, depending on traffic.*
- *46 employees are expected to be hired for this new CBOC.*
- *Kansas City's Space Deficit will remain, 38,767 sqft*

Lafayette, Louisiana
Community Based Outpatient Clinic (CBOC) Expansion
Replacement and Expansion Lease for Lafayette's CBOC

Summary: Impact on Veterans and Department of Veterans Affairs (VA) of failure to secure authorization of lease:

If Congress cannot enact the authorization for the expanded CBOC, Veterans will be forced to contend with an overcrowded, outdated facility, with the situation only worsening as workload increases.

Veterans will be denied the relief to these access problems of an almost three-fold expansion of clinic space, which would bring needed expansions of Primary Care, Mental Health, Women's Health, and Specialty Care as well as additions of Dental, Imaging, Physical Therapy, Urology, Ophthalmology, and Dermatology. Without this authorization, Veterans will continue to be required to travel 180 miles roundtrip to the Alexandria VA Medical Center to receive the additional services the expanded clinic would have offered.

There are negative effects as well on the Alexandria VA Medical Center, which suffers a significant space deficit. With expansion plans scuttled, there will be no relief in sight to address crowded conditions in that facility.

The community would also lose the benefit of 14 additional medical employees associated with the expansion.

Veterans currently served at current lease facility (if applicable): *7,227 Veterans*

Detail on adverse impact of failure of authorization:

- *Veterans will be required to travel 180 miles roundtrip to the parent facility, the Alexandria VA Medical Center, to receive the services the expanded clinic will have offered.*
- *The current size of the clinic is 11,208 Net Usable Square Footage (NUSF); the new clinic will be approximately three times the size at 29,224 NUSF to meet the current and projected workload demand.*
- *The Alexandria VA Medical Center will continue to be overcrowded and will be unable to decompress to the expanded clinic.*
- *56 employees support the programs at the existing Lafayette CBOC; the expansion would increase the number to 70 employees.*
- *Alexandria's Space Deficit will remain, 60,042 sqft*

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Lake Charles, Louisiana
Community Based Outpatient Clinic (CBOC)

Summary: Impact on Veterans and the Department of Veterans Affairs (VA) of failure to secure authorization of lease:

If Congress cannot enact the authorization for this new CBOC, Veterans will be forced to receive their care through a mobile clinic, which is extremely undersized and offers only basic primary care. For other care, Lake Charles Veterans will continue to be required to travel 200 miles round-trip to the Alexandria VA Medical Center to receive the services that would have been offered by the new clinic. The existing mobile clinic offers little patient privacy, which may impedes full and open communication with VA health professionals.

Veterans will be denied the relief to these access problems that would be brought by expansion of Primary Care as well as new services for Mental Health, Dermatology, Audiology, Ophthalmology, Prosthetics, Urology, Women's Health, Orthopedics, Cardiology, Oncology, and Physical Therapy and Rehabilitative Services.

Continued failure to authorize the clinic will also result in continued strain on the Alexandria VA Medical Center, and will increase waiting times there as demands for care increase.

The community would lose the benefit of 42 additional VA employees connected with the expanded clinic.

Veterans planned to be served under proposed lease (dependent on lease authorization): *6,000 Veterans*

Detail on adverse impact of failure of authorization:
- *Veterans will continue to be forced to receive their care in an overcrowded mobile clinic, a situation projected to get worse with increasing demand.*
- *The configuration does not afford patient privacy to the extent needed to ensure patient confidentiality.*
- *Veterans in the Lake Charles area will be required to continue to drive 200 miles roundtrip to the parent facility, the Alexandria VA Medical Center, to receive the services the new clinic will have offered.*
- *The mobile clinic cannot expand and provides only the basic primary care services; the new clinic will be 24,088 Net Usable Square Footage (NUSF) to meet the current and projected workload demand.*
- *The Alexandria VA Medical Center will continue to be overcrowded and will be unable to decompress to the expanded clinic.*
- *Six employees support the programs in the existing mobile clinic; the expansion would increase the number to 48 employees.*
- *Alexandria's Space Deficit will remain, 60,042 sqft*

Houston, Texas
Health Systems Research and Development (HSRD) Lease
Replacement Lease for Houston's Health Systems Research and Development Center

Summary: Impact on Veterans and Department of Veterans Affairs (VA) of failure to secure authorization of lease:

If Congress cannot enact the authorization for this Research and Development lease, the existing, unique lease will be required to remain at the current size, not allowing space the necessary space for important research programs that are an important part of VA's mission to serve Veterans. Even with a short-term lease constrained at less than one million dollars, a longer-term lease likely would not come in at under one million dollars a year. Failure of the authorization would mean inadequate facilities to carry out effective research, reduces the potential for grants, and thus could negatively impact VA's mission for research and associated funding. Veterans as well as the advancement of medical science benefit from VA's research programs

The community would lose the benefit of 18 additional research personnel associated with expansion of the research facility.

Current lease termination: April 2014. *These termination dates in terms of medical leasing transactions are much closer than they appears. Statutory authorization should proceed the termination date by at five fiscal years ideally. This lead time is necessary because of the mandatory competitive contracting required by law, as well as execution of the necessary contracts and any required build-out. Thus closure of the facility is a risk if authorization does not occur in FY 2014.*

Veterans currently served at current lease facility (if applicable): *N/A*

Detail on adverse impact of failure of authorization:
- *If the new lease is not authorized, Researchers will continue to be overcrowded in their existing, antiquated space.*
- *If the new lease is not authorized, attracting top Researchers will realistically be difficult, resulting in a decrease in grant funding.*
- *The current size of the facility is 35,443 Net Usable Square Footage (NUSF); the new facility will be approximately 48,000 NUSF to meet the space requirements for the Research programs.*
- *198 employees support the programs at the existing Houston HSRD lease; the expansion would increase the number to 216 employees.*
- *Houston's Research FY2012 grant funding, $18,348,477*

Tulsa, Oklahoma
Outpatient Clinic Expansion
Replacement and Expansion Lease for Tulsa's Outpatient Clinic

Summary: Impact on Veterans and the Department of Veterans Affairs (VA) of failure to secure authorization of lease:

If Congress cannot enact the authorization for this expanded Outpatient Clinic, the existing significantly overcrowded clinic will be forced to close. Veterans will be forced to drive 100 miles round trip to the next site of care to receive existing services – fee care could be a partial solution, but it is an expensive mode of care and Veterans lose the benefits of VA's focus on Veterans and the integration of care it offers. In addition, beneficiary travel expenses will increase as with closure Veterans will be forced to drive to the Muskogee VA Medical Center as demand increases.

Veterans will lose the benefit of additional services for homeless veterans, a dedicated women's clinic, and expanded mental health services

The community will lose the benefit of 154 additional employees associated with the expansion.

Veterans currently served at current lease facility (if applicable): *25,806 Veterans*

End date of lease: *11/26/2020*
NOTE ON END DATE OF LEASE: *While this lease termination date appears to be comfortably distant, that date is in terms of medical leasing transactions much closer than it appears. Statutory authorization should proceed the termination date by at five fiscal years ideally. This lead time is necessary because of the mandatory competitive contracting required by law, as well as execution of the necessary contracts and any required build-out.*

Detail on adverse impact of failure of authorization:
- *Beneficiary travel will increase significantly due to the roundtrip added for the 25,806 Veterans.*
- *The Muskogee VA Medical Center will remain significantly overcrowded and unable to decompress to meet their significant projected outpatient demand.*
- *The current size of the clinic is 55,600 Net Usable Square Footage (NUSF); the new clinic will be more than two and a half times the size at 140,000 NUSF to meet the significant projected outpatient demand for the Tulsa clinic as well as to relieve the Muskogee VA Medical Center from overcrowding.*
- *183 employees support the programs at the existing Tulsa Outpatient Clinic; the expansion would increase the number to 337 employees.*
- *Muskogee's Space Deficit will remain, 134,038 sqft*
- *Tulsa's projected outpatient demand over 20 years, 33 percent increase*
- *Muskogee's projected outpatient demand over 20 years, 27 percent increase*
- *Fee basis care expenditures - $9,375,000 annually*

Tyler, Texas
Community Based Outpatient Clinic (CBOC) Replacement and Expansion

Summary: Impact on Veterans and Department of Veterans Affairs (VA) of failure to secure authorization of lease:

If Congress cannot enact the authorization for this expanded CBOC, Veterans will be forced to continue contending with a significantly overcrowded clinic, with the situation only getting worse as patient demand increases, especially for Mental Health and Primary Care. Without the authorization, greatly needed and long-planned relief in the form of expanded Primary Care and Mental Health care will be denied. Also lost will be needed additions of Audiology, Radiology, Dietetics, Social Work, Prosthetics, and a laboratory.

For those additional services, Veterans will continue to be required to travel to the Dallas VA Medical Center, which is almost 200 miles round-trip. Another effect of a continued failure to secure this routine lease authorization will be increasing wait times at the Dallas VA Medical Center.

Veterans will be denied the long-planned relief of a needed nine-fold increase in clinic size, and the community will lose the benefit of 19 additional VA employees associated with the expanded clinic.

Veterans currently served at current lease facility (if applicable): *4,849 Veterans*

Detail on adverse impact of failure of authorization:
- *Veterans will continue to contend with an outdated, inefficient facility that can't expand to meet the projected workload demand for Mental Health and Primary Care.*
- *Veterans will continue to be required to travel almost 200 miles roundtrip to the parent facility, Dallas VA Medical Center, which is already extremely overcrowded. Veterans using the Dallas VA Medical Center will suffer increased wait times as a result.*
- *The current size of the clinic is 5,572 Net Usable Square Footage (NUSF); the new clinic will be approximately nine times the size at 48,425 NUSF to meet the current and projected demands as well as assist with the relief of the space deficiencies at the Dallas VA Medical Center.*
- *25 employees support the programs at the existing Tyler CBOC; the expansion would increase the number to 44 employees.*
- *Dallas's Space Deficit will remain, 261,682 sq ft*

San Antonio, Texas
Outpatient Clinic Expansion (OPC)
Consolidation and Expansion Lease for San Antonio's Outpatient and Specialty Clinics

Summary: Impact on Veterans and VA of failure to secure authorization of lease:

If Congress cannot enact the authorization for this consolidated OPC, the main existing Frank Tejeda Outpatient Clinic will be forced to close. A great increase in overcrowding, Veteran travel times, and wait times would occur due to the extremely limited space at the San Antonio VA Medical Center. VA would be forced to dramatically increase its use of expensive fee-based care, where Veterans would not have the advantage of receiving VA's Veteran-centered care. Potentially the cost for fee-basis care could wind up equating to two times the cost of the planned lease. Continued delays will only worsen the situation for area Veterans as workload increases.

To the extent Non-VA providers in the community are not available, wait times will be drastically increased at the San Antonio VA Medical Center due to significant space deficiencies

The community would lose the benefit of 130 new employees associated with the new clinic.

Failure of this routine lease authorization would deny Veterans a long-planned consolidation to relieve access problems that would create a clinic nearly four times the size of existing clinic space in the area. Veterans would lose the benefits of the long-planned clinic that would greatly increase their access to Primary Care, Mental Health, Women's Health, Compensation and Pension Exams, Phlebotomy, Radiology, Community Residential Care, Homeless Primary Care, Deployment Health, and Pharmacy Services.

Veterans currently served at current lease facility (if applicable): *55,753 Veterans*

End date of lease: *8/4/2019 NOTE: while this lease termination date appears to be comfortably distant, that date is in terms of medical leasing transactions much closer than it appears. This lead time for acquisition of a new lease is necessary because of the procurement processes and related due diligence (e.g., environmental studies) required by law and regulation, as well as execution of the lease contract and any required build-out.*

Detail on adverse impact of failure of authorization:

- *Veterans will be forced to receive care at non-VA facilities to continue the current services if the closure of the Frank Tejeda Outpatient Clinic occurs. This*

assumes the community has capacity to provide the care. To the extent Non-VA providers in the community are not available, wait times will be drastically increased at the San Antonio VA Medical Center due to significant space deficiencies.

- *The total size of the existing 6 clinics is 51,296 Net Usable Square Footage (NUSF); the new, consolidated clinic would be almost four times that size at 190,800 NUSF to meet the demands of the current as well as projected workload.   Without this expanded, consolidated clinic, the San Antonio VA Medical Center will continue to be extremely overcrowded.*

- *224 employees support the programs at the six existing clinics; the expansion would increase the number to 354 employees.*

- *San Antonio's Space Deficit will increase due to the workload from the Frank Tejeda outpatient clinic; current space deficit totals 561,197 sq ft.*

- *Contract care anticipated costs, $31.8 million, per year – inclusive of all services currently provided at the Frank Tejeda outpatient clinic. Providing services in-house costs, $15.9 million per year – inclusive of all services currently provided at the Frank Tejeda Outpatient Clinic.*

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Lubbock, Texas
Outpatient Clinic Expansion
Replacement and Expansion Lease for Lubbock's Outpatient Clinic

Summary: Impact on Veterans and the Department of Veterans Affairs (VA) of failure to secure authorization of lease:

If Congress cannot enact the authorization for this expanded Outpatient Clinic, Veterans will continue to confront a significantly overcrowded clinic to access VA health care. That overcrowding will only get worse as the area's demand for VA healthcare is expected to grow at a dramatic rate. A failure to secure the lease authorization will mean increased expenses for fee care and beneficiary travel. Veterans will continue to be required to travel to the Amarillo VA Medical Center to receive the additional services the expanded clinic would offer.

Veterans will lose the benefit of expansions of Primary Care, Dermatology, Podiatry, and Mental Health as well as additions of access to Endoscopy, Ambulatory Surgery, Gastroenterology, and Audiology at the expanded clinic.

In addition the community will lose the advantage of 18 additional employees associated with the expansion.

Veterans currently served at current lease facility (if applicable): *12,703 Veterans*

Detail on adverse impact of failure of authorization:
- *Endoscopy care will continue to be purchased outside of VA, which is not cost effective compared to these services being provided by VA staff.*
- *Beneficiary travel costs to the Amarillo VA Medical Clinic will continue to increase to meet access and wait time demands.*
- *The current size of the clinic is 36,000 Net Usable Square Footage (NUSF); the new clinic will be just shy of three times this size at approximately 94,000 NUSF to meet the outpatient projected demand as well as allow fee basis services to be brought in-house.*
- *110 employees support the programs at the existing Lubbock Outpatient Clinic; the expansion would increase the number to 128 employees.*

Measures of Impact of Failure to Authorize Lease:
- *Lubbock's projected outpatient demand over 20 years, 51 percent increase*
- *Amarillo's projected outpatient demand over 20 years, 23 percent increase*
- *Cost of non-VA Endoscopy services - $1,668,600 annually*

Albuquerque, New Mexico
Cooperative Studies Program Clinical Research Pharmacy Coordinating Center
Replacement Lease for Albuquerque's Research, Regulatory and Pharmacy Lease

Summary: Impact on Veterans and Department of Veterans Affairs (VA) of failure to secure authorization of lease:

While not providing direct patient care, the work of this key hub for pharmaceutical research and regulatory matters will be disrupted should the inability to secure routine medical lease authorization persist. Should Congress not find a solution, unfortunately VA sees no other alternative but to end these existing unique services and instead obtain them from for-profit organizations outside the VA Research and other work key to VA leadership in health care will suffer needless fragmentation and disruption.

If such a closure occurs, the community would lose the benefit of the 114 VA employees associated with this facility.

End date of lease: *8/31/2015*
NOTE: while this lease termination date is more than two years away, that date is actually very close in terms of medical leasing. This lead time for acquisition of a new lease is necessary because of the procurement processes and related due diligence (e.g., environmental studies) required by law and regulation, as well as execution of the lease contract and any required build-out. In fact, in light of the lease expiration date, VA could need two successive lease authorizations – one to establish a bridge lease while the longer-term solution is pursued.

Detail on adverse impact of failure of authorization:

- *Significant costs to procure these unique services will be required if this lease is not authorized, which could create a loss of control related to timelines and loss of control of VA research.*
- *The size of the clinic remains the same at 68,000 Net Usable Square Footage. 114 employees support the programs at the existing Albuquerque Cooperative Studies.*

VA assets threatened if routine lease authorization fails:

The replacement lease would continue these valuable programs which include all pharmaceutical, regulatory, and research participant safety monitoring support for all VA Cooperative Studies Programs within the multi-center clinical research auspice, including administrative, project management, drug manufacturing, packaging, labeling, processing assembly, distribution (including shipment packaging, shipping, and storage), quality control, biopharmaceutics laboratory, regulatory support (Food and Drug Administration (FDA) filings), adverse event monitoring, research site monitoring, and IT functions.

This is a very unique center and the only one within VA that provides statutorily required regulatory support FDA and real-time research participant safety monitoring for VA sponsored multi-center clinical trials. The fragmentation and dislocation created by a forced change in the work of the center would be immensely disruptive.

Phoenix, Arizona
Outpatient Clinic Annex
New Lease to Annex for Phoenix

Summary: Impact on Veterans and the Department of Veterans Affairs (VA) of failure to secure authorization of lease:

If Congress cannot enact the authorization for this new annex, Veterans will continue to confront a significantly overcrowded facility, access issues, and increases in wait time. This will only increase with anticipated substantial increases in demand. Costs will significantly increase as a result of increased beneficiary travel and fee basis expenses.

Veterans planned to be served under proposed lease (dependent on lease authorization): *64,878 Veterans*

Detail on adverse impact of failure of authorization:

- *Veterans will continue to be served in an extremely overcrowded facility, resulting in continued access and wait times issues*
- *The Phoenix VA Medical Center will be unable to meet their significant projected outpatient demand.*
- *The new clinic will be approximately 203,000 NUSF.*
- *628 employees support the programs at the existing Phoenix VA Medical Center; the expansion would increase the number to 628 employees.*

Measures of impact of failure to authorize lease:

- *Phoenix's Space Deficit will remain, 493,359 sqft*
- *Phoenix's Outpatient Projected Demand, 26 percent increase over next 20 years*

Honolulu, Hawaii
Outpatient Clinic (OPC)
New Lease for Honolulu with Department of Defense (DoD) and Department of
Veterans Affairs (VA)

Summary: Impact on Veterans and VA of failure to secure authorization of lease:

If Congress cannot enact the authorization for this new OPC, Veterans in this area will continue to be negatively impacted in access and wait times. The existing Honolulu VA and Tripler Medical Center is currently overcrowded. Projected outpatient demand increases of 30 percent over the next 20 years will only make the situation worse. Veterans now are forced to spend two hours driving to and from appointments. While a relatively short distance, extreme island traffic conditions make the drive a very long one and impede access.

If the lease authorization continues to fail, Veterans will be deprived of a clinic much more accessible to them that would have included Primary Care, Mental Health, Specialty Care, Radiology, Laboratory, Pharmacy and Tele-health. It would also have provided space to house a center for the National Tele-radiology Program, a key element to advance VA's leadership in rural health care. The clinic will also provide space for VBA and DoD to maximize collaborations and sharing of clinical and ancillary functions.

In addition, the community would lose the benefit of approximately 200 VA employees who would have staffed the clinic.

Veterans planned to be served under proposed lease (dependent on lease authorization): *22,173 Veterans*

Detail on adverse impact of failure of authorization:

- *Veterans will continue to be served at the significantly undersized and overcrowded Honolulu and Tripler Medical Center.*
- *Veterans will continue to suffer from the lack of access for these services closer to where they reside. By mileage, it's only 22 miles roundtrip; however, due to island traffic conditions, the drive time can be up to 2 hours.*
- *VA and DoD will not be able to move ahead on a collaborative project that will further progress on joint endeavors to improve services for veterans and servicemembers.*
- *200 employees are expected to be hired for this new OPC.*
- *Honolulu's Space Deficit will remain, 171,234 sq ft*
- *Projected workload demand increases in next 20 years for outpatient, 33 percent*

Chico, California
Outpatient Clinic Expansion
Replacement and Expansion Lease for Chico's Outpatient Clinic

Summary: Impact on Veterans and Department of Veterans Affairs (VA) of failure to secure authorization of lease:

If Congress cannot enact the authorization for this expanded outpatient clinic, Veterans will continue to be served in an overcrowded, out-dated clinic. In addition, Veterans will continue to be required to travel to the Sacramento VA Medical Center to receive the additional services the expanded clinic would have offered. Veterans will also be deprived of the benefit of the additions of Pulmonary and Cardiology care. Veterans will be deprived of additional services for women and homeless Veterans.

The community would be denied the benefit of the 11 employees associated with the expansion.

Veterans currently served at current lease facility (if applicable): *8,489 Veterans*

Detail on adverse impact of failure of authorization:

- *Veterans will continue to be served in an outdated, inefficient facility.*
- *The Sacramento VA Medical Center, the parent facility, will remain significantly overcrowded and unable to decompress.*
- *The current size of the clinic is 17,952 Net Usable Square Footage (NUSF); the new clinic will be more than twice this size at 42,000 NUSF to meet the current demand, provide space for the projected demand, and allow space for the Sacramento VA Medical Center to decompress.*
- *75 employees support the programs at the existing Chico Outpatient Clinic; the expansion would increase the number to 86 employees.*
- *Sacramento's Space Deficit will remain, 164,035 sq ft*

Redding, California
Outpatient Clinic Expansion
Replacement and Expansion Lease for Redding's Outpatient Clinic

Summary: Impact on Veterans and Department of Veterans Affairs (VA) of failure to secure authorization of lease:

If Congress cannot enact the authorization for this expanded outpatient clinic, Veterans will be forced to use an overcrowded, outdated clinic to access their VA healthcare benefits. Veterans will also be required to travel to the Sacramento VA Medical Center to receive the additional services the expanded clinic would have offered. Veterans will lose the benefit of a 60 percent expansion in clinic size.

The community will lose the benefit of 29 additional employees associated with an expanded clinic.

Veterans currently served at current lease facility (if applicable): 14,856
Veterans

Detail on adverse impact of failure of authorization:

- *Veterans will continue to be served in an outdated, inefficient lease, creating overcrowding, resulting in dissatisfied Veterans.*
- *The Sacramento VA Medical Center, the parent facility, will remain significantly overcrowded and unable to decompress.*
- *The current size of the clinic is 48,293 Net Usable Square Footage (NUSF); the new clinic will be approximately 77,000 NUSF to meet the current demand, provide space for the projected demand, and allow space for the Sacramento VA Medical Center to decompress.*
- *171 employees support the programs at the existing Redding Outpatient Clinic; the expansion would increase the number to 190 employees.*

Measures of impact of failure to authorize lease:

- *Sacramento's Space Deficit will remain, 164,035 sq ft*

San Diego, California
Outpatient Clinic (OPC) Expansion
Replacement and Expansion Lease for San Diego's Mission Valley OPC

Summary: Impact on Veterans and Department of Veterans Affairs (VA) of failure to secure authorization of lease:

If Congress cannot enact the authorization for the expanded CBOC, the existing clinic will be forced to forego expansion which would otherwise double the size of the clinic. Veterans will as a result face increasing overcrowding with VA contracting more care to non-VA facilities, which is not cost effective compared to securing a new larger space.

If Congress does not resolve the issue of medical lease authorizations, Veterans will be denied the relief to these access problems that would have been provided by a greatly expanded clinic, bringing the following services closer to them: Primary Care, Mental Health, Eye Clinic, Audiology, Radiology, and Laboratory, and Compensation and Pension exams.

The community would also lose the benefit of an additional 25 VA employees associated with this expanded clinic.

Veterans currently served at current lease facility (if applicable): *32,832 Veterans*

Detail on adverse impact of failure of authorization:

- *The current size of the clinic is 47,995 Net Usable Square Feet (NUSF); the new clinic would have doubled in size to approximately 99,986 NUSF to meet the current demands of the clinic and relieve overcrowding of the parent facility, San Diego VA Medical Center.*
- *125 employees support the programs at the existing Mission Valley CBOC; the expansion would increase the number to 150 employees.*
- *San Diego's Space Deficit will remain, 403,700 sqft*

San Diego, California
Outpatient Clinic Expansion
Replacement and Expansion Lease for San Diego's Chula Vista Outpatient Clinic

Summary: Impact on Veterans and Department of Veterans Affairs (VA) of failure to secure authorization of lease:

If Congress cannot enact the authorization for this expanded outpatient clinic, Veterans will continue to receive care in an overcrowded, outdated clinic that does not meet VHA criteria for patient privacy or room size, with increasing demand causing increased wait times and travel times. In addition, Veterans will continue to be required to travel to the San Diego VA Medical Center to receive the Specialty Care and Podiatry services the expanded clinic would have offered. Veterans will lose the benefit of a more than three-fold expansion of clinic size and added space for Specialty Clinics and Podiatry.

The community will lose the benefit of 10 employees associated with the expansion.

Veterans currently served at current lease facility (if applicable): *7,327 Veterans*

Detail on adverse impact of failure of authorization:

- *The current size of the clinic is 10,000 Net Usable Square Footage (NUSF); the new clinic will triple in size to approximately 31,000 NUSF to meet the current demands of the clinic and expand to decompress the parent facility.*
- *35 employees support the programs at the existing Chula Vista Outpatient Clinic; the expansion would increase the number to 45 employees.*

Lincoln, Nebraska
Community Based Outpatient Clinic (CBOC)
Replacement Lease for Lincoln's Owned Clinic

Summary: Impact on Veterans and Department of Veterans Affairs (VA) of failure to secure authorization of lease:

If Congress cannot enact the authorization for this outpatient clinic, Veterans would be forced to use the existing 84-year old facility that is now not ideally suited for efficient clinical use. Failure of the lease authorization will prevent VA from carrying out an effective re-use of properties that makes obvious sense in terms of efficient use of space and resources. Other options are also not desirable - wholesale contracting to non-VA providers, which increases costs, or transfer of all care to the parent facility, requiring a 114 mile round trip for Veterans compared with the planned location for the clinic. VA would use funds for high maintenance cost of an ill-suited facility which could otherwise go to expanding access and providing patient care.

Veterans currently served at current lease facility (if applicable): *15,200 Veterans*

Detail on adverse impact of failure of authorization:

- *Veterans will continue to be served in an extremely old, oversized, inefficient building that was converted from a single structure hospital to a clinic. This creates under-utilized space that cannot be disposed of and inefficiencies in patient flow.*
- *The VA-owned Lincoln campus could not be used for other purposes in an arrangement that could benefit VA and taxpayers.*
- *The owned Lincoln campus will continue to have to be maintained in its entirety, expending unneeded dollars to repair the poor condition of the buildings, and on operations and maintenance of under-utilized buildings.*
- *Contracting for care would be another other to provide the existing services at the owned Lincoln clinic. However, this would be cost prohibitive and a management challenge due to the distance between the parent facility and Lincoln.*
- *Requiring Veterans to receive care at the parent facility, Omaha VA Medical Center, is the other option. However, this would increase the beneficiary travel for over 114 miles roundtrip per patient. Lincoln's Condition Correction, $20,653,568*
- *Lincoln's Building Age, 84 years*

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Brick, New Jersey
Community Based Outpatient Clinic (CBOC) Expansion
Replacement and Expansion Lease for Brick's CBOC

Summary: Impact on Veterans and the Department of Veterans Affairs (VA) of failure to secure authorization of lease:

If Congress cannot enact the authorization for this expanded CBOC, Veterans will continue to confront having to access services they have earned through an overcrowded, outdated clinic. The clinic was stood up in 1993 designed to serve 5,000 Veterans – today more than 11,500 use it. If Congress fails to advance this lease authorization, Veterans will continue to be required to travel 120 miles round-trip to the East Orange VA Medical Center to receive the additional services the expanded clinic would have offered.

If the circumstances regarding medical leases continue, Veterans will be denied relief for their current access problems that would have been provided by almost doubling the size of the current facility. Veterans will be denied greater access to existing programs, including Primary Care, Mental Health, Specialty Care, Women's Health, and Ambulatory Surgery. They also will be denied needed expansions of Dental Care, as well as additional services of Optometry, Physical Therapy, HUDVASH Outreach, Caregiver Support coordination, Health Promotion Disease Prevention programs, and a Radiology Oncology Outreach program.

The community will also lose the benefit of an additional 20 VA employees associated with the clinic expansion.

Veterans currently served at current lease facility (if applicable): *11,516 Veterans*

Detail on adverse impact of failure of authorization:

- *The existing lease was constructed in 1993 to serve 5,000 Veterans. The Veterans served has more than doubled, but the size of the clinic has remained the same.*
- *The current size of the clinic is 34,355 Net Usable Square Feet (NUSF); the new clinic will almost double that size to approximately 60,000 NUSF to meet the projected demands and allow space for additional services to better serve patients in the Brick area.*
- *Veterans will continue to be served in an outdated and inefficient lease, creating overcrowding*
- *108 employees support the programs at the existing Brick CBOC; the expansion would increase the number to 128 employees.*

Charleston, South Carolina
Community Based Outpatient Clinic (CBOC) Expansion
Consolidation and Expansion Lease for Charleston's Primary Care and Mental Health
Clinics

Summary: Impact on Veterans and the Department of Veterans Affairs (VA) of failure to secure authorization of lease:

If Congress cannot enact the authorization for this consolidated CBOC, Veterans will continue to confront overcrowded, outdated facilities. The existing configuration especially impedes the ability for VA to provide closely integrated Primary Care and Mental Health care. These access issues will only worsen with time as health care demand increases.

Veterans will be denied the relief for long-standing access problems that would have been provided by a seven-fold increase in clinic size. Continued failure of Congress to advance the lease authorization will also have negative effects for Veterans using the Charleston VA medical center, which will experiencing worse overcrowding as demand increases.

The community will lose the benefit of 20 additional VA employees associated with the larger clinic.

Veterans currently served at current lease facility (if applicable): *20,722 Veterans*

Detail on adverse impact of failure of authorization:

- *The two significantly undersized existing leases providing Mental Health and Primary Care will continue to be overcrowded, and get worse with increasing demand.*
- *Efficiencies in the continuum of care between Primary Care and Mental Health will continue to be disjointed.*
- *The current sizes of the two clinics are 10,200 Net Usable Square Feet (NUSF); the new clinic will be approximately seven times this size at 75,000 NUSF to meet the projected demand of these clinics as well as to reduce pressures on the Charleston medical center.*
- *40 employees support the programs at the two existing Primary Care and Mental Health clinics; the expansion would increase the number to 60 employees.*
- *Charleston's Space Deficit will remain, 322,375 sq ft*

Cobb County, Georgia
Community Based Outpatient Clinic (CBOC)
New Lease for Cobb County

Summary: Impact on Veterans and the Department of Veterans Affairs (VA) of failure to secure authorization of lease:

If Congress cannot enact the authorization for this new CBOC, the Veterans in this area will continue having to confront an overcrowded Atlanta VA Medical Center and a 70 mile round trip required to receive services they have earned, which can discourage Veterans from using VA. If Congress fails to pass this routine authorization, VA will be required to increase its use of contracted care, resulting in higher costs and fragmentation of care, under which Veterans will not get the benefit of VA's special understanding of their needs.

Veterans will be denied the relief to access problems that would have been provided by this new CBOC. Veterans would not gain the benefits of greatly improved access to Primary Care, Mental Health, Specialty Care, Food and Nutrition Services, Radiology, Dental, Eye Care, Audiology, Physical and Occupational Therapy, and other Medical Specialty Care Services.

The community would be denied the benefit of 77 new VA employees associated with the new clinic.

Veterans planned to be served under proposed lease (dependent on lease authorization): *64,000 Veterans*

Detail on adverse impact of failure of authorization:

- *The Veterans will continue to be served at the significantly overcrowded Atlanta VA Medical Center*
- *Veterans will continue to travel 70 miles round trip to receive VA services.*
- *The Atlanta VA Medical Center will remain significantly overcrowded and not meet access standards for Primary Care and Mental Health.*
- *The Atlanta VA Medical Center will have to increase the use of fee basis care for select services in Cobb, Bartow, Cherokee, and Paulding counties, where costs will exceed $8 Million annually.*
- *77 employees are expected to be hired for this new CBOC.*
- *Atlanta's Space Deficit will remain, 480,567 sq ft*

Myrtle Beach, South Carolina
Community Based Outpatient Clinic (CBOC) Expansion
Consolidation and Expansion Lease for Myrtle Beach's CBOC

Summary: Impact on Veterans and the Department of Veterans Affairs (VA) of failure to secure authorization of lease:

If Congress cannot enact the authorization, the existing significantly overcrowded clinics will continue to reside in two, separate, inefficient space configurations for Primary Care, Mental Health, and limited Specialty Care. That overcrowding will worsen if delays continue for an expanded clinic, because of projections of dramatic increases in demand. That overcrowding will also affect access to care at the Charleston VA Medical Center. Veterans will continue to be required to travel to the Charleston VA Medical Center to receive the additional Specialty Care services the expanded clinic would have offered. Veterans will lose the benefit of an eight-fold expansion in clinic space.

The community would lose the benefit of 15 additional employees associated with the consolidation and expansion.

Veterans currently served at current lease facility (if applicable): *11,106 Veterans*

Detail on adverse impact of failure of authorization:

- *Veterans will continue to be served in two, separate overcrowded clinics to receive their Primary Care and Mental Health.*
- *The Charleston VA Medical Centers, the parent facility, will remain significantly overcrowded*
- *The current size of the two clinics that would be consolidated is 21,000 Net Usable Square Footage (NUSF); the new clinic will be more than four times this size at approximately 84,000 NUSF to meet the significant projected demand as well as help to decompress the parent facility.*
- *60 employees support the programs at the existing Myrtle Beach clinics; the consolidation would increase the number to 75 employees.*
- *Charleston's Space Deficit will remain, 322,374 sqft*
- *Myrtle Beach's projected outpatient demand over 20 years, 45 percent increase*
- *Charleston's projected outpatient demand over 20 years, 37 percent increase*

New Port Richey, Florida
Outpatient Clinic (OPC) Expansion
Consolidation and Expansion Lease for New Port Richey's Outpatient Clinics

Summary: Impact on Veterans and the Department of Veterans Affairs (VA) of failure to secure authorization of lease:

If Congress cannot enact the authorization for this outpatient clinic, the existing outpatient clinic will be forced to close, and Veterans will confront using the four remaining separate overcrowded, outdated clinics spread out in the New Port Richey area, resulting in increased travel times and disjointed care. Closure would require some Veterans to travel 60 miles round-trip to the parent facility, the Tampa VA Medical Center.

Besides the effect of a closure, New Port Richey Veterans would be denied the relief to serious access issues that would be solved by a new clinic more than double the size of the combined square footage of the five small overcrowded inefficient clinics. They would lose the benefit of expansions of Primary Care and Mental Health, as well as additional services for Specialty Care, Diagnostics, Prosthetics, Pulmonary, and Physical Therapy.

The community would lose the benefit of 38 additional VA employees connected with an expanded clinic.

Veterans currently served at current lease facility (if applicable): *14,845 Veterans*

End date of lease: *4/17/2020 – NOTE: While this lease termination date appears to be comfortably distant, that date is in terms of medical leasing transactions much closer than it appears. Statutory authorization should proceed the termination date by at five fiscal years ideally. This lead time for acquisition of a new lease is necessary because of the procurement processes and related due diligence (e.g., environmental studies) required by law and regulation, as well as execution of the lease contract and any required build-out.*

Detail on adverse impact of failure of authorization:

- *Veterans will continue to be served in four separate, significantly undersized clinics for Eye, Dental, Primary Care, and Mental Health.*
- *Veteran services will continue to be disjointed due to the continuation of the four clinics.*
- *The current outpatient clinic will be forced to close due to its size requiring authorization, and Veterans will be required to drive 60 miles roundtrip to the Tampa VA Medical Center, increasing mileage reimbursement costs. Services will continue to be contracted to the community in the West Pasco County.*
- *The current size of the five clinics totals 53,565 Net Usable Square Feet (NUSF); the new, consolidated clinic will be approximately 114,000 NUSF.*
- *183 employees support the programs at the existing five clinics; the expansion would increase the number to 221 employees.*

Ponce, Puerto Rico
Community Based Outpatient Clinic (CBOC) Expansion
Replacement and Expansion Lease for Ponce's CBOC

Summary: Impact on Veterans and Department of Veterans Affairs (VA) of failure to secure authorization of lease:

If Congress cannot enact the authorization for this replacement and expanded CBOC, the existing clinic will be required to close, forcing all patients to drive for over an hour in dense traffic to the significantly overcrowded San Juan VA Medical Center.

Veterans will be denied the relief to serious access problems that would be provided by the clinic authorization – first preventing a closure and then allowing a doubling in size of the current facility. Veterans would lose the benefit of reasonable access to the following services: expanded Primary Care, Mental Health, Ambulatory Surgery, Physical Therapy and Rehabilitation, Laboratory, Pharmacy, Radiology, Audiology, Eye Clinic, and Prosthetics. The new clinic will enhance and expand the following clinics: Women's Health, Audiology and Speech Pathology, Radiology, and Home Care. The new clinic will add new services, including chemotherapy, gastroenterology, Day Hospital, and MRI.

The community would lose the benefit of 30 new VA employees associated with an expanded facility.

Veterans currently served at current lease facility (if applicable): *11,619 Veterans*

End date of lease: *2/27/2020*
NOTE: while this lease termination date appears to be comfortably distant, that date is in terms of medical leasing transactions much closer than it appears. This lead time for acquisition of a new lease is necessary because of the procurement processes and related due diligence (e.g., environmental studies) required by law and regulation, as well as execution of the lease contract and any required build-out.

Detail on adverse impact of failure of authorization:
- *Veterans will be required to drive to the San Juan VA Medical Center, which can take over an hour to drive due to traffic and/or island conditions.*
- *The San Juan VA Medical Center is already significantly overcrowded; adding the workload demand from the Ponce clinic of 113k outpatient stops will only exacerbate wait times.*
- *The current size of the clinic is 56,550 Net Usable Square Feet (NUSF); the new clinic will be double that size at approximately 114,300 NUSF to meet the projected demand and space requirements.*
- *146 employees support the programs at the existing Ponce CBOC; the expansion would increase the number to 176 employees.*
- *San Juan's Space Deficit will increase. The current space requirements exceed 104,000 sq ft; adding the demands of a closed Ponce clinic will add at least another 75,000 sq ft of needed space.*

Chattanooga, Tennessee
Outpatient Clinic Expansion
Replacement and Expansion Lease for Chattanooga's Outpatient Clinic

Summary: Impact on Veterans and Department of Veterans Affairs (VA) of failure to secure authorization of lease:

If the expansion is not authorized, a new, under-sized lease will be procured to ensure Veterans are served in a seismically sound clinic. However, due to the projected outpatient demand, wait times will increase significantly due to the lack of space at this clinic as well as the parent facility in Nashville. In addition, Veterans will continue to be required to travel 90 miles to the Nashville VA Medical Center to receive the additional services the expanded clinic will offer.

Neither this clinic nor the parent facility will be able to meet the projected demand within the existing space; therefore, to ensure continued services currently received, much care will most likely need to be contracted out, resulting in higher costs of care. Veterans will be denied the benefit of a clinic almost two times the current size that besides relieving overcrowding will allow expansions of Primary Care and Mental Health as well as additions of Dental, Laboratory, Work Therapy, Geriatrics, and an eye clinic.

The community will not have the benefit of 96 clinic employees associated with the expansion.

Veterans currently served at current lease facility: *18,322 Veterans*

Detail on adverse impact of failure of authorization:

- *Veterans will be forced to continue care in an extremely under-sized clinic, resulting in increased wait times as projected outpatient workload is realized.*
- *The Nashville VA Medical Center, the parent facility, which is 90 miles away, will remain extremely overcrowded and unable to decompress.*
- *The current size of the clinic is 40,094 Net Usable Square Footage (NUSF); the new clinic will be almost two times this size at 75,000 NUSF to meet the significant projected outpatient demand as well as to decompress the parent facility.*
- *148 employees support the programs at the existing Chattanooga outpatient clinic; the expansion would increase the number to 244 employees.*

d. Tables analyzing the costs of alternatives to leasing that were considered.

Response. In response to question 34.d, the Department provides tables [below] analyzing the total life cycle cost of the alternatives to the 2013 and 2014 major medical facility leases.

Veterans Affairs - Alternatives Analysis for 2013 and 2014 - Lease Notifications ($000) 4/

			Total Life Cycle Costs				
		Square Footage	New Lease	New Construction	Contract Out 3/	Renovation	Notes
2013	**Albuquerque, NM** *Clinical Research Pharmacy Coordinating Center / Pharmacy Research Cooperative Studies Lease*	80,000	$739,969	$808,582	N/A 2/	N/A 1/	
2013	**Brick, NJ** *Community Based Outpatient Clinic Lease*	60,000	$381,399	$397,693	$338,957	N/A 1/	Although not specifically stated in the 2014 budget request, the contract out alternative is estimated to be less costly than the new lease alternative but was not selected due to an insufficient availability of contractors to meet Veteran needs in this area.
2013	**Charleston, SC** *Primary Care / Dental Clinical Annex Lease*	75,000	$670,618	$692,117	$862,810	N/A 1/	
2013	**Cobb County, GA** *Community Based Outpatient Clinic Lease*	64,000	$168,192	$185,224	$173,043	N/A 1/	
2013	**Honolulu, HI** *Advance Leeward Outpatient Healthcare Access (ALOHA) Lease*	118,823	$592,832	$625,215	$737,051	N/A 1/	
2013	**Johnson County, KS** *Community Based Outpatient Clinic Lease*	22,910	$271,561	$281,173	$343,480	N/A 1/	
2013	**Lafayette, LA** *Replacement Lafayette VA Multi-Specialty Outpatient Clinic*	29,224	$147,736	$170,170	$191,758	N/A 1/	
2013	**Lake Charles, LA** *New Lake Charles VA Multi-Specialty Outpatient Clinic*	24,088	$76,531	$84,212	$84,402	N/A 1/	
2013	**New Port Richey, FL** *Outpatient Clinic Lease*	114,000	$763,818	$778,789	$741,674	N/A 1/	Although not specifically stated in the 2014 budget request, the contract out alternative is estimated to be less costly than the new lease alternative but was not selected due to an insufficient availability of contractors to meet Veteran needs in this area.
2013	**Ponce, PR** *Outpatient Clinic Lease*	114,300	$352,776	$414,186	$364,602	N/A 1/	
2013	**San Antonio, TX** *Lease Consolidation*	190,800	$773,862	$806,143	$777,519	N/A 1/	
2013	**San Diego, CA** *Community Based Outpatient Clinic Lease*	99,986	$1,221,151	$1,243,266	$2,297,440	N/A 1/	
2013	**Tyler, TX** *Outpatient Clinic*	48,425	$282,883	$296,838	$457,273	N/A 1/	
2013	**West Haven, CT** *Lease for Errera Community Care Center*	45,000	$3,217,883	$3,247,253	$4,297,307	N/A 1/	
2013	**Worcester, MA** *Expand Worcester Community Based Outpatient Clinic Lease*	40,000	$233,849	$239,219	$270,561	N/A 1/	

	Square Footage	New Lease	New Construction	Contract Out 3/	Renovation	Notes
2014	**Cape Girardeau, MO** Expand Community Based Outpatient Clinic Lease	43,000	$175,057	$196,743	$195,136	N/A 1/	Total Life Cycle Cost for the new lease was originally calculated and presented in the 2014 budget request as $178,984.
2014	**Chattanooga, TN** *Multi-Specialty Community Based Outpatient Clinic*	75,000	$688,959	$702,111	$1,412,209	N/A 1/	
2014	**Chico, CA** *Expand Community Based Outpatient Clinic Lease*	42,000	$258,866	$277,314	$329,126	N/A 1/	
2014	**Chula Vista, CA** *Expand Community Based Outpatient Clinic Lease*	31,000	$441,131	$447,062	$719,063	N/A 1/	
2014	**Hines, IL** *New Research Lease*	164,000	$1,398,689	$1,665,302	N/A 2/	$1,508,512	
2014	**Houston, TX** *Replacement Research Lease*	48,000	$700,251	$727,329	N/A 2/	N/A 1/	
2014	**Lincoln, NE** *Community Based Outpatient Clinic Lease*	72,000	$523,708	$533,493	$673,988	N/A 1/	
2014	**Lubbock, TX** *Expand Community Based Outpatient Clinic Lease*	94,000	$407,052	$424,365	$724,663	N/A 1/	
2014	**Myrtle Beach, SC** *Community Based Outpatient Clinic Lease*	84,000	$805,184	$814,437	$1,518,128	N/A 1/	
2014	**Phoenix, AZ** *Outpatient Clinic Lease*	203,000	$2,962,281	$2,993,812	$4,831,924	N/A 1/	
2014	**Redding, CA** *Expand Community Based Outpatient Clinic Lease*	77,000	$472,812	$509,239	$773,051	N/A 1/	
2014	**Tulsa, OK** *Replacement Community Based Outpatient Clinic Lease*	140,000	$883,093	$912,125	$1,824,779	N/A 1/	

1/ Renovations are generally not applicable since these projects are located in growing markets where VA currently has a large space gap (space deficit) and there is insufficient VA-owned space in the geographic area that is surrounding.

2/ This alternative would contract out research programs to the private sector, which is not compatible with VHA Office of Research and Development mission goals to, "discover knowledge, develop VA researches and health care leaders, and create innovations that advance health care for our Veterans and the Nation." In addition, it conflicts with VA's Major Initiative addressing research and development, particularly as it applies to the unique health care needs of Veterans. For these reasons, this alternative is not viable and is excluded from this analysis.

3/ It should be noted that inclusion of Total Life Cycle costs for contracting out alternative does not imply that contract service providers will be available in all cases to provide Veterans with the highest-quality healthcare services.

4/ According to a market survey conducted for this analysis, there are no suitable, appropriately-sized vacant buildings available within a ten-mile radius of the existing location. For this reason, the Acquisition of an Existing Facility alternative is not viable and has been excluded from this analysis. Also, according to VHA's Office of Interagency Health Affairs - Office of VA-DoD Coordination, there are currently no facility sharing opportunities in the proposed project's market. As such, the VA-DOD Collaboration alternative is not viable and has been excluded from this analysis.

Question 35. Please provide national quantity and cost data for purchased utilities at VHA facilities, to include water, electricity, gas, and sewage for FY 2010 through FY12.

Response. The below tables detail the cost and consumption data for purchased utilities at VHA facilities for FY 2010 through FY 2012.

Fiscal Year	Electricity	Water	Natural Gas	Sewer	Total
2010	$ 319,555,793	$ 28,998,131	$ 142,732,253	$ 25,083,061	$ 516,369,238
2011	$ 318,471,652	$ 35,191,003	$ 116,937,075	$ 26,153,607	$ 496,753,337
2012	$ 304,407,607	$ 31,737,399	$ 94,379,904	$ 25,857,457	$ 456,382,367

Fiscal Year	Electric Consumption (KWH) CY / 1000	Natural Gas Consumption (CUFT) CY / 1000	Water Consumption (Thou. GAL) CY / 1000
2010	3,230,546	14,503,095	7,954
2011	3,295,110	14,652,000	7,539
2012	3,299,530	13,806,224	7,655

Question 36. Please provide national quantity and cost data for waste disposal, divided by category to include general, regulated medical, hazardous chemical, etc. for FY 2010 through FY12.

Response. The following attachment is the Waste Management and Compliance data that provides the national quality and cost data for waste disposal, divided by category to include general, regulated medical, hazardous chemical, etc. for FY 2010 and FY 2011. VHA is finalizing FY 2012 as part of our roll out and implementation of the new VHA real time waste management and cost avoidance web based tracking system developed by Practice GreenHealth (PGH).

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VHA EPS FY" 2010 Waste Report

Waste Management Category	In tons per year	Percent of Total Waste		Cost of Waste per pound	Cost of Waste Annually	Percent of Total Cost
Solid Waste	118459.27	69%	Solid Waste	$0.06	$13,935,963.30	49%
Regulated Medical Waste	11435.79	7%	Regulated Medical Waste	$0.35	$ 7,891,380.60	28%
Recycled Waste	41889.25	24%	Recycled Waste	$0.03	$ 2,403,999.39	8%
Hazardous Waste	1145.26	1%	Hazardous Waste	$1.85	$ 4,235,744.07	15%
Total Waste	172929.57	100%	Total Cost		$28,467,087.36	100%

Waste Volume in Tons

Hazardous Waste 1%

Recycled Waste 24%

Regulated Medical Waste 7%

Solid Waste 68%

Cost of Waste in Dollars($)

Hazardous Waste 15%

Recycled Waste 8%

Solid Waste 49%

Regulated Medical Waste 28%

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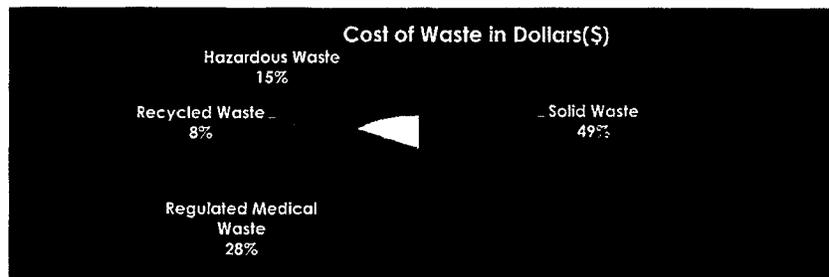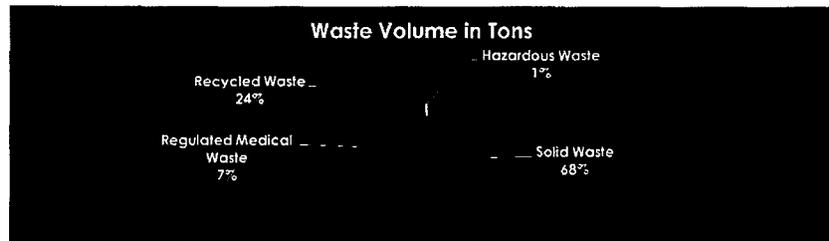
VHA EPS FY" 2011 Waste Report						
Waste Management Category	In tons per year	Percent of Total Waste		Cost of Waste per pound	Cost of Waste Annually	Percent of Total Cost
Solid Waste	96977.486	54%	Solid Waste	$0.07	$12,807,821.68	43%
Regulated Medical Waste	13715.8345	8%	Regulated Medical Waste	$0.33	$8,958,490.12	30%
Recycled Waste	68233.442	38%	Recycled Waste	$0.04	$5,141,045.44	17%
Hazardous Waste	746.1945	0%	Hazardous Waste	$2.11	$3,146,452.69	10%
Total Waste	179672.957	100%	Total Cost		$30,053,809.93	100%

Waste Volume in Tons

Hazardous Waste
0%

Recycled Waste
38%

Solid Waste
54%

Regulated Medical Waste
8%

Cost of Waste in Dollars $

Hazardous Waste
10%

Solid Waste
43%

Recycled Waste
17%

Regulated Medical Waste
30%

**Department of
Veterans Affairs**

Memorandum

Date: **APR 0 4 2013**

From: Under Secretary for Health (10)

Subj: Workgroup to Review Composition of Networks

To: Deputy Under Secretary for Health for Operations and Management (10N)
Deputy Under Secretary for Health for Policy and Services (10P)
Principal Deputy Under Secretary for Health (10A)

1. This memorandum establishes a workgroup to review the number and composition of Veterans Integrated Service Networks (VISN). The workgroup will review current boundaries of VISNs based on analysis of Veteran population and health care utilization trends. The workgroup shall also review the overall number of VISNs and may consider the combination of certain VISNs or further segmentation of certain VISNs.

2. The workgroup shall be chaired by the Deputy Under Secretary for Health for Operations and Management (10N) and co-chaired by the Deputy Under Secretary for Health for Policy and Services (10P). The Chair and Co-Chair may designate an acting chairperson and co-chairperson.

3. Proposed workgroup composition shall be comprised of the following individuals:
   Network Director VISN 4 (10N4)
   Network Director VISN 19 (10N19)
   Network Director VISN 21 (10N21)
   Assistant Deputy Under Secretary for Health for Policy and Services (10P)
   Assistant Deputy Under Secretary for Health for Policy and Planning (10P1)
   Assistant Deputy Under Secretary for Health for Clinical Operations (10NC)
   Assistant Deputy Under Secretary for Health for Administrative Operations (10NA)

The workgroup may identify any individuals it deems necessary to serve as adjunct group members for the purposes of completing its mission. Additionally, the workgroup may identify any additional resources it deems necessary for the completion of its mission.

4. The workgroup shall establish a methodology document for conducting its review and analysis. The workgroup shall present the proposed methodology to the Under Secretary for Health for approval. Once approved, the workgroup shall apply the study methodology to analyze the number and composition of VISNs.

5. The workgroup shall develop recommendations to the Under Secretary for Health regarding the optimal number of VISNs, their boundary structures, and an ongoing review cycle for composition and number of VISNs.

Page 2.

Workgroup to Review Composition of Networks

6. The workgroup is requested to complete its analysis not later than September 30, 2013.

Robert A. Petzel, M.D.

Question 37. The FY 2014 budget request commits to improving the functionality of VA's national utility metering data collection and analysis system. What type of improvements is the Department planning to make?

Response. In FY 2014, VA will continue to build on its successful metering program by improving the functionality of its data reporting and analysis capability. Both electric and non-electric (water, natural gas, etc.) information will be more visible and useful across VA from facility managers to policymakers. System enhancements will help ensure the capture and display of key data from meters around the country, allowing better evaluation of facility performance to reduce energy use. VA's capability to respond quickly and accurately to information requests and perform annual reporting will be improved. Additionally, VA will pursue avenues to more cost-effectively add, maintain, and modify meter installations across the Department.

Specific areas of improvement include:

• VA will add meters to fill gaps that have been identified or created since past meter installations

• VA will begin linking meter data into local facility management systems

• VA will create additional capacity to use historical information to guide current operations—currently VA has limited ways to use historical information

• VA will develop new analysis capability on existing data to improve local, regional, and national decisionmaking

INFORMATION TECHNOLOGY PROGRAMS

Question 38. The President's Budget requests $344 million for the Interagency Program Office (IPO) to support the integrated electronic health record project. Please describe the assumptions used to arrive at this estimate, and how the IPO plans to use this funding, given that the Department of Defense is still making a decision regarding the core technology they will use for this initiative.

Response. The budget request for FY 2014 is based on the Lifecycle Cost Estimate and will support the following major iEHR efforts:

• Identify Management
• Access Control Services
• Immunization
• Laboratory
• Pharmacy
• Presentation Services
• Service-Oriented Architecture (SOA) Suite Enterprise Service Bus (ESB)

Question 39. Please provide documentation to detail estimated savings through ideas generated by the Ruthless Reduction Task Force.

OIT Response: The Ruthless Reduction Task Force (RRTF) was established to identify opportunities for cost avoidance and to help VA focus resources on access, benefits and homelessness. Over 60 projects have been identified under RRTF that would result in an estimated total cost avoidance of $2.5 billion. Below is a more in depth breakdown of the cost avoidance, inclusive of approximate cost avoidance for pending and active projects.

• Total Estimated Cost Avoidance: $2.5 billion
• Total Estimated Cost Avoidance for Pending Projects: $2.166 billion
  – Total Estimated Cost Avoidance to harmonize identity management and access control across VA: $1.7 billion

– Note: A "pending project" is defined as a project for which a plan of action and milestones (PoAM) idea scope is still being defined, or one that is awaiting development of the PoAM slide deck or else assignment of a project manager (PM.)

• Total Estimated Cost Avoidance for Active Projects: $340 million
  – Note: An "active project" is defined as a project for which a PoAM has been developed and to which a PM has been assigned

Question 40. In FY 2014, how much does VA anticipate spending to improve the Department's Section 508 compliance?

Response. Making VA accessible for all Veterans, beneficiaries, and employees is important not only because it is the law, but because it is the right thing to do. Previously, VA's Section 508 IT compliance efforts were divided between OIT's "Section 508 Program Office" and VHA's "Health 508 Office."

In FY 2014, all Section 508 efforts will be centralized within OIT. The combined Federal IT staff on this endeavor will amount to 11 FTE.

The President's FY 2014 budget request includes $11.9 million for VA's Section 508 program. This funding will cover:

• Contracted resources to support the development and execution of Section 508-related training for developers, testers, and non-technical staff

• Testing support services to (1) bring new software into compliance with Section 508 requirements, and (2) audit existing Section 508-compliant software to ensure that it remains compliant

• Maintenance of hardware and software that is used to test IT systems for Section 508 compliance

• Development of an enterprise-wide approach to bringing all VA SharePoint repositories into compliance with Section 508 requirements

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RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. RICHARD BURR TO HON. ERIC K. SHINSEKI, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

GENERAL

Question 41. In the Department of Veterans Affairs (VA) 2012 Performance and Accountability Report (PAR), VA indicated that it has "developed and executed a plan to reduce the cost associated with activities covered in [Executive Order 13589, Promoting Efficient Spending]." VA also indicated that, for 2012, it "exceeded its spending reduction target of $173.4 million by an additional $69 million."

A. Please provide the Committee with a copy of the plan that was developed in response to the Executive Order.

[The referenced files, due to their volume, are not being reproduced here.]

B. Please outline where those spending reductions were realized and what was done with the funds that were saved through those reductions.

Response. Spending reductions were realized in the categories of travel, supplies and materials, printing, employee information technology (IT) devices, and management support contracts. Realized savings were used for:

• Over-time hours for compensation claims processing staff to support the reduction of the benefits claim backlog;

• Non-recurring maintenance projects to improve the health care environment;

• Critical infrastructure and life cycle refresh for existing IT equipment to support current and new VA staff; and

• Additional health care-related equipment purchases.

Question 42. In response to questions about VA's fiscal year 2013 budget request, VA indicated that, at the end of fiscal year 2011, there was $1.2 billion in outstanding delinquent debt owed to VA, of which $732 million was created in connection with VA benefit payments. VA also indicated that, during fiscal year 2011, VA wrote off or waived $247 million of debts to VA.

A. What was the total amount of outstanding delinquent debt at the end of fiscal year 2012?

Response. At the end of FY 2012, VA reported $3.7 billion in outstanding debt.

B. What portion of that amount was debt created in connection with VA benefit payments?

Response. At the end of FY 2012, VA reported $1.6 billion in outstanding benefit debt.

C. What is the total value of debts for which VA waived recoupment during fiscal year 2012 and what is the total value of debts that were written off during fiscal year 2012?

Response. In FY 2012, VA waived debts totaling $116,167,896 and wrote-off debts totaling $85,194,153.

D. During fiscal year 2013, how much new debt does VA project will be established?

Response. For FY 2013, VA estimates new benefit debts of $1.2 billion.

E. During fiscal year 2014, how much new debt does VA project will be established?

Response. For FY 2014, VA estimates new benefit debts of $1.3 billion

Question 43. In response to questions regarding VA's fiscal year 2013 budget request, VA indicated that approximately $305 million in mandatory funding would be used to pay for non-direct benefits.

A. Does that figure include any amounts spent on contract vocational and educational counseling?

Response. The $6 million from the Readjustments Benefits account authorized for contract vocational and educational counseling is a benefit to Veterans and is therefore not included in the $305 million total for non-direct benefits. The $305 million in mandatory funding used to pay for non-direct benefits includes funding for: equal access to Justice Act payments, medical examination payments, and income verification matching (38 United States Code (U.S.C.) § 5317) from the Compensation and Pensions (C&P) account. This also includes: reporting fees, State Approving Agencies, reimbursements to the General Operating Expense account as authorized under Public Laws (P.L.) 101–237 and 105–368, and reimbursements to the Office of Information Technology account as authorized under P.L.s 106–419, 108–454, and 112–56 from the Readjustments Benefits account.

B. For fiscal year 2014, please identify how much in mandatory funding will be spent on non-direct benefits and how those funds would be spent.

Response. For FY 2014, VA expects to spend $285.3 million in mandatory funding on non-direct benefits. Below is a detailed breakdown of the requested funding:

Compensation and Pension ($000s)	
Medical Exams	$231,376
Equal Access to Justice Act	$11,768
Income Verification Matching	$9,232
C&P Total	$252,376
Readjustment Benefits ($000s)	
State Approving Agencies	$19,000
Reporting Fees	$13,308
Reimbursement to GOE	$568
RB Total	$32,876
TOTAL	$285,252

C. Are any mandatory funds expected to be spent to hire contractors? If so, please specify the amount(s) and purpose(s).

Response. In accordance with Section 504 of the Veterans' Benefits Improvement Act of 1996, Public Law 104–275, VA is authorized to pay for contracting of disability evaluation examinations from the C&P account. In FY 2014, VA estimates this amount to be $231.4 million.

Also, section 3697 of title 38 U.S.C, authorizes VA to use $6 million from the Readjustment Benefits account to pay for educational or vocational counseling services obtained by VA by contract for Veterans applying for or receiving Education or Vocational Rehabilitation and Employment benefits.

Additionally, under section 3674 of title 38 U.S.C., VA is authorized to reimburse State Approving Agencies up to $19 million from the Readjustment Benefits account. This funding is for the reasonable and necessary salary, travel, and administrative expenses incurred by employees of the State Approving Agencies in carrying out contracts or agreements entered into with VA for the purpose of ascertaining the qualifications of educational institutions for furnishing courses of education to eligible persons or Veterans.

D. Are mandatory funds expected to be used to pay the salary of any VA employees? If so, please specify the amount(s) and purpose(s).

Response. Section 5317 of title 38 U.S.C., directs VA to pay the expenses of carrying out certain income verification matching activities with the mandatory C&P

appropriation. Accordingly, the C&P appropriation reimburses the General Operating Expenses (GOE) account and the Office of Information Technology account for administrative costs associated with verification of eligibility for the pension program through income verification matching. The FY 2014 reimbursement to the GOE account is estimated to be $8.4 million, which will be used to support 97 FTE. Reimbursement to the Office of Information Technology in FY 2014 is estimated to be $110,000, which will be used to support one FTE.

P.L. 104–275 directs VA to make payments for contracts for the pilot program for disability examinations from the C&P appropriation. Historically, VA appropriations acts have provided that the mandatory C&P appropriation is the source of funding for the pilot program for disability examinations. Accordingly, the C&P appropriation has reimbursed the the GOE account for the purposes of conducting a pilot program to contract disability evaluation examinations of claimants for benefits administered through VBA. The FY 2014 reimbursement amount is estimated to be $2.1 million, which will support 25 FTE.

Question 44. This budget would cut VA central office (VACO) funding by 5 percent; however, the offices that comprise VACO would realize an increase of 106 full-time equivalents (FTE) if this budget were adopted. During the budget rollout on April 10, 2013, VA responded to a question inquiring about the contradiction of an increase in FTE and a funding decrease that the additional staff is paid for out of the Supply Fund and Franchise Fund. Additionally, throughout the budget request for the General Administration account, many offices within VACO indicate budget allocations and staffing under the heading "reimbursement."

A. Of the 3,334 staff requested in the fiscal year 2014 request, how many are funded through the Supply Fund and Franchise Fund? Please breakout this number by individual VACO offices (for example, Office of the Secretary, Office of General Counsel, Office of Policy and Planning, etc.).

Response. The 3,334 staff represent the FTE level funded within the General Administration (GenAd) account in the President's FY 2014 budget request. A total of 76 GenAd FTE are reimbursed by the Supply Fund for services provided (62 FTE in the Office of General Counsel, 7 in the Office of Business Oversight, and 7 in the Office of Acquisitions, Logistics and Construction). None of the 3,334 FTE are direct Supply Fund or Franchise Fund employees. The 106 FTE increase reflected in GenAd represent staff being hired during the later stages of FY 2013 which will be fully annualized in FY 2014. The on-board FTE at the beginning of the fiscal year is not expected to change significantly over the course of the year.

The 106 FTE consists of 31 FTE from budget authority (BA) and 75 FTE from reimbursable authority (RA). They are primarily funded through VA's Human Capital Investment Plan (RA), VA's Identify Credentials Management Program (RA), and VA's enterprise-wide facilities transformation efforts (BA and RA).

B. Please provide the Committee with a detailed description of the heading "reimbursement." Please include the office, department, or agency that is being reimbursed, a description of the program or service for which they are being reimbursed, and the number of staff associated with the reimbursement. Please break this out by individual VACO offices (for example, Office of the Secretary, Office of General Counsel, Office of Policy and Planning, etc.).

Response. The reimbursement process for VA's GenAd account occurs when one office provides a service that benefits another office, and the office receiving the service reimburses the providing office for the cost of that service. Authority to provide reimbursements is allowed under the Economy Act (31 United States Code (U.S.C.) § 1535), Account Adjustment Statute (31 U.S.C. § 1534), or other specific authority, including appropriations language. In many instances, these authorities are utilized to "pool" funds to pay for products or services that benefit more than one appropriation. VA charges the benefiting appropriations amounts that are commensurate with the value received by their staff office(s) and/or Administrations.

Authorized reimbursements are requested through the Office of Management and Budget apportionment process. Of the 3,334 FTE requested in FY 2014, 1,067 are reimbursable FTE in the GenAd account. Of this total, 76 GenAd FTE are reimbursed by the Supply Fund for services provided directly to the Fund (62 FTE in the Office of General Counsel for legal services provided to the Fund; 7 FTE in the Office of Business Oversight for logistics reviews for the Fund; and 7 FTE in the Office of Acquisition, Logistics, and Construction for management oversight of the Fund). Below is a description of the reimbursable programs and FTE (if applicable) performed within the GenAd account.

OFFICE OF THE SECRETARY

Office of Employment Discrimination Complaint Adjudication (OEDCA)—FTE: 24

OEDCA has statutory authority to collect reimbursements for costs incurred to carry out its operations. Historically, an administrative provision in the annual appropriations act has provided that VA customers may reimburse OEDCA for services provided, see, e.g., section 210 of title II of division E of section 2 of the Consolidated and Further Continuing Appropriations Act, 2013 (Public Law 113–6). OEDCA is an independent office responsible for issuing final agency decisions and orders on the merits of employment discrimination complaints filed by employees. OEDCA is also responsible for determining equitable relief and issuing final agency decisions on a complainant's entitlement for compensatory damages and attorney's fees if the complainant is the prevailing party. OEDCA collects funding from the customers it services.

Leading Executives Driving Government Excellence (EDGE)—FTE: 3

The President's Management Council initiated Leading EDGE to: 1) inspire a seamless and powerful senior executive corps with shared governmentwide identity and vision; 2) craft solutions that have impact across agencies; and 3) reignite the highest ideals of public service. To achieve these objectives, Leading EDGE employs five integrated learning components: workshops, leadership assessments, government performance projects, executive coaching, and a Web portal for increased cross-agency networking and problem-solving. In FY 2012, the program's first year, 15 Federal Government departments (totaling over 150 individual bureaus) reimbursed VA to participate in Leading EDGE.

OFFICE OF GENERAL COUNSEL (OGC)

OGC receives reimbursement for legal services it provides where authorized by statute.

MSCA Medical Support and Compliance Account—FTE: 63

Public Law 101–508 MSCA (formally Medical Care Collection Fund (MCCF))

The Budget Reconciliation Act of 1990, Public Law 101–508, established the Medical Care Cost Recovery Revolving Fund (MCCF). VA medical centers receive the funds collected through the MCCF program and may use those funds for direct patient care. The reimbursement OGC receives for its collection efforts, as authorized by 38 U.S.C. §1729A(c)(1)(B), enables it to provide legal services related to the recovery of reasonable charges from third parties (health insurance companies, workers compensation plans, no-fault automobile insurance carriers, and third-party tortfeasors) that are legally responsible for paying for medical care and services provided to Veterans. In addition, the Medical Support and Compliance Appropriations Account has traditionally contained specific language that provides that the account is available to fund "legal expenses of the Department for collecting and recovering amounts owed the Department as authorized under chapter 17 of title 38, United States Code, and the Federal Medical Care Recovery Act." See Public Law 113–6, the Consolidated and Further Continuing Appropriations Act, 2013. Through OGC's services in this program, VA has collected over $260 million which it returned to VA medical centers for providing care to Veterans.

Credit Reform—FTE: 41

The Federal Credit Reform Act (FCRA) states that "[a]ll funding for an agency's administration of a direct loan or loan guarantee program shall be displayed as distinct and separately identified subaccounts within the same budget account as the program's cost" (emphasis added). Generally, the FCRA requires a fund established for a credit program to have two types of accounts. One is a program account that records administrative expenses and disburses the subsidy cost to the financing cost, and the other is a financing account that records all of the cash-flows resulting from direct loans or loan guarantees (It disburses loans, collects repayments and fees, makes claim payments, holds balances, borrows from Treasury, and earns or pays interest.).

OGC provides legal services under the FCRA and receives reimbursement from the following two programs' accounts as authorized by law:

Veterans Housing Program: OGC provides legal services related to the origination and liquidation of guaranteed loans and to the acquisition and sale of properties acquired as a result of guaranteed loans that are foreclosed.

Native American Housing Program: OGC provides legal services regarding the negotiation of memoranda of understanding with tribal governments, the origination

and liquidation of Native American Direct Loans (NADL), and the acquisition and sale of properties acquired as a result of NADL loans that are foreclosed.

Supply Fund Contract Attorneys and Staff—FTE: 62

OGC personnel provide direct contract support regarding all legal aspects of Supply Fund procurements, including defending the Department against protests, and are reimbursed by the Revolving Supply Fund. Section 8121 of title 38, U.S.C., authorizes VA to use the Supply Fund to cover "all expenses necessary" for the operation and maintenance of a supply system.

Veterans Canteen Service (VCS)—FTE: 1

The employee is under the supervision of the OGC Regional Counsel and the Assistant Regional Counsel in St. Louis, Missouri, where the VCS has its headquarters. The attorney provides advice and representation in administrative hearings and court proceedings as it pertains to employee/labor relations and Equal Employment Opportunity matters and acts as a liaison with personnel from other OGC regions who perform representational tasks involving VCS personnel and operations. Section 7804 of title 38, U.S.C., authorizes VA to use the Veterans Canteen Service Revolving Fund to cover administrative and operating expenses of the VCS.

Veterans Administration Law Enforcement Training Center (LETC)—FTE: <1

OGC provides reimbursable legal services from an attorney, part-time, to LETC to plan, coordinate, develop, and teach courses in legal aspects related to the field of law enforcement. LETC is a Franchise Fund entity that is authorized to collect fees for services provided and to use such fees to cover the total costs of providing such services.

Enhanced-Use Lease (EUL)—FTE: <1

OGC provides legal support to VA's Office of Asset Enterprise Management (OAEM), which administers VA's EUL program. VA's EUL program, codified at 38 U.S.C. §§ 8161–8169, authorizes VA to out-lease underutilized and vacant real property to lessees for terms of up to 75 years. In return, the lessees develop and operate the out-leased real property consistent with the EUL statute (which is currently limited to providing eligible Veterans and non-Veterans with "supportive housing," as defined in 38 U.S.C. § 8161(3)) and provide VA with negotiated consideration (i.e., in-kind consideration and/or cash, depending upon when the underlying EUL was executed). VA's EUL policy is contained in VA Directive and Handbook 7415. Section 8165 of title 38 U.S.C. authorizes the Secretary to use the proceeds from any EUL to reimburse applicable appropriations of the Department for any expenses incurred in the development of additional EULs. Notably, per Chapter 8, paragraph 3 of the Handbook (copied below), OAEM may charge a "reimbursement fee" for EUL projects that involve VA receiving cash lease consideration. This fee is charged to reimburse OAEM and OGC for their direct and indirect project-related expenses associated with negotiating and administering the underlying EUL.

EU Reimbursement Policy and Procedures. Each executed EU lease project managed by OAEM may be subject to a reimbursement fee to be charged against the proceeds from the project. This charge is designed to reimburse OGC and OAEM for direct and indirect project-related expenses associated with planning, developing, executing, managing and providing legal advice and services for the respective EU project, transactions and lease. This fee is not to exceed reasonable VA expenses.

Construction Facility Management (CFM)—FTE: 6

OGC attorneys review and comment on legal issues associated with the Office of Acquisition, Logistics, and Construction (OALC) and CFM major construction and real property projects located throughout the country. The attorneys are solely dedicated to OALC/CFM work and are supported through funding reprogrammed from CFM within the GenAd account. At least one will support OALC/CFM major leasing projects. The attorneys who will support the OALC/CFM major construction program will be assigned to the major projects in Denver, Colorado; Orlando, Florida; New Orleans, Louisiana; and Palo Alto, California. Additionally, the attorneys will assist with the remaining projects in the Western, Central, and Eastern Regions, as well as the National Region, which supports the National Cemetery Administration (NCA). OALC/CFM initiated this arrangement of direct legal support to assist in the expedient resolution of legal issues associated with major construction and leasing projects.

OFFICE OF MANAGEMENT

Defense Finance and Accounting Service (DFAS)—FTE: 0

The Office of Finance within the Office of Management has an Inter-Agency Agreement with DFAS to process VA's payroll and leave and earnings statements. Obligations are incurred and managed centrally, and VA offices reimburse the Office of Management for their share of the costs. No FTE are reimbursed.

Office of Business Oversight (OBO)—Veterans Health Administration (VHA)—FTE: 20

OBO receives reimbursements from VHA to support OBO personnel in conducting expense and revenue reviews that ensure VHA field facilities comply with existing financial rules, regulations, and policies and assure the quality of VHA fiscal information.

OBO—Supply Fund—FTE: 7

OBO collects funding from the Supply Fund to cover expenses for OBO logistics reviews of the Supply Fund to ensure VHA field stations and VA Central Office organizations comply with existing rules, regulations, and policies.

OBO—A–123—FTE: 4

OBO personnel conduct and test reviews of internal controls of financial reporting as required by Office of Management and Budget Circular A–123 at VA facilities. The VA organizations that contribute funding toward these reviews are VHA, the Veterans Benefits Administration (VBA), NCA, and Office of Information and Technology.

OAEM—Green Management—FTE: 5

OAEM receives reimbursement from VHA for support of the VA Green Management Program at VHA field facilities. The portfolio managers support the Department's initiative, Establish Enterprise Energy Cost Reduction and Implement VA-wide Greenhouse Gas Initiative to Address VA's Carbon Footprint—Greening VA. These professionals assist OAEM in managing the Green Management Program and meeting its performance and reporting mandates.

OAEM—Building Utilization Review and Repurposing (BURR)—FTE: 3

OAEM receives reimbursement from VHA for support it provides to eliminate Veteran homelessness through VA's EUL program. Another initiative, BURR, uses VA's EUL program through public/private partnerships to leverage VA's vacant and underutilized buildings and land nationwide to provide housing for Veterans and their families who are homeless or at-risk of homelessness.

Office of Management—VA Center of Innovation (VACI)—FTE: 0

The VACI program taps the talent and expertise of individuals inside and outside of government to innovate and improve Veterans access to services, lower costs, improve quality, and enhance the performance of VA operations. The offices receiving the benefits and services provide reimbursement to support any contractual costs and operating expenses.

OFFICE OF HUMAN RESOURCES AND ADMINISTRATION (HRA)

Human Capital Investment Plan (HCIP)—FTE: 298

The HCIP includes VA's Learning University and focuses on the development of VA's workforce through enterprise-wide training. This is accomplished by leadership training, workforce competency training, Veteran hiring efforts, employee wellness, and the Corporate Senior Executive Management Office. HCIP program costs are funded by each program office through reimbursements to HRA on a pro-rata FTE basis.

Office of Resolution Management (ORM)—FTE: 267

Historically, an administrative provision in the annual appropriations act has provided that VA customers may reimburse ORM for services provided, see, e.g., section 210 of title II of division E of section 2 of the Consolidated and Further Continuing Appropriations Act, 2013 (Public Law 113–6). ORM promotes a discrimination-free work environment focused on serving Veterans by preventing, resolving, and processing Equal Employment Opportunity discrimination complaints and providing Alternative Dispute Resolution services as required by law. Each office's costs are proportionate to the number of employees that use the services across the entire VA system.

VA Child Care Subsidy Program (CCSP)—FTE: 0

VA CCSP is a nationwide program that assists lower income VA employees (household income of less than $59,999 per year) with the cost of child care. There are over 2,000 VA employee participants who receive child care services and receive a subsidy. Reimbursement is strictly for the costs of the program.

VA Central Office Services—FTE: 20

The Office of Administration (O/A) provides numerous services for the VA Central Office campus. O/A houses the simplified acquisitions staff which processes all procurement and acquisition requests for purchases under a threshold of $150,000 for VA organizations in 11 buildings throughout the National Capital Region. Funding supports acquisitions, labor support, and warehouse staff. O/A manages the National Transit Benefits Program Office which administers the transit benefits program for VA nationwide. Funds cover the salaries and benefits of the National Transit Benefits Program Office. O/A oversees the contract of the health units which provides health care services to VA Central Office employees in designated buildings and maintains the VA Central Office fitness center. The costs support the contract and personnel who manage the contract. O/A has a contract to transport VA Central Office employees across campus during duty hours.

OFFICE OF POLICY AND PLANNING (OPP)

Enterprise Data Contracts—FTE: 0

OPP requires three types of contract support to be the authoritative organization for data governance, Veterans' statistics, statistical analysis, and modeling to manage the Department's business intelligence tools and processes and to manage VA resources for developing interactive mapping tools and products. The three contracts will enhance data collection reporting and analysis capabilities while providing standards and guidelines for corporate-level business intelligence program management. A major contract for OPP is data-mining, which acquires Veteran demographics to supplement existing VA data sources. The integrated data will be used by VA to conduct statistical research and analysis, develop predictive models, and conduct outreach to Veterans. The offices that receive the data and analysis and benefit from these services reimburse OPP for these contracts.

Secretary's Carey Awards Program—FTE: 0

The Secretary of Veterans Affairs' Robert W. Carey Performance Excellence Award is an annual award that recognizes organizations within the Department that have implemented management approaches that result in sustained high levels of performance and service to the Veterans we serve. OPP's Enterprise Program Management Office, executor of the Carey Awards Program, uses award criteria aligned with the Malcolm Baldrige Criteria for Performance Excellence. These criteria are nationally recognized as a framework and standard for organizational excellence. VHA, VBA, and NCA provide funding for contractor support to train personnel to understand the Baldrige criteria in order to develop application packages, provide support to Carey examiners during consensus week, provide technical editing support, and provide feedback to applicants for continuous improvement purposes.

OFFICE OF OPERATIONS, SECURITY, AND PREPAREDNESS (OSP)

Identity, Credential and Access Management Program (ICAM)—FTE: 30

A new program in FY 2014, ICAM, along with the ongoing transformation initiative of Continuous Readiness in Information Security (CRISP), will strengthen VA's security by sharing information on the character and conduct of VA employees during the on-boarding, station code or inter-Department transfer, or off-boarding processes, consistent with Privacy Act requirements, VA Privacy Policy, and collective bargaining agreements where applicable. Each program office reimburses OSP for its share of the costs of this program.

Personal Identity Verification (PIV) Card—FTE: 0

Costs reflect procurement, distribution, and management support related to Homeland Security Presidential Directive—12 PIV cards and consumables for the Department. Each VA office reimburses OSP for its share of the PIV cards and consumables.

Homeless Veterans Initiative Office (HVIO)—FTE: 15

OPIA's HVIO provides policy development, interagency coordination, and public/ community engagement in collaboration with VHA, which is responsible for the operation and clinical implementation of eliminating homelessness among Veterans. VHA provides reimbursement to fund this initiative.

OFFICE OF ACQUISITION, LOGISTICS, AND CONSTRUCTION (OALC)

Consistent with appropriation language (see, e.g., Public Law 113–6, the Consolidated and Further Continuing Appropriations Act, 2013), OALC receives funding from the Major Construction and VHA Medical Facilities appropriations to cover costs for resident engineers who provide on-site supervision of VA's Major Construction projects and for VHA lease projects located throughout the country.

OALC also receives reimbursement for FTE from NCA and the Supply Fund to cover the costs of the work and services related to those programs. In all circumstances, funding will cover employee costs including salary and benefits, training, travel, permanent change of station expenses, contracts, and other associated costs of these programs. Additional detail is below:

• Reimbursement for on-site resident engineers—187 FTE from Major Construction, as authorized in appropriation language;

• Reimbursement for proportionate share of OALC management support provided from the Supply Fund—7 FTE; and

• Reimbursement for NCA Real Property Land Acquisitions/Actions support—2 FTE.

READJUSTMENT BENEFITS

Question 45. One item that VA pays for using mandatory funding is reporting fees provided to educational institutions. In response to questions about the fiscal year 2013 budget request, VA indicated that information was not available for 2011 regarding the number of institutions that received reporting fees from VA or the size of those payments.

A. Is that information now available regarding 2011 reporting fees? If so, please provide the number of institutions that received reporting fees, the 10 largest payments made to an institution, and the 10 smallest payments made to an institution.

Response. VA paid 9,557 educational institutions a total of $9,370,303 in reporting fees in calendar year 2011. The tables below show the institutions with the 10 largest and 10 smallest total payment amounts.

SCHOOL NAME	Largest Reporting Fee Amounts for Calendar Year 2011 (in $'s)
University of Phoenix (Online)	230,317.00
American Public University System (American Military University)	109,697.00
University of Maryland University College	65,313.00
Grantham University	60,696.00
Kaplan University	58,707.00
Central Texas College	45,947.00
Columbia Southern University	41,257.00
University of Phoenix (San Diego)	39,424.00
Florida State College at Jacksonville	39,085.00
DeVry University Online	38,530.00

SCHOOL NAME	Smallest Reporting Fee Amounts for Calendar Year 2011 (in $'s)
A and B Training Academy	7.00
A Head of Time Design Academy	7.00
A Step Ahead Academy and Salon	7.00
A T E of Texas Inc., DBA American Fly	7.00
A.B. Training Center, LLC	7.00
Abrams College (CHAPTER 31)	7.00
Academy of Acadiana—New Iberia	7.00
Academy of Cosmetology	7.00

SCHOOL NAME	Smallest Reporting Fee Amounts for Calendar Year 2011 (in $'s)
Academy of Equine Dentistry(CHAPTER 31)	7.00
Academy of Hair Design	7.00
1,046 other institutions	7.00

B. Is that information available regarding reporting fees paid in 2012? If so, please provide that information.

Response. VA paid 10,578 educational institutions a total of $10,442,799 in reporting fees in calendar year 2012. The tables below show the institutions with the 10 largest and 10 smallest total payment amounts.

SCHOOL NAME	Largest Gross Payments in Calendar Year 2012 (in $'s)
University of Phoenix (Online)	339,132.00
American Public University System (American Military University)	169,596.00
Ashford University (Online)	143,835.00
University of Maryland University College	91,740.00
Liberty University	79,119.00
Grantham University	75,600.00
Kaplan University	72,060.00
Columbia Southern University	59,076.00
Central Texas College	55,752.00
University of Phoenix (San Diego)	51,372.00

SCHOOL NAME	Smallest Gross Payments in Calendar Year 2012 (in $'s)
Louisiana Technical College—Shreveport	12.00
YogaMotion—Center for Holistic Education	12.00
Yoga Yoga Teacher Training	12.00
Yoga Connection, The	12.00
Yale University School of Medicine—School of Public Health	12.00
Yale University School of Drama	12.00
Xtra-mile Driver Training, Inc. (CHAPTER 31 ONLY)	12.00
Xenon International Academy—Grand Island	12.00
Xenon International Academy	12.00
Wyzsza Szkola Komunikacji I Zarzadania	12.00

Question 46. The fiscal year 2014 budget request reflects that VA now expects to spend $4,764,000 from readjustment benefits in fiscal year 2013 for "[r]eimbursement to [General Operating Expenses] and [Information and Technology]," which is $4,226,000 more than VA had originally projected would be spent in fiscal year 2013 for that purpose. The budget submission also reflects that, in fiscal year 2014, VA expects to spend $568,000 for that purpose.

A. Please provide an itemized list of how that $4.8 million is now expected to be spent during fiscal year 2013.

Response. Please see the following chart:

Readjustment Benefits	FY 2013 ($000s)	Authority
Reimbursements to GOE		
Information Pamphlets on Education Benefits	$234	PL 101-237: sec 421
Education Outreach Letters	$304	PL 105-368: sec 206
Reimbursements to IT		
Licensing and Certification System Start-Up Funds	$158	PL 106-419: sec 121
Computer System Modifications for Apprenticeship and OJT	$2,189	PL 108-454: sec 104
Veterans Retraining Assistance Program (VRAP) IT Expenses	$1,880	PL 112-56: sec 211

Readjustment Benefits	FY 2013 ($000s)	Authority
Total Reimbursements	$4,764	

B. Please explain the specific changes that led to this expected increase during fiscal year 2013.

Response. The increases in the FY 2013 current estimate are a result of available funds carried over from FY 2012 to FY 2013 for reimbursements to the Office of Information and Technology. At the time the following laws were passed, $3 million was made available for Licensing and Certification systems under Pub. L. 106–419; $3 million was made available for Apprenticeship and on-job training (OJT) systems under Pub. L. 108–454; and $2 million was made available for VRAP systems under Pub. L. 112–56. Each fiscal year, the remaining unused funds are still available for the intended purpose identified in law. The increase for FY 2013 reflects the remaining funds being carried over for obligation during FY 2013.

C. Please provide an itemized list of how these funds are expected to be spent during fiscal year 2014.

Response. Please see the following chart:

Readjustment Benefits	FY 2014 ($000s)	Authority
Reimbursements to GOE		
Information Pamphlets on Education Benefits	$248	PL 101-237: sec 421
Education Outreach Letters	$320	PL 105-368: sec 206
Reimbursements to IT		
Licensing and Certification System Start-Up Funds	$0	PL 106-419: sec 121
Computer System Modifications for Apprenticeship and OJT	$0	PL 108-454: sec 104
Veterans Retraining Assistance Program (VRAP) IT Expenses	$0	PL 112-56: sec 211
Total Reimbursements	$568*	

*Assuming funds associated with PL 106-419, PL 108-454, and PL 112-56 are obligated in FY 2013, the remaining $568 thousand is budgeted to carry out the authority provided by PL 101-237 and PL 105-368.

Question 47. In the fiscal year 2014 budget request, VA proposes legislation to increase funding for "contract vocational and educational counseling" for certain veterans or members of the Armed Forces.

A. In fiscal year 2012, how many individuals requested this type of counseling, how many individuals were provided with this type of counseling, and how much in total was spent to provide counseling to those individuals?

Response. Please see table below showing FY 2012 data:

Total Veteran Requests for Ch. 36	Completed with Counseling	Completed by Vocational Rehabilitation and Employment (VR&E) Staff	Completed by Contractor	Ed Voc Funding for Contractor Services
15,513	5,341	271	5,070	$1,853,640.95

*Requests which are not completed with counseling include those that are pending completion, as well as those that did not attend their required counseling appointments despite follow-up outreach attempts.

B. In fiscal year 2013, how many individuals are expected to seek this type of counseling, how many individuals are expected to be provided with this counseling, and how much in total is expected to be spent on these counseling services?

Response. Please see table below showing FY 2013 data:

Total Veteran Requests for Ch. 36	Still Pending	Completed with Counseling	Completed by VR&E Staff	Completed by Contractor	Ed Voc Funding for Contractor Services
14,322	1,193	5,585	279	5,306	$2,089,792.93

FY 2013 estimates are based on the assumption that 60 percent of the year is complete, which equates to 60 percent of annual demand. Part of the decrease in Veteran requests is caused by the National Defense Authorization Act (NDAA) and VR&E counselors at Integrated Disability Evaluation System (IDES) installations accelerating Servicemembers into the Chapter 31 program. Veterans with service-connected disabilities who received Chapter 36 counseling often also became eligible

for and enrolled in the Chapter 31 program. As a result of NDAA accelerating eligibility and entitlement to Chapter 31 services, transitioning Servicemembers going through the IDES are receiving counseling under Chapter 31 instead of under Chapter 36.

C. In fiscal year 2014, how many individuals are expected to seek this type of counseling?

Response. In FY 2014, VA estimates there will be a total of 15,754 Veterans requesting Chapter 36 counseling. FY 2014 estimates are 10 percent above FY 2013 projections due to anticipated increases in Veteran requests through mandatory TAP, increased outreach to eligible Veterans using Post-9/11 GI Bill, and VOW/VEI efforts.

Question 48. In the fiscal year 2014 budget request, VA proposes legislation to permanently authorize work-study activities for which authorization is currently set to expire in June 2013. Those work-study activities include outreach programs with State approving agencies, working in State homes, and administration of a national cemetery or state veterans' cemetery.

A. During fiscal year 2012, how many individuals participated in each of those work-study activities.

Response. The following table shows how many individuals participated in each of those work-study activities:

Category	Work-Study Students for FY 2012
SAA Outreach	11
National Veteran Cemetery	106
State Veteran Cemetery	19
VA State Homes	166
Total	302

B. To date, during fiscal year 2013, how many individuals have participated in each of those work-study activities?

Response. Since VA collects work-study statistics at the end of each fiscal year, data for FY 2013 is not yet available.

C. Please describe the resources required to administer this portion of the work-study program.

Response. VA does not anticipate any additional administrative costs associated with permanent authorization of this program.

Question 49. The Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012 provided a temporary expansion of eligibility for specially adapted housing for certain veterans with disabilities causing difficulty with ambulating.

A. How many veterans have qualified for this expansion?

Response. VA claims examiners are processing claims for benefits under Section 202 of P.L. 112–154. VA does not track the status and disposition of claims for benefits under Section 202 of P.L. 112–154 separately from other claims. Also, due to the recent implementation of this law, VA has not yet compiled data related to this temporary expansion.

VA notes that the law specifies that assistance under certain provisions of Section 202 of P.L. 112–154 may only be furnished for applications approved on or before the sunset date (September 30, 2013). Because approval of a Specially Adapted Housing (SAH) grant is a two-step process, in order for a Veteran or Servicemember to be qualified for benefits under those provisions of Section 202, the individual must receive a medical rating from VA of eligibility for SAH grant benefits, as well as a determination of site feasibility and suitability by VA to ensure the home can be adapted to meet the individual's needs. For a Veteran or Servicemember to receive benefits authorized by those provisions, both the medical rating and the site feasibility and suitability determination would need to be completed on or prior to the expiration date of the provisions (September 30, 2013).

In the fourth quarter of FY 2013, VA will be conducting a manual count of Veterans and Servicemembers who have been medically rated eligible for Section 202 benefits and who have begun the process of site feasibility and suitability to obtain actual data. VA will be happy to provide this information to SVAC upon conclusion of the count. VA is also researching options for a system enhancement to the Specially Adapted Housing/Special Housing Adaptation (SAHSHA) system, which would

allow SAH staff to flag and report on in-process grants associated with Section 202 eligibility.

B. How many houses have been adapted using this authority?

Response. VA is unable to provide the requested figures at this time. Upon conclusion of the fourth quarter of FY 2013 manual count, VA will provide more information to the Committee.

C. What is the average cost and the total cost per veteran of those who qualified and used the expansion?

Response. VA is unable to provide the requested figures at this time; however, please note that each eligible Veteran may receive a grant of up to $63,780.00. Upon conclusion of the fourth quarter of FY 2013 manual count, VA will provide additional information to the Committee.

VETERANS BENEFITS ADMINISTRATION

Disability Compensation

Question 50. In January 2013, VA sent to Congress a strategic plan for eliminating the backlog that projected VA would decide 1.6 million claims in fiscal year 2014. Less than three months later, VA submitted its budget request, which projects that VA will decide 1.3 million claims in fiscal year 2014.

A. What specific performance metrics did VA assess in lowering this projection and what did they show?

Response. The projections of received and completed claims in VA's Strategic Plan to Eliminate the Compensation Claims Backlog, submitted to Congress on January 25, 2013, were based on assumptions made earlier in the budget cycle that included a higher level of claims receipts and FTE than is reflected in the 2014 VA Budget Submission. VA revised its projections prior to submission of the FY 2014 budget to Congress based on FY 2013 actual experience to date that reflected a lower volume of claims receipts than previously projected. Projections are periodically updated based on recent experience, the impact of the transformation initiatives, and enhanced forecasting capabilities.

B. Are there any on-going initiatives that are not having the impact on production that VA expected? If so, please explain.

Response. VBA closely monitors the impact of initiatives on performance. All currently on-going initiatives have provided improvements to the disability claims process. A previous initiative called the Veterans Benefits Management Assistance Program (VBMAP) did not have an impact as expected and was not pursued further.

VBMAP was a professional services contract for rapid development of claims for increased benefits, initial compensation claims, pension claims, and dependency verification claims. The VBMAP contract was awarded September 2011, requiring 100% quality and 300,000 developed claims. The VBMAP vendor did not meet the quality or volume requirements of the contract. In June 2012, VA halted shipment of claims to allow the vendor to improve performance. The contract ended after the base period, September 12, 2012.

Question 51. According to VA's January 2013 backlog plan, VA expected that, in the first quarter of 2014, the number of claims VA decides would start to outpace the number of claims being received and that the total number of pending claims would be reduced in 2014. The fiscal year 2014 budget submission reflects that claims receipts will exceed production in 2014 and the number of pending claims will continue to grow.

A. What specific information and metrics initially led VA to project that the first quarter of 2014 would be the point when output would start to exceed input?

Response. The January 2013 strategic plan presented a worst case scenario in terms of a large number of incoming claims due primarily to the implementation of the Veterans Opportunity to Work (VOW) program for separating servicemembers. We anticipated that 200K+ additional claims might come in. Our belief was that if they did come in, they, and many other supplemental claims, would be submitted electronically, be fully-developed, and be simpler to process overall. Those assumptions led us to believe that if the large volume of new VOW-related claims occurred, we had a reasonable chance of turning them around very quickly; thus, we showed very large production increases in FY 2014 and especially FY 2015. In this worst case scenario, we believed that by not later than first quarter FY 2014 we would see significant production improvements from Transformation. We understood the high risk that we would be assuming in production and that possible risk generated significant discussion about resource requirements.

B. In revising this projection, what metrics did VA assess and what did they show?

Response. In revising the January 2013 projections for the FY 2014 budget submission, we had trend data showing that traditional receipts were moving downward but we were not yet ready to ignore the potential impact of additional VOW-related claims. In reviewing the risk associated with the dramatic increase in production we postulated in the January plan, we concluded that with the resources requested we needed to adjust our production plan to reflect a less risky output projection. The combination of less projected production with the still very real possibility of a large influx of VOW-related claims turned FY 2014 into a year where we might see no significant reduction in the inventory.

Since the FY 2014 budget was submitted, we have not seen any significant effect from VOW on total receipts in FY 2013 or the beginning of FY 2014. In addition, we achieved a significant increase in FY 2013 production. The net result was that we actually reached the point where production exceeded receipts on a consistent basis in the third quarter of FY 2013.

Question 52. In the January 2013 backlog plan, VA noted that it did not take into account 774,000 claims that may be filed as a result of the VOW to Hire Heroes Act and the Honoring America's Veterans and Caring for Camp Lejeune Families Act.

A. Does VA still expect those laws to generate an additional 774,000 claims?

Response. VA still expects that the VOW to Hire Heroes Act will result in an increase in claims between FY 2013 and FY 2015. VA will provide comprehensive benefits briefings at 250 sites worldwide. Together with the Veterans Employment Initiative, this could result in many additional claims as Servicemembers transition to civilian life.

Estimates show that the population assigned to Camp Lejeune between 1957 and 1987 was 630,000. Although the law provides health care to certain eligible Veterans and their eligible family members, it does not change the eligibility requirements for granting disability compensation. However, as a result of increased media exposure to the issue of contaminated water at Camp Lejeune, VA still expects that this law could generate additional claims between FY 2013 and FY 2015.

B. What specific assumptions led VA to project in the fiscal year 2014 budget submission that less claims will be filed in 2013 and 2014 than VA projected in the backlog plan?

Response. As previously mentioned, the projections of received claims VA's Strategic Plan to Eliminate the Compensation Claims Backlog, submitted to Congress on January 25, 2013, were based on assumptions made earlier in the budget cycle that included a higher level of claims receipts and FTE than is reflected in the 2014 VA Budget Submission. VA revised its projections prior to submission of the 2014 budget to Congress based on FY 2013 actual experience to date that reflected a lower volume of claims receipts than previously projected. Projections are periodically updated based on recent experience, the impact of the transformation initiatives, and enhanced forecasting capabilities.

Question 53. The Winston-Salem regional office helps with national missions, such as the Benefits Delivery at Discharge program and the Quick Start program, in addition to handling claims from North Carolinians. That office currently has about 50,000 pending claims.

A. For that workload, how many employees would be appropriate and how many are there currently?

Response. Based on the RAM for FY 2012, the Winston-Salem RO compensation rating claims processing FTE ceiling was 605. Due to workload challenges, 25 additional FTE were approved in August 2012. As of April 30, 2013, the actual on board FTE was 621.

B. What specific factors are considered in determining how claims processing staff are allocated among the regional offices?

Response. The RAM is a systematic approach to distributing field resources each fiscal year. The RAM uses a weighted model to assign compensation and pension FTE resources based on RO workload in rating receipts, rating inventory, non-rating receipts, and appeals receipts. VBA leaders use the model as a guide, making some adjustments for special circumstances or missions performed by individual ROs. Special missions include the Appeals Management Center, the Records Management Center, Day-One Brokering Centers, IDES processing sites, Benefits Delivery at Discharge sites, Quick Start processing locations, national call centers, fiduciary hubs, pension management centers, etc. Similar, workload-based models are used for each VBA business line.

C. When did VA last assess the staffing needs of each regional office and what did that assessment show?

Response. VBA assesses staffing needs in each RO at the beginning of each fiscal year based on the RAM. In FY 2013, VBA shifted to a RAM weighted more heavily on receipts and current workload, rather than the previous model which was weighted more on performance. As a result, some resources have been shifted to those ROs processing a greater portion of claims receipts and those currently carrying a greater portion of the claims inventory. The FY 2013 RAM has yet to be fully implemented, since rebalancing FTE resources is dependent upon attrition, and VBA must operate within its overall funding level. VBA anticipates continued use of this workload-driven RAM going forward.

D. When is the next assessment scheduled to occur? Please share the results of that review with the Committee.

Response. The RAM will be reviewed to ensure consistency with achieving VBA's national mission and updated with current workload and performance metrics for each RO at the beginning of FY 2014. VA can share the results of the review with the Committee once it has been finalized.

Question 54. VA has a number of initiatives underway to reach its goal of a 98 percent accuracy rate.

A. In total, how much did VA spend in fiscal year 2012 to carry out all of those quality initiatives?

Response. VBA's transformation plan is based on over 40 high-impact initiatives across people, process, and technology through a systematic and repeatable gap analysis process. It is difficult to separate each initiative's precise impact on quality and productivity; however, the FY 2012 funding for three of the initiatives with the greatest impact on quality is provided below:

- VBMS: $23.9 million (VBA GOE funding)
- Challenge training: $9.5 million
- Quality Review Teams: $51 million

B. In total, how much is VA expecting to spend in fiscal year 2013 to carry out all of those quality initiatives, including the quality review teams at each regional office?

Response. As previously noted, several initiatives will impact quality. A summary of FY 2013 funding for the primary initiative focused on improving quality is provided below:

- VBMS: $20.8 million (VBA GOE funding)
- Challenge training: $10.1 million
- Quality Review Teams: $52 million
- Station Enhancement Training: $925,000

C. In total, how much is VA requesting for fiscal year 2014 to carry out all of those quality initiatives, including the quality review teams at each regional office?

Response. For FY 2014, VBA has requested the following funding for these initiatives:

- VBMS: $35.7 million
- Challenge training: $9.9 million
- Quality Review Teams: $53 million

D. Nationwide, how many full-time equivalents are currently assigned to these quality review teams?

Response. Currently, there are 583 Quality Review Specialists nationwide.

E. If the fiscal year 2014 budget request is adopted, how many individuals Nationwide would be assigned to these teams?

Response. During the development and piloting of the Quality Review Team (QRT) positions, analysis showed an appropriate staffing ratio of one Quality Review Specialist to 15 claims processors. VBA anticipates continuing to utilize this staffing ratio for QRT positions during FY 2014. Since RO staffing will remain consistent from FY 2013 to FY 2014, there will be no change to the number of Quality Review Specialists in FY 2014.

Question 55. In the 2012 PAR, VA indicated that the use of Disability Benefits Questionnaires has "resulted in more timely rating decisions, fewer duplicated examinations, a reduced need for VA examinations, and a potential to improve rating accuracy."

A. Please provide any statistics on the timeliness of rating decisions in cases involving Disability Benefits Questionnaires compared to cases that do not.

Response. All Veterans benefit from the efficiencies built into the Disability Benefits Questionnaires (DBQ) tools. Submitting a claim with a DBQ completed fully and accurately by a treating clinician can obviate the need to request a C&P examination, thus reducing the time required to obtain all the evidence necessary to decide the claim. Additionally, since DBQs are streamlined, condition-focused, and capture

the specific rating criteria needed to evaluate a medical condition, they elicit from the examiner responses to very specific questions that yield all necessary facts to evaluate a disability claim. Since the initiation of the DBQ process in 2012, VA has received just over 15,000 DBQs from treating clinicians and more than 2.54 million DBQs completed through the C&P exam process.

At this time, there is insufficient data to compare the differences in timeliness of rating decisions in cases involving DBQs with those that do not as there are a limited number of cases in which DBQs are not used. Additionally, other factors may affect timeliness which are not related to DBQ use, such as requesting military and other Federal records.

B. Please provide any statistics on the number of duplicated examinations that have been avoided as a result of the use of Disability Benefits Questionnaires and the cost savings associated with that reduction.

Response. Because DBQs are streamlined, condition-focused, and capture the specific rating criteria needed to evaluate a medical condition, they elicit from the examiner responses to very specific questions that yield all necessary facts to evaluate a disability claim. Therefore, the DBQ examination report is less frequently found insufficient for rating purposes, reducing the number of additional exams on any given Veteran's claim. However, there is insufficient data related to a measurable difference in the number of duplicate examinations requested. This is not because the value and efficiency of DBQs is not being seen, but because of other factors that held the national insufficiency rate steady since the implementation of DBQs.

C. Please provide any statistics on the reduction of VA examinations attributable to the use of Disability Benefits Questionnaires and the cost savings associated with that reduction.

Response. The data set of DBQs completed by treating clinicians is too small to allow for accurate measure of overall examination avoidance. However, conservatively assuming that half of the DBQs completed by a treating clinician avoided the need for a C&P examination, it is possible that 7,500 fewer examinations were ordered. With the average cost of an examination at $500, this equates to $3.75 million in cost savings. Again, these are estimates based on a non-statistically significant sample of DBQs. VBA anticipates that the examination avoidance figure will actually be higher once DBQs are fully automated and become the norm for use by treating clinicians.

Question 56. In the fiscal year 2014 budget request, VA projects that VA will complete 1.1 million claims in fiscal year 2013 and 1.3 million claims in fiscal year 2014.

A. If those projections are accurate, how many claims does VA expect would need to be completed in fiscal year 2015 in order to meet VA's goal of eliminating the backlog by 2015?

Response. Over the last 6 months, VBA has received a lower volume of claims than previously projected. From October 1, 2012, through June 3, 2013, VBA received 5.7 percent fewer receipts than last year at the same time. As a result, VA will revise its estimates of the number of completed claims needed through FY 2015 in connection with developing the FY 2015 budget submission. Projections are periodically updated based on recent experience, the impact of the transformation initiatives, and enhanced forecasting capabilities. Eliminating the claims backlog in 2015 remains VA's goal.

B. What specific performance outcomes suggest to VA that that level of output during 2015 is possible?

Response. These increased levels of output are possible due to the implementation of VA's comprehensive Transformation Plan, which is designed to eliminate the claims backlog and achieve our goal of processing all claims within 125 days at a 98-percent accuracy level in 2015. This major transformation in claims processing includes a series of tightly integrated people, process, and technology initiatives that are being implemented according to a carefully developed multi-year timeline. The transformational initiatives are being rolled out in a progressive, intentional sequence that enables efficiency gains while minimizing risks to performance. We are confident that we will meet this goal as we continue to implement the Transformation Plan. It is important to note that the timeline for eliminating the claims backlog could be affected if policymakers establish new presumptive conditions, courts make new precedential decisions, or legislators make laws that establish new entitlements. VA continues to monitor the performance impact of transformation as well as other external factors that could potentially have an impact.

VBA has increased its rating output in each of the past 3 months, and in May 2013, VBA set production history by processing more claims (109,097) than any previous month. Additionally, VA is eliminating the backlog by prioritizing claims for those Veterans who have been waiting the longest for a decision, including claims over 2 years old, followed by claims over 1 year old. From April 19, 2013,

through June 19, 2013, VBA successfully processed 65,507 2-year-old claims, and 67,050 1-year-old claims. Over this same period, VBA reduced its backlog, defined as those claims pending for over 125 days, by over 58,000 claims, from 588,868 to 530,104.

Question 57. VA's "appeals resolution time" in fiscal year 2012 was 866 days, an increase of 210 days since fiscal year 2010.

A. How much in total is expected to be expended by the Veterans Benefits Administration (VBA) to process appeals during fiscal year 2013?

Response. In FY 2013, VBA estimates that funding to process appeals will total $84.5 million, including $63 million for Decision Review Officers assigned at ROs and $21.5 million on Appeals Management Center staffing and operations. There are also VSRs and RVSRs assigned to Appeals Teams at ROs. However, VBA is unable to specifically identify the payroll costs associated with those employees.

B. What level of funding is requested in total for fiscal year 2014 for purposes of processing appeals by VBA?

Response. The FY 2014 budget includes $85.9 million for processing appeals, including $64 million for Decision Review Officers assigned at ROs and $21.9 million on Appeals Management Center staffing and operations. There are also VSRs and RVSRs assigned to Appeals Teams at ROs. However, VBA is unable to specifically identify the payroll costs associated with those employees.

Question 58. In the fiscal year 2014 budget request, the discretionary request for the disability compensation program includes $526 million for Other Services. Please provide a detailed itemized list of how that funding would be utilized during fiscal year 2014. To the extent any of the funds will be spent on contracts, please explain the nature of the contract and the expected outcomes.

Response. The discretionary request for $526 million contains funding of $420.6 million for contracts that directly impact or support the delivery of disability compensation claims:

- Contract Medical Examinations ($239.1 million)
- Veterans Claims Intake Program (scanning) ($132.1 million)
- Program management and systems engineering support services for the Veterans Benefits Management System ($32.3 million)
- Development of instructional methodologies and systems that support the training and skills development of the disability compensation workforce ($8.2 million)
- Program management, scientific, technical, and engineering support for Compensation Service and the VBA Operations Center ($6.2 million)

The request also includes $31.9 million for studies and analyses that support strategic planning ($16.4 million) and innovation ($15.5 million).

The remaining $73.5 million is for administrative and management support costs associated with VBA-internal support agreements, such as Franchise Fund fees for Debt Management Center, Financial Services Center, Computer Data Center Operations services, and for support attained via interagency agreements with the Department of Homeland Security, the Department of the Treasury, and the National Archives and Records Administration.

Question 59. In response to questions about VA's fiscal year 2012 budget request, VA provided this prediction: "Investments in information technology will begin to pay dividends as deployment of the Veterans Benefits Management System (VBMS) begins in 2012, allowing for increased productivity and reduced operating costs in processing disability compensation claims." Then, in response to questions about the fiscal year 2013 budget request, VA indicated that "VA will be able to better examine increases in productivity and reduction in costs once additional software releases are deployed in November 2012 and May 2013."

A. Please quantify any increased productivity or reduced costs realized during fiscal year 2012 and to date in fiscal year 2013 as a result of VBMS, in terms such as individual productivity of claims processing staff, cost per case, or overall operating costs.

Response. VBA began deployment of VBMS Generation 1 in September 2012, concluding the calendar year with 18 stations on the system. It is important to note that early adopters of first generation technology participated heavily in the development and refinement of efficiencies and functionality of the system, which had a direct impact on productivity as a result of the live test environment. These stations paved the way for the accelerated deployment of VBMS, which will enable VBA to track and measure productivity outcomes in a consistent and accurate manner once all ROs are operating with the new technology and after a period of stabilization. The first 18 stations enabled VBA to also test business processes and functionality for the establishment of eFolders in VBMS and the model for tracking and shipping of paper-based claims with two scanning vendors. Under VBA's accelerated VBMS

deployment schedule, all ROs have implemented VBMS as of June 10, 2013. However, nearly 557,000 paper claims in our current inventory remain to be processed.

It is difficult to extract the impact of each transformation initiative from the combined people, process, and technology model to determine individual initiative's contribution to productivity outcomes. At the end of April 2013, approximately 5,800 claims have been fully processed in VBMS in an average of 121.1 days fiscal year to date.

B. Please quantify the increased productivity and reduced costs now expected in fiscal year 2014 as a result of VBMS, in terms such as individual productivity of claims processing staff, cost per case, or overall operating costs.

Response. VBMS is projected to provide a 20 percent increase in productivity in FY 2014.

Question 60. In connection with VA's fiscal year 2012 budget request, VA was asked to explain VA's plan to bring down the backlog of disability claims by 2015. In part, VA responded that "productivity * * * will rise from 89 annual claims per [compensation and pension] direct labor FTE in 2012 to 129 in 2015."

A. Now, how many claims are projected to be completed during fiscal year 2015 per compensation and pension direct labor FTE?

Response. Our current estimates suggest a productivity of 100 to 101 per direct FTE in FY 2015 and 90 to 91 per direct FTE in FY 2014, after finishing FY 2013 at approximately 81 per direct FTE. The 81 figure reflects a slow first six months of FY 2013 as the integrated lanes and accelerated fielding of VBMS approached completion and a very robust productivity the final six months of FY 2013.

B. What specific metrics or performance outcomes lead VA to conclude that that level of productivity per FTE is attainable?

Response. As discussed in question 51, our assumptions for FY 2014 and FY 2015 productivity in the January 2013 plan reflected a high risk assumption of our ability to deal with a large number of VOW-related claims relatively quickly in comparison to the traditional receipts we expected. The final six months of FY 2013 showed a sustained production per direct FTE of almost 93 claims due to Transformation. Continued Transformation is expected to permit achieving even higher levels of productivity per direct FTE in FY 2014 and FY 2015.

Question 61. According to information provided in connection with the fiscal year 2013 budget request, VBA planned to expend $46.9 million in fiscal year 2013 to pay for claims processing staff to work overtime.

A. During fiscal year 2012, how much in total was actually expended to pay for overtime work by claims processing staff and what outcomes were achieved as a result of those overtime hours?

Response. In FY 2012, $42.9 million was spent on overtime for C&P claims processing. Approximately 50,000 rating claims were completed during overtime.

B. During fiscal year 2013, how much is now expected to be spent on overtime by claims processing staff and what outcomes are expected to be achieved as a result of those overtime hours?

Response. VBA recently reallocated an additional $32.9 million for mandatory overtime for C&P claims processing, bringing the total overtime for C&P claims processing in FY 2013 to $65.5 million. VBA anticipates approximately 80,500 claims completed on overtime in FY 2013.

C. For fiscal year 2014, what level of funding is requested to pay for overtime hours worked by claims processing staff and what outcomes are expected to be achieved as a result of those overtime hours?

Response. Of the $45 million budgeted for overtime, VBA anticipates using approximately $40 million to fund overtime for C&P claims processing. FTE productivity is expected to be higher during FY 2014, resulting in an estimated 53,000 claims completed on overtime during FY 2014.

Question 62. In VA's testimony before the Committee on the fiscal year 2013 budget request, the Secretary indicated that "VA plans an aggressive communications strategy surrounding the release of [additional Disability Benefits Questionnaires] that will promote the [fully-developed claims (FDC)] program." VA's responses to post-hearing questions also indicated that VA was "considering promoting the program by implementing an FDC training course for Veterans Service Officers * * * and disseminating FDC program information, benefit applications, and marketing materials, such as an FDC program trifold brochure, to VSOs, Veterans, and other potential claimants."

A. How many fully-developed claims are expected to be filed during fiscal year 2013 and during fiscal year 2014?

Response. VA is on track to receive more than 80,000 fully developed claims (FDCs) in FY 2013, and projects to receive more than 200,000 FDCs in FY 2014.

B. To date in fiscal year 2013, how many days on average is it taking to complete fully-developed claims?

Response. FDCs are taking an average of 121 days to complete as of September 17, 2013.

C. For fiscal year 2014, how long is it projected to take to complete fully-developed claims?

Response. In FY 2014, an FDC is projected to take an average of 100 days.

D. For fiscal year 2013, how much is expected to be spent on FDC marketing materials and on an FDC training course?

Response. In FY 2013, VBA's Benefits Assistance Service has $450,000 allocated for FDC marketing materials and FDC training.

E. For fiscal year 2014, what level of funding is requested for purposes of promoting the fully-developed claims program? Please specify the amounts, if any, requested for an FDC training course and for marketing materials.

Response. In FY 2014, VBA's Benefits Assistance Service has $450,000 allocated for FDC marketing materials and FDC training.

Question 63. VA processes claims at 56 regional offices around the country and those offices vary in the quality and timeliness of their decisions.

A. For fiscal year 2012, please identify the specific regional offices with the highest attrition rates for claims processing personnel.

Response.

Station*	2012 Attrition Rate**
Fargo	17.18%
Honolulu	14.87%
Indianapolis	13.29%
Wilmington	13.28%
Chicago	12.17%
Albuquerque	12.12%
Boston	11.05%
Anchorage	10.84%
San Juan	10.77%
Denver	10.65%
Reno	10.45%
Baltimore	10.40%
Oakland	9.79%
Newark	9.23%

*Stations with > 9% attrition for claims staff
**VSRs, RVSRs and DROs only
Attrition defined as employees who left VBA

B. What are the expected attrition rates for claims processing positions during fiscal year 2013 and fiscal year 2014?

VBA Response. Based on a 5-year average of 7.57 percent and a slight downward trend, we can estimate VBA-wide attrition to be 7 percent for each of the next 2 years. Please note: We define attrition for the purposes of this response as employees who leave VBA.

Question 64. In response to questions regarding the fiscal year 2013 budget request, VA indicated that it planned to provide disability examinations to veterans residing overseas using contractors as well as VA employees.

A. How many examinations are expected to be provided through contractors during fiscal year 2013 and 2014 and how much would be expended for that purpose?

Response. In FY 2013, $4.798 million was budgeted for disability exams and associated travel to support 1,500 Veterans in residing overseas, with $575,000 paid to VHA contractors for performance of these disability exams in supported locations (Germany and Japan). For FY 2014, $4.316 million was budgeted for disability exams and associated travel to support an estimated 1,550 Veterans.

B. How many examinations are expected to be provided through VA employees during fiscal year 2013 and 2014 and how much would be expended for that purpose?

Response. VHA employees have not conducted overseas examinations in FY 2013. There are no examinations scheduled for either the remainder of FY 2013 or FY 2014. The Office of Disability and Medical Assessment (DMA) plans to use the Disability Examination Management contract to the greatest extent possible to provide examinations to Veterans residing at specific geographic locations overseas. DMA has executable plans to deploy a small contingent of internal staff, if necessary.

Question 65. In response to questions about the fiscal year 2013 budget request, VA indicated that it was requesting $10 million in order to contract with private entities to retrieve medical records from private medical providers.

A. In total, how much was spent on that initiative during fiscal year 2012 and what was the average time it took the contractors to obtain private medical records (or otherwise close out the development action)?

Response. VBA spent $508K in FY 2012 on the private medical records initiative. The average time to obtain private medical records or acceptable responses (none available or destroyed) from medical providers was 11.5 days.

B. How much is now expected to be spent on this initiative during fiscal year 2013 and how long on average is it currently taking the contractors to obtain private medical records (or otherwise close out the development action)?

Response. VBA obligated $2.1 million in FY 2013 to continue the private medical records pilots at the ten pilot ROs: Chicago, Indianapolis, Houston, Jackson, Portland, Phoenix, New York, St. Louis, New York, and Waco. The average time for contractors to obtain private records remains around 11.5 days.

C. Is any funding requested with respect to this initiative for fiscal year 2014? If so, please specify the amount.

Response. VA requested $10 million in FY 2014, the estimated annual cost to run the program nationally.

Question 66. According to the 2012 PAR, VA plans to continue efforts to revise the disability rating schedule during fiscal year 2013.

A. How much in total was actually expended during fiscal year 2012 to update the disability rating schedule? Please provide an itemized list of how that funding was expended and what results were achieved with that funding.

Response. VA is in the process of updating the VASRD. As part of this process, members of Compensation Service, Regulations Staff hosted multiple public forums and gathered scientific evidence regarding disabling conditions and their impact on the average impairment of earnings capacity. These public forums were also used as a platform to solicit public input regarding these deliberations. In addition, during these forums, working groups were formed to support the ongoing review process. For FY 2012, the non-payroll expenditures for the VASRD modernization project totaled $366,139. The table below shows a breakdown.

Event	Date	Expenses
VASRD FORUM—NYC	October 11-20	$84,626
VASRD Forum—NYC	January 17-26	$52,688
Travel	FY 2012	$27,467
Medical consultation contract	FY 2012	$201,358
TOTAL		$366,139

The medical consultation contract provided subject matter expertise to assist with medical content relevant to rating disabilities, consult on policy issues and revisions to the disability benefits questionnaires, and various other responsibilities.

B. During fiscal year 2013, how much in total does VA currently plan to expend to revise the rating schedule? Please provide an itemized list of how that funding has been or will be expended and what results have been or are expected to be achieved with that funding.

Response. So far in FY 2013, an event focused on mental health disorders was held on May 1 and 2, with expenses totaling $4,300, and a meeting focused on skin diseases was held from March 28 through April 5, with expenses totaling $2,000.

VA plans to fund additional VASRD modernization project conferences this year. These conferences are needed for the body systems still pending final review and revision, which include the musculoskeletal system and mental disorders. The purpose of these work group conferences is to intensify the review process and to expedite research, development, and deliberations within these sections of the VASRD. The diverse work group includes medical doctors, psychologists, attorneys, Veterans Service Organization representatives, and VA adjudicators. The benefit of these conferences is the generation of more ideas and energizing of the collaborative process which is at the heart of the VASRD review. Each conference will require participants to travel, with estimated costs of $12,000 to $15,000.

VBA medical officers responsible for drafting the VASRD regulations will also meet with SMEs to obtain clinical expertise and opinions useful in revising the VASRD regulations. The estimated cost for FY 2013 is $15,000.

C. What level of funding is requested for fiscal year 2014 for purposes of updating the rating schedule and how are those funds expected to be spent? What results are expected to be achieved with that funding?

Response. It is anticipated that conferences, travel, and outside consultation will be completed in FY 2013. In FY 2014, remaining work including workgroup participation, regulation drafting, and internal and external concurrence, will be accomplished by VA without travel or outside consultation. VA has $15,000 in funding in FY 2014 to support any unforeseen travel or conferences. There are currently 5 FTE assigned to the VASRD modernization project. VA anticipates that two body systems (endocrine and hematologic/lymphatic) will progress through external concurrence during FY 2014, with final publication in FY 2015. For the remainder of the body sytems, VA anticipates that they will progress through the workgroup, drafting and internal concurrence phases during FY 2014. Final publication of all body systems is expected to be completed in 2016. A copy of the updated project management plan and operating plan, as well as the project schedule, will be provided when completed.

Question 67. According to a September 2012 Government Accountability Office (GAO) report, VA has experienced delays and challenges in obtaining earnings loss studies needed to complete revisions to the disability rating schedule. The fiscal year 2014 budget request reflects that "VA is in the process of issuing a request for proposals for data-driven earnings loss studies."

A. Since 2009, how much has VA expended in relation to earnings loss studies and what results have been achieved with that funding?

Response. Since 2009, VA has entered into two contracts for earnings loss studies. Both contracts were made with a single contractor and most of the work completed was in support of development of an earnings loss model. Other expected deliverables were not completed prior to the decision to terminate the contract, including the following: a database of comparison groups; a compilation of service-connected Veterans and comparison group(s); and a peer-reviewed final report. The contractor was also unable to apply the earnings loss model formula it had developed for data acquisition because the contract was terminated before the income data was supplied. VA has paid $158,820 with the last payment made on these contracts in FY 2011. The Contracting Officer is currently in the process of making a final termination determination on the total amount that is due to the contract based on the partial work completed. VA estimates that the total payment for both contracts is approximately $663,000. From this contractor, VA gained insight regarding limitations on the scope of any future earnings loss study. For example, VA learned that due to statutory limitations, individualized earnings data cannot be obtained from the Internal Revenue Service and therefore, any future plans for an earnings loss study cannot aspire to use individualized data. Additionally, earnings loss models cannot be designed to forecast earnings loss for each available diagnostic code because there is insufficient data available to build a statistically competent and reliable model for each diagnostic code.

B. In fiscal years 2013 and 2014, how will funding for earnings loss studies be expended and what results are expected to be achieved?

Response. For FY 2013, VA anticipates no costs for the earnings loss studies. VA is currently preparing for earnings loss studies in FY 2014 and will seek bids from contractors with demonstrated experience in administering such studies for other government entities to yield an adequate analysis of earnings loss for each of the major diagnostic codes in the VASRD. VA estimates that $1.8 million will be spent on earnings loss studies in FY 2014.

Question 68. In response to questions about VA's fiscal year 2013 budget request, VA indicated that there were 15 full-time employees at the Louisville regional office dedicated to processing claims based on exposure to contaminated water at Camp Lejeune.

A. Currently, how many employees at the Louisville regional office are dedicated to handling these claims?

Response. There are currently 15 full-time employees at the Louisville RO dedicated to processing claims based on exposure to contaminated water at Camp Lejeune.

B. If the fiscal year 2014 budget request is approved, how many employees would be dedicated to handling these claims at the Louisville regional office?

Response. During fiscal year 2014, the number of full-time employees dedicated to processing Camp Lejeune claims will remain at 15. Adjustments will be made as necessary based on the number of claims received including those received in connection with the Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012. While this law does not change the eligibility requirements for

granting entitlement to compensation, it could potentially drive an increased volume of claims related to Camp Lejeune, as new healthcare benefits are provided to certain eligible Veterans and their eligible family members.

Question 69. As one strategy to deal with VA's backlog of disability claims, VA has brokered claims between VA offices. In response to questions about the fiscal year 2013 budget request, VA indicated that it "has not completed an analysis on the cost-effectiveness of brokered work."

A. In total, during fiscal year 2012, how many paper-based claims were brokered by VA?

Response. In support of its national priorities and workload management strategies, VBA brokers its claims processing workload among ROs and dedicated brokering sites as necessary. A total of 46,591 paper-based claims were completed as part of the national brokering strategy. This represents 4.5 percent of the 1,044,207 claims completed during FY 2012.

B. During fiscal year 2013 and fiscal year 2014, how many paper-based claims does VA expect to broker?

Response. Through April 2013, a total of 25,558 paper-based claims have been brokered this fiscal year. Workload demands and other factors may affect the actual volume of paper-based claims that are brokered. National deployment of Generation One of VBMS (our baseline system) began in 2012, with 18 ROs operational as of the end of the calendar year. Deployment to the remaining stations, originally scheduled to be completed by the end of CY 2013, was accelerated and completed as of June 2013, likely reducing the number of paper claims that will be physically brokered in FY 2014.

C. What is the status of efforts to determine the cost-effectiveness of brokering paper-based claims?

Response. With the implementation of VBMS, a cost-effectiveness study is no longer warranted. As VBMS will allow for a completely electronic claims process, future brokering efforts will be conducted in a paperless environment, thus eliminating the need for the transfer of paper-based claims folders among ROs.

Question 70. VA and the Department of Defense (DOD) have rolled out worldwide an Integrated Disability Evaluation System (IDES), through which an injured or ill servicemember, before being medically discharged from the military, completes both the DOD disability rating system and the VA disability rating process.

A. During fiscal year 2012, how much in total did VA expend with respect to the Integrated Disability Evaluation System and how many VA employees were dedicated to the IDES process?

Response. During FY 2012, VBA spent approximately $54.8 million for salaries and GOE for 490 FTE dedicated to disability claims processing in the IDES process. Compensation staff and VR&E Counselors are included in this count. Veterans filing claims through the IDES sites are captured in the nationwide Veteran caseload count and total compensation benefit obligations; therefore, mandatory funding cannot be separated for this program.

B. During fiscal year 2013, how much in total does VA expect to expend with respect to the Integrated Disability Evaluation System and how many VA employees will be dedicated to the IDES process?

Response. During FY 2013, VBA estimates it will spend approximately $63.0 million for salaries and GOE to support 580 FTE dedicated to disability claims processing in the IDES process.

C. During fiscal year 2014, how much in total is VA requesting with respect to the Integrated Disability Evaluation System and how many VA employees would that level of funding support?

Response. During FY 2014, VBA estimates it will spend approximately $63.6 million for salaries and GOE to support 580 FTE dedicated to disability claims processing in the IDES process.

Pension and Fiduciary Service

Question 71. In response to questions about the fiscal year 2013 budget request, VA indicated that the Pension and Fiduciary Service was "working with VA's Office of Enterprise Development (OED) to replace the current electronic workload management system, Fiduciary-Beneficiary System (FBS)" and that "[c]ompletion of the first phase is expected in the Fall of 2012." Please provide an updated timeline for the replacement of FBS.

Response. Pension and Fiduciary Service began its pilot of the replacement system, the Beneficiary Fiduciary Field System, on August 30, 2013. The fiduciary hubs at Louisville, KY and Lincoln, NE were selected as the initial sites to test the functionality and capability of this application. National deployment of the replacement system is scheduled for December 31, 2013.

Question 72. In response to questions about VA's fiscal year 2012 budget request, VA provided this information: "The 2012 budget request does not include funds to develop an online training program for fiduciaries but we have conducted research to identify existing certification programs. We plan to develop a system in 2013." Then, in response to questions about the fiscal year 2013 budget request, VA indicated that "[t]he online training program for fiduciaries is still in the initial stages of development."

A. Please provide an update on the status of this initiative.

Response. The first phase of the fiduciary training initiative is publication of a new Fiduciary Guidebook for volunteer fiduciaries (92 percent of VA fiduciaries); most of whom are the relatives, caregivers, and friends of beneficiaries in VA's fiduciary program and have a one-on-one relationship with the beneficiary. The Guidebook will instruct fiduciaries on their responsibilities, their duty to act independently to determine the beneficiary's needs, the rights of beneficiaries, and the procedures for completing an accounting. The intent is to clarify the roles of VA, fiduciaries, and beneficiaries in the program, and improve communications. It will also provide helpful answers to frequently asked questions. The "Guidebook for VA Fiduciaries" is currently available online at: http://benefits.va.gov/fiduciary/Fid_ Guide.pdf. Hard copy guidebooks will be published by the end of the fiscal year.

The second phase of the fiduciary training initiative will target paid and unpaid fiduciaries and will include web-based training, as well as self-certification of the training material. The second phase is expected to deploy in October 2014.

B. Does the fiscal year 2014 budget request include any funding to advance this initiative?

Response. Yes, current funding is available to advance the fiduciary training initiative into the second phase.

Question 73. In response to questions about VA's fiscal year 2013 budget request, VA indicated that the Pension and Fiduciary Service "entered into a contract with Accurint, which is a service of LexisNexis Risk Solutions, to provide instant criminal background checks on prospective fiduciaries."

A. How much is expected to be expended for this purpose during fiscal year 2013?

Response. During FY 2013, Pension and Fiduciary Service expects to expend $82,565 for the purpose of contracting for instant criminal background checks on prospective fiduciaries.

B. How much is requested for this purpose for fiscal year 2014?

Response. Pension and Fiduciary Service does not anticipate an increase in the contract amount from FY 2013 to FY 2014.

Question 74. In the fiscal year 2014 budget request, the discretionary request for the pension, dependency and indemnity compensation, burial, and fiduciary programs includes $17.5 million for Other Services for fiscal year 2014. Please provide a detailed itemized list of how that funding would be utilized during fiscal year 2014. To the extent any of the funds will be spent on contracts, please explain the nature of the contract and the expected outcomes.

Response. The discretionary request for $17.5 million contains funding of $11.7 million for contracts that directly impact or support the delivery of pension claims:

• Contract Medical Examinations ($2.3 million)
• Program management, scientific, technical, and engineering support for Pension and Fiduciary Service ($1.2 million)
• Development of instructional methodologies and systems that support the training and skills development of the Pension and Fiduciary workforce ($8.2 million)

The remaining $5.8 million is for administrative and management support costs associated with VBA-internal support agreements, such as Franchise Fund fees for Debt Management Center, Financial Services Center, Computer Data Center Operations services, and for support attained via interagency agreements with the Department of Homeland Security, the Department of the Treasury, and the National Archives and Records Administration.

Question 75. The fiscal year 2014 budget submission reflects that VA "is in the process of developing fiduciary regulations." What is the expected timeline for completion of these regulations?

Response. The draft fiduciary regulations are among VA's highest priority regulations. VA anticipates publication in the second quarter of FY 2014.

Question 76. Between 2009 and 2012, there was a 128.2 percent increase in the average days to complete burial claims. From 2010 to 2012, there was a 3.2 percent decrease in the amount of initial burial claims submitted to VA, yet there was a 4.6 percent decrease in the amount of claims processed.

A. What has led to the substantial increase in days to process burial claims even though the number of claims has decreased?

Response. All burial claims are processed at the Pension Management Centers (PMC) in addition to Dependency and Indemnity Compensation (DIC) and pension claims. The PMCs have focused more resources on DIC and pension claims due to the dramatic growth in volume of incoming claims between FY 2010 and FY 2012. As a result, the average days to process burial claims has increased. VA recognizes that burial benefits are an important benefit and has reviewed the process for adjudicating burial claims to determine how to streamline the process and improve the timeliness of claims. To address these issues, VBA is working to simplify and automate the burial program.

Current burial regulations require VA to obtain statements and receipts from claimants showing that funeral expenses were incurred. Upon receipt, VA calculates the precise payment, up to a statutory maximum, and reimburses claimants. The process is paper and time intensive and often requires claimants and service providers to cover some portion of burial and funeral costs until VA reimburses them for allowable costs.

Because the average cost of a funeral far exceeds the available benefit and VA could pay certain burial benefits based on evidence in its records at the date of a Veteran's death, VA is drafting proposed regulations that, if approved, would enable it to automatically pay certain burial benefits to eligible survivors upon a confirmed notice of death. Such automatic payments are only possible with regulatory or legislative authority for payment of burial benefits at a flat-rate and without a formal claim. VA will, to the extent possible, seek such authority through regulatory change. By establishing flat-rate payment of burial benefits and automating the processing of burial claims, VA will expedite the delivery of benefits to survivors and other claimants and free up resources for working claims in the backlog.

B. The 2014 target for average days to complete burial claims is 90 days, while the strategic target is 21 days. What actions have been or will be taken to reduce the average days to complete a burial claim?

Response. See answer provided in 76a, above.

Appeals Management Center

Question 77. Since 2003, certain cases remanded by the Board of Veterans' Appeals have been handled at a centralized entity called the Appeals Management Center.

A. During fiscal year 2012, how much was spent on the Appeals Management Center and what level of staffing did that funding support?

Response. In FY 2012, $20.8 million was allocated to the Appeals Management Center (AMC) for payroll, non-payroll, and travel. This supported staffing of 249 FTE, of which 235 were production FTE.

B. During fiscal year 2013, how much is now expected to be spent on the Appeals Management Center and what level of staffing will that funding support?

Response. Approximately $20.4 million will be allocated to the AMC for FY 2013 to support staffing of 230, of which 222 are production FTE.

C. In total, how much funding is requested for fiscal year 2014 for the Appeals Management Center and what level of staffing would that funding support?

Response. Currently, estimated FY 2014 staffing levels are consistent with FY 2013 levels, and consequently, funding is also consistent with FY 2013.

D. For fiscal years 2013 and 2014, what are the key performance targets for the Appeals Management Center?

Response. The FY 2013 AMC key performance targets consist of the following metrics and corresponding targets:

• Average days pending for claims from homeless Veterans—70 days
• Claims inventory—13,500
• Average days pending—145 days
• Average days to complete—270 days
• Claims production—30,000
• 12-month claims accuracy—90%

FY 2014 targets will be set at the beginning of the next FY, and will consider actual performance in FY 2013 and VBA's organizational goals for FY 2014.

Education

Question 78. According to the 2012 PAR, one reason that VA did not meet its timeliness goals for processing education claims is that "[o]vertime for claims processing was limited."

A. How much was requested for overtime for fiscal year 2012, what amount was expended, and what amount would have been adequate to help prevent claims processing delays?

Response. VBA initially allocated $8.8 million in overtime funds for education claims processing in FY 2012. In the second quarter of FY 2012, some funds were reallocated for overtime for disability compensation claims processors. As VBA identified degradation in performance metrics for education claims, additional funding was secured for overtime. By the end of FY 2012, a total of $9 million was spent on overtime for education claims processing.

B. How much has been allocated for overtime for fiscal year 2013 and how much would be adequate?

Response. VBA initially allocated $10 million in overtime funds for the processing of education claims in FY 2013. Through September 7, 2013, $7.2 million has been spent. VBA anticipates reaching $8 million in total expenses for FY 2013. This is lower than our initial allocation due to the efficiencies resulting from the Chapter 33 Long-Term Solution (LTS). We will continue to monitor the performance metrics of education claims and adjust overtime spending in order to maintain the expected levels of performance.

C. How much is requested for overtime for fiscal year 2014 and what amount is expected to be adequate?

Response. With the improved functionality of LTS, VBA anticipates allocating between $5 million and $7 million in overtime for education claims processing. VBA will monitor Education performance metrics and distribute additional overtime funding as needed in order to maintain performance.

Question 79. According to the fiscal year 2014 budget request, the discretionary request for Education programs includes $16.6 million for Other Services. Please provide a detailed itemized list of how those funds would be utilized during fiscal year 2014. To the extent any of the funds will be spent on contracts, please explain the nature of the contract and the expected outcomes.

Response. The $16.6 million request contains funding of $5.4 million for contracts that support Education Service, including:

• Program management and systems engineering support services for the Post-9/11 GI Bill ($4.4 million),
• Development of instructional methodologies and systems the support the training and skills development of the Education workforce ($600,000),
• Publication and distribution of outreach pamphlets and letters to satisfy intent of Public Law 101–237 and Public Law 105–368 ($200,000),
• National Student Clearinghouse Contract for degree attainment data ($100,000), and
• State Approving Agency Contract to support development and implementation of a RAM ($100,000).

The remaining $11.2 million is for administrative and management support costs associated with VBA-internal support agreements, such as Franchise Fund fees for Debt Management Center, Financial Services Center, Computer Data Center Operations services, and for support attained via interagency agreements with the Department of Homeland Security, the Department of the Treasury, and the National Archives and Records Administration.

GENERAL ADMINISTRATION

Office of the Secretary

Question 80. According to the fiscal year 2014 budget request, 88 FTE are requested for the Office of the Secretary, which is 1 less than VA requested for fiscal year 2013 (89 FTE) and 11 less than VA now expects for fiscal year 2013 (99 FTE).

A. Please provide a list of what positions, including pay-grades, would be included in the Office of the Secretary and its subsidiary offices if the fiscal year 2014 budget is approved.

Response.

Grade	#Positions
SES	15
15	14
14	28
13	18
12	4
11	5
9	3

Grade	#Positions
8	2
7	1
6	5

B. Please provide a list of the 10 additional positions that were added in fiscal year 2013.

Response. The positions identified in the 2014 budget reflect the proper staffing to support the VA leadership initiatives that will move the Department forward in achieving the Secretary's stated goals to increase access, eliminate the claims backlog, and end homelessness for Veterans. Staff positions are added/deleted accordingly as emerging requirements develop from administration, Congressional, or other external sources.

Grade	#Positions
15	2
14	3
13	4
4	1

C. If the fiscal year 2014 budget is adopted, what (if any) positions would be eliminated?

Response. No positions would be eliminated.

D. If the fiscal year 2014 budget is adopted, would any employees be transferred from the Office of the Secretary to other positions within VA? If so, please specify.

Response. There would be no requirement to move employees.

Question 81. According to the fiscal year 2014 budget request, the Office of the Secretary now expects to spend $4.3 million on Other Services during fiscal year 2013, which is $4.2 million more than VA originally requested for fiscal year 2013 for Other Services. Please provide an itemized list of how those additional funds ($4.2 million) are expected to be spent.

Response. In FY 2012 the Presidents Management Council approved and launched the Leading Executives Driving Government Excellence (Leading EDGE) program. Ninety-five percent of the $4.2 million reflected in the 2014 budget reflects the estimated cost to run this program. The program is funded through reimbursement funds provided from all Federal agencies including VA and any unused funds are returned to the appropriate organization.

Question 82. The Office of the Secretary requests $3.7 million for Other Services for fiscal year 2014. Please provide an itemized list of how those funds are expected to be expended.

Response. In FY 2012 the Presidents Management Council approved and launched the Leading Executives Driving Government Excellence (Leading EDGE) program. Ninety-five percent of the $4.2 million reflected in the 2014 budget reflects the estimated cost to run this program. The program is funded through reimbursement funds provided from all Federal agencies including VA and any unused funds are returned to the appropriate organization.

Question 83. According to the fiscal year 2014 budget request, the Office of the Secretary now expects to spend $495,000 on travel during fiscal year 2013, which is $216,000 more than VA originally requested for fiscal year 2013. Please provide an itemized list of how those additional funds ($216,000) are expected to be spent. For example, how many additional trips will that funding support and what would be the expected purposes of those additional trips.

Response. Based on past trends the average travel budget for OSVA is approximately $450k; OSVA was approved additional funds through remaining carryover dollars, which allowed them to request a more realistic travel budget sufficient to support Senior Leaders, and related necessary staff, in executing travel that supports initiatives that will move the Department forward in achieving the Secretary's stated goals to increase access, eliminate the claims backlog, and end homelessness for Veterans. The additional funds also support travel to fulfill invitations from Members for constituent activities in their districts.

Question 84. According to the fiscal year 2014 budget request, the Office of the Secretary now expects to spend $265,000 for supplies and materials during fiscal

year 2013, which is $165,000 more than VA originally requested for fiscal year 2013 for that purpose. Please provide an itemized list of how those additional funds ($165,000) are expected to be spent.

Response. Based on past trends the average supplies and materials budget for OSVA is approximately $200k; OSVA was approved additional funds through remaining carryover dollars, which allowed them to request a more realistic budget for supplies and materials including expenditures for increase in administrative requirements that support initiatives that will move the Department forward in achieving the Secretary's stated goals to increase access, eliminate the claims backlog, and end homelessness for Veterans.

Question 85. According to the fiscal year 2014 budget request, the Office of the Secretary now expects to spend $43,000 for printing and reproduction during fiscal year 2013, which is $27,000 more than VA originally requested for fiscal year 2013 for that purpose. Please provide an itemized list of how those additional funds ($27,000) are expected to be spent.

Response. The OSVA mission is support of the Secretary of Veterans Affairs, Deputy Secretary and Chief of Staff the execution of missions, goals, and priorities of the Administration to support our Nation's Veterans. Increase in printing and reproduction costs support strategic messaging initiatives necessary to effectively support initiatives that will move the Department forward in achieving the Secretary's stated goals to increase access, eliminate the claims backlog, and end homelessness for Veterans.

Question 86. The Leading Executives Driving Government Excellence (Leading EDGE) Program is an executive level training and leadership program across the entire Federal Government and, according to the budget request, among one of its activities is "[a]rchiving program benefits to the taxpayer in terms of savings and cost avoidance."

A. For fiscal year 2012, how much savings and cost avoidance did Leading EDGE produce?

B. For fiscal year 2013, how much savings and cost avoidance does Leading EDGE expect to produce?

C. For fiscal year 2014, how much savings and cost avoidance does Leading EDGE expect to produce?

D. For each fiscal year, please describe in detail the savings and cost avoidances Leading EDGE achieved or expects to achieve.

Response for A-D:

The President's Management Council (PMC) initiated *Leading EDGE* (Executives Driving Government Excellence) to: 1) inspire a seamless and powerful senior executive corps with shared governmentwide identity and vision; 2) craft solutions that have impact across agencies; and 3) reignite the highest ideals of public service. To achieve these objectives, *Leading EDGE* employs five integrated learning components: workshops, leadership assessments, government performance projects (GPPs), executive coaching, and a web portal for increased cross-agency networking and problem-solving. In 2012, the program's first year, fifteen Federal Government departments (totaling over 150 individual bureaus) reimbursed Veterans Affairs (VA) to participate in *Leading EDGE*.

Five teams of program participants engaged in the learning component most linked to cost savings and avoidance when they developed solutions to seven significant, cross-government challenges, subsequently reviewed by the Office of Management and Budget and the Office of Performance Management. The following list details the estimated cost savings based on the proposals of the 2012 government performance projects (GPPs):

• Review of Federal shared services procurement data suggests an annual possible savings of $5.5 billion (supported by Industry reports) through centralized acquisition

• Establishment of centralized disability hiring in the Federal Government acts as a catalyst for better return on human capital investment and could yield 0.01 percent in annual employment savings ($30 million)

• Reduction of Federal employee attrition gained through enhanced leadership development efforts across government could reduce annual employment costs by 10 percent ($30 billion)

• Establishing interagency security clearance reciprocity and convenient access to all government buildings in Federal agencies for all employees could yield annual cost savings of $38 million

• Establishment of a Grants Management University could yield $30 million in grant administration savings given the number of Federal employees engaged in grants management

• Establishment and monitoring of *Do Not Pay* performance metrics could substantially reduce the $115 billion in improper payments by the Federal Government

• A "Shared-First" approach to IT shared service delivery could yield annual cost savings of $50 million and represent increased buying power for IT investments

Some of the qualitative benefits represented in these projects, such as expedited procurement processes, improved employee morale, and strengthened senior executive leadership are just as valuable as more easily quantified cost savings. The calendar year 2013 *Leading EDGE* effort began only recently and specific GPPs are as yet undecided, so estimated costs savings and avoidance for the year is not possible at this time.

Question 87. The VA Center for Innovation was established in 2010 to "identif[y], prioritize[], fund[], test[] and evaluate[] the most promising solutions to VA's most important challenges to increase Veteran access to VA services, improve the quality of services delivered, enhance the performance of VA operations, and reduce or control the cost of delivering those services that Veterans, their families, and survivors receive."

A. Please provide the Committee with the number of staff assigned to the Center, the total cost for staff salaries, whether any of the staff is considered to be reimbursable and which office would be reimbursed, and whether any of the staff were reassigned from the Office of Information and Technology.

Response. The VA Center for Innovation (VACI) is a matrixed organization, modeled on private sector best-practices to better ensure VA-wide collaboration and coordinated execution. Not all of the individuals who perform work associated with VA innovations are members of the Office of the Secretary staff. By design, only the Director and the Deputy Director function out of OSVA. Most members of the VACI team work full time on innovations while some contribute in an adjunct status as a collateral duty in addition to the work they perform for other parts of the Department. Ten staff are assigned to the Center, of which four are military Veterans. None are considered reimbursable and one is assigned from the Office of Information and Technology. The total cost for staff salaries is $742,774.

B. Please provide the Committee with the amount of funding available for grants through Industry Competitions, Employee Competitions, Special Projects, and Prize Contests.

Response. The VA Center for Innovation (VACI) uses contracts as opposed to grants to implement its work with private sector entities involved in the implementation of innovations. To further reduce risk to the government, VACI general requires use of firm fixed price contracts. For prize challenges, VACI uses cash prizes as authorized by the America COMPETES Act of 2010.

Over 95% of the VACI annual budget is used for direct funding of innovations that increase access to healthcare and other services, reduce or control the cost of delivering those services, improve quality at VA, and enhance the Veteran experience with the services they receive from VA. VACI uses, among other things, the Industry Innovation Competition, Employee Innovation Competition, Special Projects, and Prize Contests to achieve this. To be responsive to Veteran needs across the VHA and VBA mission areas, VACI funding is contained in three appropriations. Annually, as much as $35 million in Medical Services, $11 million in IT, and $15 million in VBA General Operating Expenses (GOE) is budgeted to fund innovations through VACI. The amounts available in a given Fiscal Year for contracts through the Industry Innovation Competition, Employee Innovation Competition, or Special Projects varies depending on the specific focus areas for that operating year.

C. How many proposals have been selected for implementation through the VA Center for Innovation and the VA Innovation Initiative? Of these proposals, how many have been fully implemented on a national scale?

Response. Since its inception in mid-2010, the VA Center for Innovation (VACI) has selected and implemented 149 innovations. The Industry Innovation Competitions and Employee Innovation Competitions generate the vast majority of the selected innovations. Special Projects tend to target emergent opportunities and/or innovations that have a longer lifecycle than the typical 24-month period.

VACI functions as a supplier of novel and innovative capabilities to the Department, principally VHA and VBA. VHA and VBA are responsible for selection and funding of completed innovation projects for implementation and deployment across their respective domains. The pace and extent of deployment depends on the availability of resources, project scope, and overall innovation maturity.

Innovation projects execute over a period of performance of 12 to 24 months following the selection, pilot design, and contracting processes. A substantial part of the VACI portfolio is in either the period of performance phase or the design and contracting phase. As these projects mature over the coming months and years, they

move into the evaluation phase. Successful innovations compete for VHA and VBA resources required for adoption and wider implementation.

20 innovation projects have already been or are being adopted by VHA and VBA or are operating independently of VA in service to the Department's mission. These completed innovations include 7 industry innovations, 8 employee innovations and 5 innovations from the prize competitions and special projects categories.

The seven Industry Innovations adopted include a number of new Blue Button services that allow Veterans across the Nation to freely access their medical records in a format that is portable across health providers, projects that use technology to improve TBI care and mental health screening, and a cardiology mobile application that allows physicians to receive medical images on mobile devices for faster and better care for Veteran heart patients.

Among the several successful Employee Innovations, eight projects have been selected for full implementation. These projects cover a wide range of clinical practices, such as radiology, patient safety, and novel approaches to caring for brain injuries and brain diseases affecting Veterans.

The Special Project and prize competition category generated the first open source software community to lower costs and increase innovation rates for VA's electronic health record, the first automated claims processing prototype, a mobile application to connect any local services that can help Veterans in need, and a new way for Veterans to have their military service experience count for private sector employment.

Board of Veterans' Appeals

Question 88. The fiscal year 2014 budget request includes $75 million for the Board of Veterans' Appeals (Board).

A. With that funding and funding provided in Public Law 113–6, what FTE level is expected during fiscal year 2013 and 2014?

Response. With the additional $8 million in funding provided, the Board of Veterans' Appeals (BVA or Board) will be able to sustain 538 full-time equivalents (FTE) in fiscal year (FY) 2013 and 613 FTE in FY 2014.

B. Please provide a breakdown of the positions that would be filled in fiscal year 2014 and the number of staff for each type of position.

Response. All 100 positions hired in FY 2013 & FY 2014 with the additional $8 million in funding will be staff attorneys.

C. With that funding and the funding provided in Public Law 113–6, what performance outcomes does the Board expect to achieve during fiscal years 2013 and 2014?

Response. BVA has initiated an aggressive hiring plan to execute the $8 million in additional funding in FY 2013. In parallel to this aggressive hiring plan, BVA has developed and implemented a robust new training program that is designed to handle the high volume of incoming staff to maximize efficiencies at the earliest point. All new FTE will undergo this training. BVA expects production gains based on these efforts to be realized beginning in FY 2014. There is direct correlation between the number of FTE and the number of decisions produced; looking at recent years, each FTE produces up to 90 decisions per year.

D. Of that funding, how much will be used to pay for union representation/union time?

Response. The Board pays for union representation/union time in two ways:

(1) costs (salary and benefits) of union representatives; and
(2) costs (salary and benefits) of BVA's managers who work on labor relations matters, labor relations counsel, and other labor relations support staff.

In total, the Board expects to pay approximately $2,011,926 for labor relations matters per annum.

Question 89. According to the fiscal year 2014 budget request, the Board now expects to spend $2.3 million on Other Services during fiscal year 2013, which is $253,000 higher than the amount requested for fiscal year 2013, and the Board is requesting $2.3 million for Other Services for fiscal year 2014.

A. Please provide an itemized list of how these funds are expected to be spent during fiscal year 2013.

Response. The $2,253,000 for "Other Services" in FY 2013 will be allocated as follows:

All Shred Document Shredding Contract for disposition of sensitive records	$20,000.00
Lean Six Sigma Study of the Board's Operations for identification of possible efficiencies in processes	344,000.00

West Group Contract—On-line Access to the Westlaw Legal Database for legal research by the Board's Veterans Law Judge and attorney staff	290,000.00
Transit Benefits	555,000.00
United Parcel Services (UPS) Appellant Records Shipment Contract	70,000.00
Transcription Service (2 Vendors)	663,000.00
Board's Share of VACO's Human Capital Investment Plan (HCIP) Training Support	130,000.00
Financial Service Center (FSC)	123,000.00
Defense Finance and Accounting Services (DFAS)	50,000.00
Security Investigation Service	8,000.00
Total Other Services	$2,253,000.00

B. Please provide an itemized list of how these funds are expected to be spent during fiscal year 2014.

Response. The $2,333,000 for "Other Services" in FY 2014 will be allocated as follows:

All Shred Document Shredding Contract for disposition of sensitive records	$20,800.00
Public Key Infrastructure (PKI) Electronic Research Materials Service and Maintenance Contract	386,000.00
West Group Contract—On-line Access to the Westlaw Legal Database for legal research by the Board's Veterans Law Judge and attorney staff	298,000.00
Transit Benefits	558,200.00
United Parcel Services (UPS) Appellant Records Shipment Contract	80,000.00
Transcription Service (2 Vendors)	670,000.00
Board's Share of VACO's Human Capital Investment Plan (HCIP) Training Support	131,000.00
Financial Service Center (FSC)	125,000.00
DFAS	51,000.00
Security Investigation Service	13,000.00
Total Other Services	$2,333,000.00

Office of General Counsel

Question 90. According to the fiscal year 2014 budget request, VA is seeking total resources of $101 million for the Office of General Counsel and 701 FTE.

A. Please provide a list of the positions that would be filled in fiscal year 2014 with that level of funding and the number of staff for each position.

Response.

Supervisory Attorney	78.0
General Attorney	400.8
Paralegal Specialist	86.1
Legal Assistant	52.1
Other	84.0
Total	701.0

B. For each regional counsel office, please identify the number and type of staff that would be located at the office during fiscal year 2014.

Response:

Region 1

Supervisory Attorney	2
General Attorney	14.3
Paralegal Specialist	1
Legal Assistant	3
Office Automation Clerk	0.5
Total	20.8

Region 2

Supervisory Attorney	2
General Attorney	12.5
Paralegal Specialist	1.8
Legal Assistant	1
Total	17.3

Region 3

Supervisory Attorney	2
General Attorney	8
Paralegal Specialist	3
Program Analyst	1
Total	14

Region 4

Supervisory Attorney	2
General Attorney	9
Paralegal Specialist	4
Administrative Officer	1
Total	16

Region 5

Supervisory Attorney	2
General Attorney	8.4
Paralegal Specialist	2
Legal Assistant	4
Total	16.4

Region 6
Supervisory Attorney	2
General Attorney	15.63
Paralegal Specialist	9
Legal Assistant	3
Total	29.63

Region 7
Supervisory Attorney	2
General Attorney	11
Paralegal Assistant	3
Legal Assistant	3
Program Assistant	1
Administrative Officer	1
Total	21

Region 8
Supervisory Attorney	2
General Attorney	8
Paralegal Specialist	6
Legal Assistant	0
Total	16

Region 9
Supervisory Attorney	2
General Attorney	8
Paralegal Specialist	2
Legal Assistant	2
Total	14

Region 10
Supervisory Attorney	2
General Attorney	12
Paralegal Specialist	2
Legal Assistant	3
Total	19

Region 11
Supervisory Attorney	2
General Attorney	8.5
Paralegal Specialist	3
Total	13.5

Region 12
Supervisory Attorney	2
General Attorney	10
Paralegal Specialist	7
Legal Assistant	2
Total	21

Region 13
Supervisory Attorney	2
General Attorney	10
Paralegal Specialist	4.8
Legal Assistant	5
Total	21.8

Region 14
    Supervisory Attorney 2
    General Attorney 13
    Paralegal Specialist 5
    Legal Assistant 3

        Total 23

Region 15
    Supervisory Attorney 2
    General Attorney 6.75
    Paralegal Specialist 1
    Administrative Officer 1

        Total 10.75

Region 16
    Supervisory Attorney 2
    General Attorney 8
    Paralegal Specialist 2
    Legal Assistant 1

        Total 13

Region 18
    Supervisory Attorney 4
    General Attorney 21.483
    Paralegal Specialist 8
    Legal Assistant 1.6875
    Secretary 2

        Total 37.17

Region 19
    Supervisory Attorney 2
    General Attorney 9
    Paralegal Specialist 2
    Legal Assistant 1

        Total 14

Region 20
    Supervisory Attorney 2
    General Attorney 10.58
    Paralegal Specialist 2.8
    Legal Assistant 2

        Total 17.38

Region 21
    Supervisory Attorney 2
    General Attorney 8
    Paralegal Specialist 4
    Legal Assistant 0.8

        Total 14.8

Region 22
    Supervisory Attorney 2
    General Attorney 6
    Paralegal Specialist 1
    Legal Assistant 2

        Total 11

Region 23

Supervisory Attorney	2
General Attorney	8
Paralegal Specialist	4
Legal Assistant	3
Total	17

Grand Total

Supervisory Attorney	46.00
General Attorney	226.14
Paralegal Specialist	78.40
Legal Assistant	40.49
Administrative Officer	3
Secretary	2
Program Analyst	1
Program Assistant	1
Office Automation Clerk	0.5
Grand Total	398.53

C. If the fiscal year 2014 budget request is adopted, what would be the expected total budget for each regional counsel office?

Response.

Grand Total Regions	398.53	$54,386,322
Front Office—VACO 101	5	$883,170
Regs Office—VACO 101	9	1,267,152
PSG I—VACO 101	19.41	3,068,983
PSG II—VACO 101	20	2,836,576
PSG III—VACO 101	23	3,778,669
PSG IV—VACO 101	19.75	3,057,628
PSG V—VACO 101	63.8	8,843,661
PSG VI—VACO 101	41	6,891,740
PSG VII—VACO 101	101.5	14,486,378
Grand Total VACO	302.46	$45,113,957
Funded Where Needed	....	$1,484,721
Grand Total OGC	701.0	$100,985,000

Question 91. According to the fiscal year 2014 budget request, VA's Office of General Counsel now expects to spend $1.3 million on Other Services during fiscal year 2013, which is $169,000 higher than the amount requested for fiscal year 2013 ($1.1 million). According to the budget request, that amount changed "due to the transfer of all [human resources (HR)] functions from the regions into VACO."

A. Please provide an itemized list of how these funds are expected to be spent during fiscal year 2013.

Response. Refer to charts below.

Notes:

(1) Budget Object Classification (BOC) codes describe the "nature" of the service or article for which obligations are first incurred.

(2) In executing the fiscal year (FY) 2013 budget, the Office of General Counsel (OGC) now plans to spend $1.6 million on Other Services. Due to an unanticipated increase in the number of retirements among its leadership, OGC has incurred more household goods storage costs and relocation expenses associated with hiring replacements for the retired personnel. OGC offset the increased spending from its planned expenditures on equipment.

OTHER SERVICES	BOC	2013 Budget
Repair of Furniture & Equip.	2520	$ 34
Contracts/Personal Services	2580,2581	$ 732
Contracts/Tuition	2583,2584	$ 344
All Other	25XX	$ 501
Subtotal Other Services		**$ 1,611**

BOC 2520		
Repair of Furniture & Equip.	2520	$ 34,000

BOC 2580/81

	Classification	2013 Budget
Contracts—VACO—employee recognition, framing, moving furniture, court reporters, transcription	2580	$52,555
Contracts—Regions—Notaries, Shredding	2580	8,702
Human Capital Investment Plan (HCIP)	2580	178,000
Security & Investigation (S&I)	2580	11,615
Office of Resolution Management (ORM)	2580	108,000
Financial Service Center (FSC)	2580	177,654
Record Center & Vault (RC&V)	2580	1,811
Child Care Subsidy	2580	—
Defense Finance and Accounting Service (DFAS)	2580	69,264
Financial Disclosure Management System (ARMY)	2580	10,000
PIV Card	2580	12,960
OA&L Contract Support	2580	57,054
eOPF Contract	2580	22,631
USA Staffing Contract	2580	17,534
USA Jobs Contract	2580	4,344
Total	2580	$732,124

BOC 2583/4		
Training	2583&84	$ 343,555

BOC 25XX		
Storage of Household Goods	2530	$ 81,575
Relocation Service	2531	401,247
Security Winston-Salem - Region 23	2528	4,495
Security Roanoke - Region 23	2528	5,603
Security Nashville - Region 8	2528	4,144
Security Huntington - Region 7	2528	1,500
Security Columbus - Region 7	2528	2,756
Total	25XX	**$ 501,320**

Grand Total		$ 1,610,999

B. Please explain what impact this transfer of H.R. functions had on the budget for each region.

Response. The transfer of H.R. functions to Central Office did not impact the budgets of OGC's regions, in past years; the VA facility providing local fiscal support for each of the 22 regions would process our payroll and pay the associated fees. After the transfer, OGC must now pay all associated payroll processing fees for its personnel, wherever located. As a result, our Service Level Agreement with VA's Fi-

nancial Service Center (FSC) increased from $35K to $178K. FSC charges OGC for common and administrative services included in payroll processing, financial reporting and accounting services, Permanent Change of Station travel, processing W–2's, and helpdesk support.

Question 92. The Office of General Counsel is requesting $1.2 million for Other Services for fiscal year 2014. Please provide an itemized list of how these funds would be spent during fiscal year 2014.

Response. See Chart below.

OTHER SERVICES	BOC	2014 Budget
Repair of Furniture & Equip.	2520	$57
Contracts/Personal Services	2580, 2581	$619
Contracts/Tuition	2583, 2584	$313
All Other	25XX	$169
Subtotal Other Services		**$1,157**
	BOC 2520	
Repair of Furniture & Equip.	2520	$57,000
	BOC 2580/81	
Contracts - VACO - employee recognition, framing, moving furniture, court reporters, transcription	2580	$30,411
Contracts - Regions - Notaries, Shredding	2580	$4,500
Human Capital Investment Plan (HCIP)	2580	$167,000
Security and Investigation (S&I)	2580	$12,076
Office of Resolution Management (ORM)	2580	$72,000
Financial Service Center (FSC)	2580	$177,654
Record Center and Vault (RC&V)	2580	$1,503
Child Care Subsidy	2580	--
Defense Financing and Accounting Service (DFAS)	2580	$70,550
Financial Disclosure Management System (ARMY)	2580	$10,000
PIV Cards	2580	$12,960
OA&L Contract Support	2580	$60,000
Total	2580	$618,654
	BOC 2583/4	
Training	2583&84	$313,200
	BOC 25XX	
Storage of Household Goods	2530	$30,000
Relocation Service	2531	$120,000
Security Winstom-Salem -Region 23	2528	$4,495
Security Roanoke -Region 23	2528	$5,603
Security Nashville -Region 8	2528	$4,351
Security Huntington -Region 7	2528	$2,160
Security Columbus -Region 7	2528	$2,000
Total	25XX	$168,609
		Grand Total $1,157,463

Question 93. In response to questions about the fiscal year 2013 budget request, VA indicated that the Office of General Counsel planned to spend $14,000 in 2012

on a "Tort training video." What was the purpose of this video and how has it been utilized?

Response. The actual cost of producing this video training module was $1,478.90, which represented the cost of transporting a VA Office of Information Technology (OIT) employee and his video equipment to a Federal building in St. Louis at which OGC personnel were conducting previously-scheduled face-to-face training on administrative tort claim adjudication procedures. Editing and polishing the raw digital recordings in-house saved the Department over $12,000 in professional services and travel. The purpose of taping that session was to provide a Web-based, on-demand, re-usable training resource for OGC personnel regarding the processes and procedures to be followed in investigating and adjudicating administrative tort claims filed against the VA pursuant to the Federal Tort Claims Act (FTCA). The overall goal of creating this Web-based training was to improve the quality and consistency of legal service relating to torts across all of OGC's regions, thereby improving service to Veterans who avail themselves of the administrative tort adjudication process afforded by the FTCA. The project has not yet launched, as the editing work must be done as collateral duty and as other duties allow. OGC anticipates taking the training live in August 2013, at which point the training will be viewed by the approximately 150 OGC employees who are engaged in torts practice. VA anticipates cost savings will be realized by eliminating travel and other costs associated with bringing those employees together to receive this training.

Question 94. Within the Office of General Counsel, Professional Staff Group VII represents VA before the U.S. Court of Appeals for Veterans Claims.

A. Currently, how many employees are assigned to Professional Staff Group VII and what is the average number of active cases per attorney?

Response. Professional Staff Group (PSG) VII has 101.5 FTE onboard and 43 active cases per attorney, on average. An "active case" is one in which the Secretary has yet to file his dispositive pleading.

B. For fiscal year 2014, what level of funding is requested to support Professional Staff Group VII and how many employees would that level of funding support?

Response.

	FTE	Funding
PSG VII	101.5	$14,487,244

C. Please provide a list of the positions that would be filled with that level of funding.

Response.

Supervisory Attorney	11.0
General Attorney	57.0
Paralegal Specialist	4.5
Legal Assistant	14.0
Clerks	11.0
Management Analyst	1.0
Supervisory Program Specialist	1.0
Support Services Specialist	1.0
Supervisory Program Analyst	1.0
Total	101.5

D. With the requested funding level, what would be the expected average number of active cases per attorney during fiscal year 2014?

Response. The average number of active cases per attorney will be maintained in the range between 45 and 50.

E. How many motions for extension of time did Professional Group VII file during fiscal year 2012?

Response. PSG VII filed a total of 2,129 extension motions in FY 2012.

F. How many motions for extension of time has Professional Staff Group VII filed to date during fiscal year 2013?

Response. During the period between October 1, 2012, and April 30, 2013, PSG VII filed approximately 1,053 extension motions.

Question 95. In response to questions about the fiscal year 2013 budget request, VA indicated that the Regulation Rewrite Project "is not expected to require additional resources, but the implementation of these rules will require more resources over time" for items such as "training program revisions, manuals and forms updating, skills certification materials, and [information technology] projects." VA also indicated that "[i]mplementation budget planning will occur in 2013."

A. Has VA developed a comprehensive implementation plan for these regulations? If so, please provide a copy of that plan to the Committee.

Response. VA's implementation planning for the Regulation Rewrite Project has been deferred in order to avoid conflicts with VA's highest priority effort to eliminate the claims backlog by 2015. The timing for publishing a final rule and the manner of implementation will be determined by the Secretary at a future date depending upon the progress being made on the claims backlog. In the meantime, VA is preparing to publish the comprehensive 21st proposed rule responding to comments from the public and Veterans Service Organizations submitted for the previous 20 proposed rules. This consolidated proposed rule encompasses all of the previous proposed rules and is expected to be published in 2013.

B. Please provide the Committee with an updated timeline for completion of this project.

Response. The Rewrite Project's staff currently expects to seek a determination on implementation by the end of 2014 in order to afford the Veterans Benefits Administration time for the necessary advance implementation coordination and budget planning. This expectation could be delayed, however, depending upon the status of VA's claims backlog. VA's goal is to implement the Regulation Rewrite Project so that it does not conflict with VA's claims transformation initiatives or impede VA's progress in eliminating the claims backlog.

Office of Management

Question 96. According to the fiscal year 2014 budget request, the Office of Management plans to spend $53 million on Other Services during fiscal year 2013, which is $16.3 million more than VA had requested for that purpose for fiscal year 2013. Please provide an itemized list of how those funds would be expended during fiscal year 2013 and identify expenditures that were not anticipated in the fiscal year 2013 budget request.

Response. The majority of the $16.3 million increase in obligations is due to higher-than-expected requirements for the Defense Finance and Accounting Service (DFAS) payroll processing services, which are funded through reimbursements and Department-level initiatives funded from FY 2012 carryover. The following are details of how the funds will be expended.

• $5 million to DFAS for VA payroll processing. The Office of Management pays for this Departmental cost and is reimbursed from other VA programs that pay for their share of the costs.

• $3 million to fund activities for VA's Financial Statement Audit, which includes audit remediation, policy updates support, and vendor follow-up.

• $1.2 million to address Improper Payments Elimination Recovery Act requirements.

• $1 million to conduct Office of Management and Budget (OMB) Circular A–123 reviews under the Office of Business Oversight.

• $400 thousand to support the VA Center of Innovation.

VA expects to obligate other contracts this fiscal year including:

• $2 million for enhanced data analysis capability to support better decision-making.

• $1.2 million for budgetary analytical support and development of an automation module to provide real-time budget data to improve the budget process and strengthen the quality of analysis.

In addition, $2.5 million in Department-level carryover has been re-allocated within General Administration for additional outreach to increase Veterans' access to VA benefits and services.

Question 97. According to the fiscal year 2014 budget request, the Office of Management requests $38 million for Other Services for fiscal year 2014. Please provide an itemized list of how those funds would be used.

Response. The $38 million in "Other Services" includes:

• $30 million for DFAS support to the Department.

• $4 million for reviewing and testing internal controls over financial reporting, as required by Appendix A of OMB Circular A–123.

- $1 million for service level agreements for the Financial Services Center, Security Investigations Center, and other service and maintenance agreements to conduct regular operations.
- $700 thousand for the Enterprise Risk Management program.
- $400 thousand for VA Center for Innovation programs.
- $350 thousand for training provided through the VA Learning University and the Human Capital Investment Plan.
- The balance of the costs within Office of Management's 'Other Services' are for Office of Personnel Management fees related to USAJobs, USA Staffing, e-Classification, and e-OPF support.

Question 98. According to the fiscal year 2014 budget request, the Office of Finance within the Office of Management manages the Debt Management Center.

A. For fiscal year 2014, what level of resources is expected to be used to operate the Debt Management Center and what level of staffing would those resources support?

Response. The VA Debt Management Center (DMC) is an enterprise center under the VA Franchise Fund, providing common administrative support services to VA and other government agencies on a fee-for-service basis and receives no direct appropriated funding. Projected revenues in FY 2014 will support $20,943,647 in expenditures and a staffing level of 189 FTE.

B. How many telephone lines does the Debt Management Center currently operate and how many would be operated during fiscal year 2014?

Response. The DMC currently has 144 telephone lines (toll-free). In 2014, VA plans to continue to have 144 lines available unless Veterans' demands increase.

C. During fiscal year 2012, how many debts were referred to the Debt Management Center, what was the total value of those debts, and how much did the Debt Management Center recoup?

Response. During FY 2012, 667,524 debts valued at $1.3 billion were referred to the DMC. During the fiscal year, the DMC collected $1.1 billion.

D. How many new debts are expected to be referred to the Debt Management Center during fiscal year 2013 and 2014?

Response. During FY 2013, VA expects referral of approximately 795,000 new debts, and during FY 2014, VA projects referral of approximately 875,000 new debts.

Question 99. According to the budget request for fiscal year 2014, the Office of Management is expected to spend $44.1 million and would have a staffing level of 262 FTE, if this budget were adopted. This would be a $4 million, or 8 percent, decline in budget authority; however, the staffing level is expected to increase by 7 percent.

A. If the Office of Management's budget is set to decrease by 8 percent, what accounts for a 7 percent increase in FTE?

Response. The Office of Management is not requesting additional staff in FY 2014. The office is hiring additional personnel during the latter part of 2013, and these new hires will only account as partial FTE for this year. In FY 2014, these partial FTE will be annualized (i.e., a staff hired in June counts as one-fourth of an FTE in FY 2013 but a full FTE in FY 2014). Due to the late hiring in FY 2013, the FTE will be lower but the on-board staffing level at year-end will be similar to the FY 2014 FTE request level.

B. If the increase in staff is a result of reimbursable or detailed FTE, please describe the work performed by those FTE for the Office of Management and the office from which they are reimbursed or detailed.

Response. The increase in staff is not related to reimbursable or detailed FTE and is explained in the response to 99A.

Office of Human Resources and Administration

Question 100. In response to questions regarding the fiscal year 2013 budget request, VA indicated that it planned to spend $242.3 million on contract costs for "Training and Transformation Initiatives." Please provide an itemized list of the specific activities this funding has supported or will support, the amount expected to be spent on each activity, and the expected outcomes.

Response. The initiatives included in the Human Capital Investment Plan (HCIP), are expected to have immediate, tangible, and measurable impact on the services provided to Veterans. HCIP expected outcomes are programs that increase staff productivity and allow VA to more quickly address the needs of Veterans. Training provided improves competencies in the areas of human resources, financial management, project management, acquisition and information technology (IT) certification enabling VA employees to provide an improved level of service to Veterans. Programs developed and administered by the Veterans Employment Services Office,

which includes the VA for VETS program, created to facilitate the reintegration, retention and hiring of Veteran employees at VA: http://vaforvets.va.gov/Pages/default.aspx, provide the means for Veterans to translate the skills acquired in military service to marketable skills for civilian employment.

The revised cost estimate for FY 2013 is $217 million, which includes support and administrative fees. The reduction is primarily due to the realigning of contracts' periods of performance. Below is a list of the initiatives supported in FY 2013.

VA LEARNING UNIVERSITY—VALU

Transformational Leadership
Support the VA's transformation into a leading 21st century organization by training managers, supervisors, and executives while providing tools to better serve veterans and their dependents.

Supervisory and Management Training
Design and deliver supervisor and management training, including the Leadership Development Programs, leadership portal, and the training delivery of commercial-off-the-shelf content.

Training Evaluation
Provide independent evaluation and quality assurance of the ADVANCE training Initiatives delivered by VALU training partners. Develop and deploy formative and summative evaluations to assess the learners during, at close, and post-training. Evaluate program and training effectiveness.

Program-Based Training/Career Technical Training
Provide training for cross cutting-career fields, in particular those that impact all of the Department's administrations and multiple staff offices. The goals are to ensure training is: (1) competency based, (2) consistent in learning events and products offered across the Department, and (3) uses formative and summative evaluation in development, assessment of learners during, at the close, and post training.

Leadership Competency Assessment and Certification
Develop a competency-based leadership assessment and certification program. Establish a leadership certification which enables VA to send a clear message about the importance of leadership as a recognized professional discipline equal to the status of a technical discipline.

VA Career Mapping
The FY 2013 purpose of this project is to continue to expand the design, development, and implementation of an innovative Career Mapping and Development Program. The goal is to ensure that VA employees have access to the functional training, experience, and education necessary to enhance their job performance, career progression, and development as multifunctional leaders.

Leadership Infusion
The FY 2013 purpose of this project is to continue to provide an OPM catalogue of training courses.

e-Content
This Initiative provides support and required licenses for educational content for VA employees. The licenses allow access to online materials, books, and training on a wide variety of subjects at a very low cost per person. Support services include: importing the content into the VA Talent Management System, assigning VA defined core competencies to the courses, and creating and revising course catalog documents.

Talent Management System (TMS) Upgrade Training
Provides training on the infrastructure system that is at the core of education, training and learning at the VA. The capabilities of the VALU TMS support significant portions of the Initiatives enacted by VA, but the VALU TMS is a tool that requires care and management itself. This Initiative ensures VA has the resources necessary to support the tools that the Department relies upon for meeting its mission.

Talent Management Support
This Initiative provides resources to manage the TMS system and to support all aspects of the Directorate's business responsibilities.

VA Acquisition Academy
   The VA Acquisition Academy (VAAA) was created to address the growing challenge facing the Department of Veterans Affairs and the Federal Government overall. This challenge is largely faced by the acquisition workforce, which has been strained to keep pace with the increased amount of and complexities associated with contracted work in support of the VA mission.

NATIONAL CENTER FOR ORGANIZATION DEVELOPMENT

Evaluation Services
   This Initiative funds an Intra-Agency Agreement (IAA) to extend a partnership between Office of Human Resources & Administration (OHRA) and National Center for Organization Development (NCOD), part of Veterans Health Administration (VHA), in order to complete projects that achieve goals for HRA and NCOD related to VA's organizational health and transformation and most efficient use of VA resources.

Staff Office Memoranda Of Understanding
   This Initiative provides funding to execute training events for the VA staff offices in order to achieve transformational impact, increase effectiveness, supports mission, and has investment justification.

OFFICE OF HUMAN RESOURCES MANAGEMENT—OHRM

HR Academy
   HR Academy supports the professional growth of VA H.R. professionals nationwide by closing the competency gaps.

Central Office Human Resources Services (COHRS)
   This Initiative provides professional services including: business process maps, workload tracking tool, staffing resources, and an on-boarding program designed to improve H.R. services enabling the COHRS to reduce hiring time.

Workforce Planning
   This Initiative develops and implements a corporate Workforce Planning (WFP) capability and forms strategic partnerships with Program Offices and Administrations enabling VA to identify and address department-wide WFP needs, make data-driven decisions, and capitalize on leading practices.

Knowledge Management
   This initiative helps transform organizations into a learning organization through a knowledge management culture by empowering employees to innovate and collaborate with peers.

Health and Wellness
   This Initiative develops, implements, and manages a health and wellness program resulting in a healthier, more productive, and motivated workforce.

HR Professional Services
   This Initiative provides H.R. and Project Management services using a variety of models and solutions to standardize position descriptions; improve training, and H.R. customer service, and increase efficiencies in H.R. processes across the VA.

Reclassification
   This project provides HRA with a customized positions classification system through Monster Government Solutions. The system includes planning, coordination, implementation, training and communication.

HR Line of Business (LOB)
   HR LOB enables efficient Human Resource Service delivery by providing personnel information management systems that meet Office of Personnel Management data requirements.

VETERANS EMPLOYMENT SERVICE OFFICE—VESO

Case Management System (CMS)/ Coaching
   Provides support to VESO thru Case Management System and development, providing the VA for Vets Help Desk, training Veterans and providing coaching call center. VESO's goals are to: increase percentage of Veterans hired within VA, the Federal Government, and non-profit sectors; reduce voluntary Veteran turnover VA-wide; and, implement a supportive reintegration infrastructure.

STRATEGIC MANAGEMENT GROUP (SMG)

Oversight and Program Management
This Initiative provides Program Management support to SMG within HRA with oversight and integrated management of HCIP portfolio processes.

Contract Assistance
This Initiative provides acquisition support to HCIP Program Offices within HRA to develop high-quality requirements packages.

HRA Strategic Support
This Initiative provides expert, strategic planning, program management, organizational transformation and communications support to HRA, its supporting programs and initiatives. Support includes planning and investment support designed to help HRA determine its strategic priorities.

OFFICE OF ADMINISTRATION—OA

Workers' Compensation Interdisciplinary FTE Support, Training and Occupational Safety and Health Conference
Provide training services and logistical support to improve the management of VA's Federal Workers' Compensation (WC) and Occupational Safety and Health (OSH) Programs. This ongoing effort aims to train more than 196 VA employees in the fundamentals of the WC interdisciplinary functions and OSH program management and helps drive cost avoidance.

Centralized Workers' Compensation (WC) Processing
This initiative is a resource to support VA field locations reviewing WC cases. VA is seeking to continue contractor support providing WC case management services.

All Employee Safety Perception Survey
The VA contracted with the National Safety Council (NSC) to conduct an all-employee Safety Perception Survey. In FY 2013, NSC's subject-matter experts provide training to improve lower scoring safety program management categories identified in the FY 2012 survey.

Medical Case Review
This Initiative request funds for a Veterans Health Administration (VHA) employee physician to review Workers Compensation (WC) cases. The pilot of the Medical Case Review program has demonstrated the potential to save costs related to WC cases, primarily related to questionable treatment and diagnoses.

Agency Medical Exams
This Initiative is to establish a centralized fund to be used by VA facilities nationwide for medical examinations to reduce unnecessary costs related to worker's compensation, as well as enhancing the management of those cases.

Administrative Investigations
This Initiative establishes a central fund for field facilities to draw and issue small non-personal service contracts in accordance with micro-purchasing procedures to perform Administrative Investigations. Cases would be evaluated against a set of criteria to ensure that only the most deserving cases are included in this initiative.

Warehouse Operations Support
The Office of Administration (OA) ensures that VA facility (office space), computer (laptop/workstation) and access costs (badges, access cards, etc.) are identified if the "contract employee" requires them to perform their work assignments.

Workspace Modifications
A fund assisting organizations to redesign office space into smaller workstations, fewer offices, utilizing collaborative and touchdown spaces.

Employee Accountability/Emergency Preparedness (Personnel Accountability System (VA-PAS) Project)
The purpose of the VA-PAS is to identify the location of VA employees and contractors. An interagency agreement with Space and Naval Warfare Systems Center, Pacific delivers a VA enterprise-wide Capability to identify personnel during an emergency and determine whether employees are safe, willing, and able to work through a Personnel Assessment and Accountability System (PAAS) and a VA Notification System (VANS).

CORPORATE SENIOR EXECUTIVE MANAGEMENT OFFICE—CSEMO

Executive Coaching
Provides a one-on-one way to assist executives during their on-boarding experience to help identify and set clear goals, ways, and methods to make their transition process efficient and effective. Executive coaching supports the executive by offering personalized leadership development experience where coach, leader and key stakeholders collaborate over time to accelerate the executive's development, achieving results that positively impact his/her organization and ultimately Veterans.

SES Collaborative Website
Continue development to content enhancement, implementation, and sustainment for CSEMO Connect, the collaborative Web site for senior executives across VA.

Senior Executive Talent Management System (TMS)
Senior Executive TMS is an automated system to recruit, develop, deploy, and support executives across the Department to achieve VA's missions and support its transformational initiatives. The system contributes to analysis and improvement of VA's executive life cycle management.

Executive On-boarding Tool
Establish an automated tool for all aspects of the executive on-boarding experience. CSEMO will be able to streamline processes, capitalize upon efficiencies in the process, and develop metrics and reporting capabilities by automating certain aspects of the on-boarding process through the use of a web-based automated system with dashboards.

Corporate Performance Management Training System
Ensure the entire Senior Executive workforce receives annual performance management training as required by Office of Personnel Management (OPM). Works with VA's automated Performance Management System tool to (1) ensure the content is accurate and updated in a timely fashion, and (2) ensure newly appointed executives are trained on the use of the automated tool.

Business Process/Systems Architect
Develop, deliver, manage and maintain CSEMO's Human Resources (HR) information systems.

ASSISTANT SECRETARY FOR HRA—(AS)

Leading EDGE (Executives Driving Government Excellence)
An executive-level training program that: (1) inspires a seamless and powerful senior executive corps with shared governmentwide identity and vision; (2) crafts solutions that have impact across agencies; and (3) reignites the highest ideals of public service. In 2012, 15 Federal departments participated in the program.

LABOR MANAGEMENT RELATIONS—LMR

Labor Management Relations (LMR) Training
This initiative supports all five Unions with Master Agreement Training. The FY 2013 effort supports the unions with training products and training facilitation.

OFFICE OF DIVERSITY AND INCLUSION—ODI

National Diversity Internship Program
Provide a centralized fund providing VA offices with the ability to pay the salary of summer interns.

Reasonable Accommodations Centralized Fund
Provide a centralized fund to reimburse VA offices required to provide reasonable accommodations (RA) for VA employees, such as those needing accommodations for disabilities. The secondary objective is to track the receipt and processing of the RA requests.

Diversity and Inclusion Training
Develop and provide comprehensive, continuing, coordinated diversity and inclusion training to all VA SES, Title 38 Equivalents, managers and supervisors at the GS–13 level and above.

Workforce Recruitment Program
Provide a centralized fund supporting VA offices with the resources to pay the salary of interns that may be converted to full-time VA employees.

OFFICE OF RESOLUTION MANAGEMENT—ORM

Conflict Management Training

Provide the VA with conflict management training for VA leadership, management and labor in an effort to reduce and resolve workplace conflict.

Question 101. For fiscal year 2014, the Office of Human Resources and Administration is requesting $305 million for Other Services. Please provide a detailed itemized list of how those funds are expected to be spent, including any specific initiatives these funds would support. To the extent any of the funds will be spent on contracts, please explain the nature of the contract and the expected outcomes.

Response. In addition to the ongoing initiatives provided through the Human Capital Investment Plan (HCIP), (initiatives listed in question 100), HRA requested funding in other services for Office of Resolution Management (ORM), Office of Administration, and Office of Human Resources Management (OHRM). The current estimate for FY 2014 has been reduced from the projected $305 to $236 million.

HCIP is part of the Departmental effort to transform the VA workforce to better serve Veterans in the 21st century. Contracts are awarded to provide training in the areas of executive and leadership training, program and project management, human resources reform, IT certification and financial management. HCIP has been evaluated using industry standards for best practices by an external auditing firm (Deloitte) and VA's National Center for Organizational Development.

ORM contracts include ADR Mediations, IT equipment, FSC, SIC, VHA Services Center, Temporary Services for a Visually Impaired Employee.

OHRM included funding for the Child Care Subsidy Program (CCSP). CCSP is a Nation-wide program that assists lower income VA employees whose total family income is less than $59,999 per year with the cost of child care. Eligible employees receive a subsidy based on their total family income. Over 2,000 VA employees have applied to participate in the program and new applications are received daily. Employees submit monthly invoices that must be processed timely and accurately. Payments are made directly via electronic funds transfer to child care providers. The Child Care Records Management System (CCRMS) includes a process for capturing documents of participants in the Child Care Subsidy Program in an electronic and database format. The CCRMS provides a methodology for classifying, identifying, tracking, filing, retrieving and storing of documents as well as data used for statistical and reporting purposes. The Child Care Subsidy Program is a reimbursement program. Each organization supports the cost of daycare for their participants in the program and OHRM maintains the funding for distribution to child to child care providers upon request.

A breakdown of current estimated FY 2014 contract costs of $236 million follows:

Office	Contract Description	Cost (in Millions)
Human Capital Investment Program	Training and Transformation Initiatives	$217.5
Office of Resolution Management (EEO complaint Processing).	Contracts for Investigation of EEO complaints, Court Transcription Services.	$11
Administration	Contracts with Other Government Agencies for Mailroom Operations, Employee Health Unit and Employee Fitness Center.	$3
Office of Human Resources Management	Child Care Subsidies	$4
Miscellaneous	Individual training,copier and equipment maintenance and other contracts.	$.4
Total	....	$235.9

Question 102. According to the fiscal year 2014 budget request, the Office of Human Resources and Administration plans to spend $13 million on travel during fiscal year 2013 and requests $20 million for travel during fiscal year 2014.

A. In total, how many employees are expected to travel during fiscal year 2013, how many unique travel trips are expected to occur, and what is the expected average cost per expected trip?

Response. Please see the response to question 102 B.

B. For fiscal year 2014, how many unique travel trips is the $20 million expected to support?

Response. The travel budget identified in the HRA chapter in the budget is primarily for travel provided for Human Capital Improvement Plan (HCIP) programs. The current estimates for travel have been reduced from what was originally submitted in the budget. The HCIP was initiated to transform the VA workforce to better meet the needs of a changing Veteran population.

HCIP allocates most of its travel funds for training programs conducted by the VA Learning University (VALU). VALU provides training on a corporate level in the areas of leadership development, competency improvement, and technical training. These training courses are provided to all VA employees, not just HRA employees. VALU, through its HCIP funding, covers the cost not only of the training but all travel costs associated with attendance at the training. Travel associated with HCIP-funded, VALU-sponsored training is tracked separately in the travel management system from all other HRA travel and therefore is listed separately from other HRA travel in the tables below.

Additional HCIP programs are also allocated funds for travel associated with special events such as Veterans Employment Hiring Fairs held at various locations throughout the country.

Other travel not associated with HCIP, but included in the HRA budget is for the Office of Resolution Management, which handles the processing of discrimination allegations and conflict resolution for both field and VA Central Office Equal Employment Opportunity-related cases. HRA travel funds also provide reimbursements to other VA offices for travel incurred for attendance at training sessions associated with new union contracts as well as travel associated with normal HRA business.

HRA Travel Costs ($ in millions)

	FY 2013	FY 2014
VALU sponsored travel	$10.1	$10.3
All other HRA travel not included in VALU totals	$1.1	$2.4
Total	$11.2	$12.7

of Unique Trips

	FY 2013	FY 2014
VALU sponsored travel	6,631	6,405
All other HRA travel not included in VALU totals	712	1,412
Total	7,343	7,817

Average Cost (whole $)

	FY 2013	FY 2014
VALU sponsored travel	$1,520	$1,611
All other HRA travel not included in VALU totals	$1,513	$1,684
Total	$1,519	$1,624

C. What steps have been taken to avoid questionable travel expenses since issuance of the September 2012 Inspector General report entitled "Administrative Investigation of VA's FY 2011 H.R. Conferences in Orlando, FL?"

Response. VA employs over 320,000 employees who provide high quality health care, benefits, and services to Veterans every day. VA is the Nation's largest integrated health care system with nearly 1,300 centers of care serving 8.6 million Veterans across the country. A large number of VA doctors, nurses, claims processors and other employees directly benefit from training events every year. Continuous workforce training and development is essential to delivering timely and quality VA care and services our Veterans have earned and deserve. VA holds centralized training forums to enhance the delivery of health care, benefits, and memorial services unique to Veterans. This includes employee development through critical training to improve customer service and the timely delivery of benefits and services; clinical training, which includes post-deployment care, treatment of chronic conditions, mental health, suicide prevention; and strategies to eliminate Veteran homelessness. Our training events are designed to achieve our goals—better access, eliminate the

backlog, and end Veteran homelessness by training and developing our employees and empowering them to provide the best care and services possible for our Nation's Servicemembers and Veterans.

VA has implemented a comprehensive action plan to revise and strengthen policies and controls on the planning and execution of training conferences and events. These actions are consistent with the recommendations in the September 30, 2012 Inspector General report and are reflected in VA policy issued on September 26, 2012.

Stringent internal controls for training conferences are in place and oversight is provided by the senior executives in the Department. Further, the newly established Training Support Office ensures consistency and the distribution of clear guidance regarding needed steps for adherence with all appropriate regulations and requirements as the Department balances critical training requirements to ensure achievement of stated goals and objectives while minimizing costs.

Automating data collection is essential to provide accurate and timely information for senior leaders so they can execute their responsibilities and respond to queries for training related events from Congressional and other Federal oversight bodies. VA is currently engaged in developing and delivering an automated data collection tool to increase accountability, control training conference spending, and produce congressionally required reports.

VA's Conference Oversight Memorandum dated September 26, 2012, supersedes all previously issued conference guidance.

The approval authorities:

• A Senior Executive must approve any conference under $20,000.
• Two Senior Executives, the Conference Certifying Official (CCO) and the Responsible Conference Executive (RCE), are appointed when a conference exceeds $20,000 to ensure adherence to all applicable statutes, regulations, and policies when planning and executing the approved conference.
• An Under Secretary or Assistant Secretary must approve any conference within the threshold $20K to $100K.
• The Deputy Secretary is responsible for approving conferences exceeding $100K to $500K.
• Conferences exceeding $500K require a waiver by the Secretary.

A Quarterly Conference Planning and Execution Briefing is now required at least 120 days prior to the quarter of execution. This briefing outlines all the conferences planned for the targeted quarter to include cost, attendees, location, purpose and outcomes.

The VA conference process has four phases: Concept, Development, Execution, and Reporting.

• The Concept Phase is a disciplined conference authorization process. In October 2012, VA began our quarterly Concept Authorization Briefing as part of the quarterly Conference Planning and Execution Briefing Cycle where senior officials review all events to ensure the best value prior to being authorized to enter the Development Phase.
• The Development Phase builds the business case for the event; provides the guidance for the planning and execution of the potential conferences; appoints a Senior Executive as the CCO and a Senior Executive as the RCE. The CCO certifies the event details are in compliance with all directives. The event plan is then submitted through the appropriate channels to the approving official for approval, disapproval or modification of the planned event.
• The Execution Phase covers the period after the conference plan has been approved and the responsible organization begins to execute the approved plan. The RCE is responsible for executing the approved plan in accordance with laws, regulations, and policy. Additionally, the RCE oversees the spending and contract execution, approving any changes to contract agreements or increases in spending.
• The Reporting Phase covers the period after the execution of the conference. The RCE submits an After Action Review (AAR) reflecting how the event was conducted; providing conference attendance and details on how the spending was tracked and reported in accordance with Public Law 112–154 and OMB M–12–12. The Administrations and Staff Offices leadership review the AAR to verify that the event was executed in accordance with the plan and all applicable policies and regulations.

Question 103. In response to questions regarding VA's fiscal year 2013 budget request, VA indicated that it planned to expend $6 million during fiscal year 2013 on a "Change Academy."

A. To date, how much has been expended on the Change Academy during fiscal year 2013, how many individuals have attended this training, and what outcomes

have been achieved? Are any of the individuals who attended this training no longer employed at VA?

Response. Change Academies are customized programs designed to address specific interests, problem solving or strategic initiatives for any leadership team to bring transformational change to a VA facility, region or network. Change Academy provides a venue to leverage actual VA work scenarios to help clarify goals and action plans and to build momentum for organizational sustainment. Change Academies are more than training events; they are partnerships to facilitate solving problems affecting VA and the needs of our Veterans. As of June 30, 2014, three events have been approved and one event, costing $11,000 for attendance by 12 employees, was completed. There are currently 20 Change Academy sessions undergoing coordination for delivery for the remainder of the FY, reaching over 4100 VA employees. The expense associated with managing the program is $1.54 million through April, 2013.

B. During fiscal year 2014, how much does VA expect to spend on the Change Academy, how many individuals are expected to attend this training, and what outcomes are expected to be achieved?

Response. There is currently $2.8 million budgeted for Change Academies for FY 2014. Task estimates are based on delivery of 12 small events of two or three day duration for up to 50 participants, 2 medium events of five day duration for up to 80 participants, and 1 large multi-event program for up to 2000 participants. This year, Change Academies will be delivered on an indefinite delivery/indefinite quantity (ID/IQ) basis. Change Academies have been an extremely successful organizational training delivery and have received strong reviews from VA participants. The outcome brings together an entire facility or department to open dialog and identify solutions to address urgent organizational needs.

Question 104. According to the fiscal year 2014 budget request, funding for VACO is expected to be reduced by 5 percent; however, the staffing level for the Office of Human Resources and Administration would add 50 FTE above the 2013 level and the number of FTE has grown by 72 percent since 2009. The Office of Resolution Management, which handles equal employment opportunity (EEO) complaints within the Office of Human Resources and Administration, would have the single largest increase in staffing with an additional 24 reimbursable FTE. Has VA seen a growth in EEO complaints in the last year? If not, what accounts for the growth of these positions?

Response. The higher FY 2014 FTE in ORM is largely due to the annualization of ORM FTE hired late in fiscal year FY 2013. ORM FTE is expected to reach 267 FTE in FY 2014, as a result, there is no FTE growth during FY 2014.

Question 105. The Corporate Senior Executive Management Office (CSEMO), within the Office of Human Resources and Administration, was created to provide a "centralized approach to the executive life cycle management." Under its responsibilities, CSEMO has created two training programs—Senior Executive Leadership Development Course I (SLC I) and Senior Executive Leadership Development Course II (SLC II). According to the budget request, 40 Senior Executive Service (SES) employees have completed SLC I and 476 SES employees have completed SLC II.

A. For each training program (SLC I and SLC II), please provide the amount VA expects to spend in fiscal year 2014.

Response. For SLC I—Core Training, the one-week senior executive onboarding course, VA projects holding three sessions (Cohorts 4, 5, and 6) in FY 2014 at a total cost of $127,578.84. For SLC II—Basic, the strategic decisionmaking course currently held at University of North Carolina-Chapel Hill, VA projects holding three sessions (Cohorts 20, 21, and 22) at a total maximum projected cost of $649,627.95.

B. How much was spent on each training course (SLC I and SLC II) for fiscal year 2009 through fiscal year 2013? Please breakdown by fiscal year, by category of spending (travel, facility rentals, course material, etc.), and by training program.

Response. In 2012, VA Senior Executives called for a redesign of the VA's Senior Executive On-boarding and Development Programs. Based on senior executive feedback, the Executive Forum was terminated because it was not providing new VA executives what they needed to be successful. The Department piloted a new onboarding program, the Senior Executive Strategic Leadership Course I—Core Training. This course was designed to acclimatize new senior executives to VA culture, highlight red lines or issues that posed a threat to new senior executives, set the conditions for a successful transition into the role of strategic leader, and promote corporate problem-solving through networking. About 80% of the program is delivered by VA Senior Executives.

The SLC I—Core Training course is followed by the Strategic Leadership Course II—Basic. This university-based course builds on SLC I by focusing on critical thinking skills, strategic decisionmaking, tools to facilitate leading and driving change, and networking opportunities to promote corporate problem-solving. Additionally, VA senior executives work VA Strategic Challenges during SLC II. These challenge questions provide the senior executives an opportunity to apply what they are learning at SLC II to real-world VA challenges. They then brief their analysis and recommendations to a VA senior leader on the final day of SLC II. Not only does the activity reinforce lessons learned at SLC II, but the VA gains from a fresh perspective on a VA program or policy.

For SLC I—Core Training:

Cohort	Program	Travel	Total
1	58,728.96	32,938.28	91,667.24
2	53,464.35	25,436.23	78,900.58

For SLC II—Basic:

Cohort	Program	Contractor Support	OPM Fee	Travel	Total
1	177,687.50	—	7,995.94	17,500.00	203,183.44
2	187,714.50	—	8,447.15	21,000.00	217,161.65
3	163,584.76	—	7,361.31	16,800.00	187,746.07
4	189,525.00	—	7,107.19	18,725.22	215,357.41
5	194,940.00	—	7,310.25	25,032.66	227,282.91
6	204,445.00	24,282.33	8,577.28	17,761.46	255,066.07
7	202,732.50	24,282.33	8,513.06	23,624.59	259,152.48
8	203,107.5	24,282.34	8,527.12	22,355.11	258,272.07
9	197,255.00	24,282.33	8,307.65	22,426.96	252,271.94
10	202,425.00	—	7,584.19	22,254.56	232,083.75
11	169,577.50	—	6,359.16	20,974.88	196,911.54
12	168,715.00	—	6,326.81	20,974.88	196,016.69
13	188,237.50	—	7,058.91	19,782.60	215,079.01
14	193,027.50	—	7,238.53	28,005.65	228,271.68
15	163,025.00	—	6,113.44	17,036.47	186,174.91
16	161,985.00	—	6,074.44	14,436.74	182,496.18
17	138,110.00	—	5,179.13	12,186.36	155,475.49
18	144,647.50	—	5,424.28	13,345.62	163,417.40
19	TBD	0.00	TBD	TBD	TBD

OPM Fee for use of contract vehicle in FY 2011 was 4.5%, then 3.75% in FY 2012.

C. For training programs that are not conducted on VA property, please provide the dates and locations of each training program.

Response. For SLC I—Core Training: Cohort 1 was conducted July 22–27, 2012 and Cohort 2 during August 26–31, 2012, at the Bolger Center in Potomac, MD, which is a U.S. Postal Service facility. For SLC II—Basic: All cohorts were held at the Rizzo Conference Center, Kenan-Flagler Business School at the University of North Carolina, Chapel Hill, NC.

Cohort dates follow:

FY 2011

Cohort	Date
1	March 20–25, 2011
2	June 26–July 1, 2011
3	September 18–23, 2011

FY 2012

Cohort	Date
4	October 2–7, 2011
5	November 13–18, 2011

FY 2012—Continued

Cohort	Date
6	December 4–9, 2011
7	January 22–27, 2012
8	February 12–17, 2012
9	March 11–16, 2012
10	April 22–27, 2012
11	May 6–11, 2012
12	May 13–18, 2012
13	May 17–22, 2012
14	July 15–20, 2012
15	August 12–17, 2012
16	September 9–14, 2012

FY 2013

Cohort	Date
17	October 14–19, 2012
18	January 27–February 1, 2013
19	June 16–21, 2013

Question 106. The Veterans Employment Services Office, under the Office of Human Resources and Administration, oversees the VA for Vets initiative. The VA for Vets initiative includes a Web site with a skills translator that helps veterans find employment at VA and other Federal agencies.

A. What Federal agencies have signed a memorandum of understanding (MOU) with VA to utilize the capabilities of VA for Vets?

Response. To date, the U.S. Departments of Agriculture, State, Homeland Security, and Interior have signed MOUs with VA to utilize VA for Vets. The American Red Cross, a non-profit organization, also has a MOU in place with VA. An MOU is forthcoming with the Department of Commerce. The Departments of Labor and Health and Human Services, the National Credit Union Association, and the National Aeronautics and Space Administration have all met with VA to discuss the MOU process.

B. How is VA reaching out to other agencies in order to expand the usage of VA for Vets through MOUs?

Response. VA's Veteran Employment Services Office (VESO) participates on the joint VA/DOD Veteran Employment Initiative Task Force to maximize the career readiness of all Servicemembers. The VESO Director serves as a co-chair for the Task Force's Veterans Employment Working Group. The Task Force developed and submitted a list of recommendations to the President outlining the steps needed to ensure a successful transition for Military Servicemembers.

The recommendations included the development of a single portal for Servicemembers and Veterans to gain access to resources on employment and transition services and for employers to post jobs for Veterans.

VA supports this effort by providing access to the VA for Vets platform throughout the Federal Government through MOU's. This access is at no additional cost to either the VA or other agencies that use VA4Vets.

Specifically, VA is responsible for having MOUs in place by 2015 with 35 percent of all the 24 agencies that comprise the Veteran Employment Council. This number equates to 9 MOUs by 2015. VA is on track to meet or exceed the target using the Task Force and the Veteran Employment Council as the avenue to reach out to the agencies to reinforce the benefits and importance of signing the MOU

C. Please describe the assistance provided to veterans through the program (i.e., career coaching and counseling).

Response. VA for Vets provides a fully integrated, online job-search and career-building platform, the VA for Vets Career Center, which allows Veterans to assess their talents and strengths, translate their military skills and training, build resumes, and identify and apply for Federal job opportunities. Career Coaches work one-on-one with Veterans and provide guidance on resume writing, job searches and interview preparation. The program further supports Veteran employees at VA by offering career development services and reintegration support for Military Servicemembers.

D. There are numerous veteran employment Web sites supported by various Federal agencies. Given the enhanced tools developed by VA for use by other Federal agencies, what efforts, if any, have been pursued by VA to establish one Federal Web site for veteran employment information and tools?

Response. As mentioned in the response to subquestion 106 B above, the joint VA/DOD Task Force recommended a single portal for Servicemembers and Veterans to gain access to employment and transition services and to determine the feasibility of deploying the VA for Vets platform across government. VA is also undertaking internal initiatives to work toward establishing one Federal portal for Veterans to access employment information and tools by integrating its private employment Web site (VetSuccess.gov) with its Federal employment Web site, VA for Vets. VA will be integrating these two Web sites into one platform to create a seamless and consistent experience for Veteran users.

These combined efforts will give Veterans instant access to open Federal and private sector job listings as well as provide access to the enhanced VA for Vets services in a single source.

E. Please provide the Committee with the number of unique veterans who have used the VA for Vets site, the number of veterans utilizing the job coaching and counseling, and the number of Federal jobs obtained through the program.

Response. As of June 30, 2013, 944,127 unique visitors, both Veterans and civilians, have visited the Web site. As of June 30, 2013, 12,733 Veterans have utilized the job coaching and counseling. As of June 30, 2013, 1,921 Federal jobs have been obtained by Veterans through the program.

Question 107. The Veterans Recruitment Appointment (VRA) is one of the hiring authorities that allow Federal agencies to hire eligible veterans. Veterans can be appointed to positions up to GS–11 or equivalent. Participating veterans are hired under excepted appointments to positions that would otherwise need to be competed. After 2 years of service, the veteran must be converted to a career position if they have performed satisfactorily.

A. According to the fiscal year 2014 budget request, 35 percent of the VA workforce was comprised of veterans in 2013. Of those, how many veterans were hired using VRA, over the last five years?

Response. Please see the chart provided in response to subquestion B.

	Leg Auth	Description	2008	2009	2010	2011	2012	2013	Total
107A	VRA		1,644 (12.47%)	2,019 (16.03%)	1,691 (14.44%)	1,801 (14.83%)	2,619 (19.54%)	1,589 (20.00%)	11,363 (16.00%)
107B	VEOA & 30% Disabled	Veterans hired under authority other than VRA	4,961 (37.64%)	4,448 (35.31%)	4,063 (34.69%)	3,649 (30.04%)	3,447 (25.72%)	1,908 (24.02)	22,476 (31.66%)
107C	VRA		662 (40.27%)	548 (27.14%)	993 (26.83%)	705 (18.49%)	1,040 (22.46%)	742 (20.60%)	4,690 (41.27%)
	Others	Veterans hired other than VRA, VEOA & 30% Disabled	6,575 (49.89%)	6,131 (48.66%)	5,959 (50.87%)	6,697 (55.13%)	7,338 (54.74%)	4,448 (55.98%)	37,148 (52.34%)

B. Please provide the Committee the number of veterans, during the last five years, hired under other hiring authorities, such as the Veterans Employment Opportunities Act (VEOA) or 30 percent or more disabled.

Leg Auth	Description	2008	2009	FY 2010	2011	2012	2013	All
J8M	PL 107-288 VRA	1,444	1,309	1,275	1,382	2,028	1,196	8,634
LBM	REG 315.604 APPT OF DIS VET	3	11	14	37	19	26	110
LZM	REG 315.707 30% CONV DIS VET	1	0	0	1	1	3	6
MGM	REG 316.302(B)(2) TERM (VRA eligibility)	62	477	101	107	165	99	1,011
MMM	REG 316.302(B)(4) TEMP (30%+ disabled vet)	5	69	21	23	56	37	211
NCM	REG 316.402(B)(2) TERM (VRA eligibility)	24	31	114	27	72	32	300
NEM	REG 316.402(B)(4) TEMP (30%+ disabled vet)	106	122	166	225	279	199	1,097
V8V	38 USC	22	18	19	10	2	11	82
ZBA	PL 106-117 VEOA	4,960	4,448	4,063	3,648	3,446	1,905	22,470
N/A	OTHER LEGAL AUTHORITY TO APPT EMPLOYEE	6,553	6,113	5,940	6,687	7,336	4,437	37,066
Total		13,180	12,598	11,713	12,147	13,404	7,945	70,987
% of veterans appointed using veteran legal auth		50.28%	51.48%	49.29%	44.95%	45.27%	44.15%	47.78%
% of veterans appointed not using veteran legal auth		49.72%	48.52%	50.71%	55.05%	54.73%	55.85%	52.22%

C. Of those initially hired under VRA, how many (number and percentage) were converted to career or career-conditional appointments after two years?

Description	2008	2009	FY 2010	2011	2012	2013	All
PL 107-288 VRA	439	426	866	540	783	537	3,591
REG 315.604 APPT OF DIS VET	12	13	23	44	22	14	128
REG 315.707 30% CONV DIS VET	147	179	233	259	429	256	1,503
REG 316.302(B)(2) TERM (VRA eligibility)	13	54	26	34	45	50	222
REG 316.302(B)(4) TEMP (30%+ disabled vet)	2	10	1	10	22	26	71
REG 316.402(B)(2) TERM (VRA eligibility)	4	0	7	1	6	4	22
REG 316.402(B)(4) TEMP (30%+ disabled vet)	45	45	70	76	162	111	509
38 USC	21	10	4	5	13	13	66
PL 106-117 VEOA	398	273	517	295	270	186	1,939
OTHER LEGAL AUTHORITY	3,346	3,255	5,777	4,207	10,414	2,234	29,233

D. Of those hired in the last five years under other authorities, how many (number and percentage) are still employed at VA? Please detail, if employees are no longer with VA, whether their positions were terminated, the positions hired for were temporary, or they left for other reasons.

SEPARATION NOA CODE	SEPARATION DESC	2008	2009	2010	2011	2012	2013	All
VETERAN SEPARATIONS								
DURING FY2008 THRU FY2013								
301	RET DISAB	3	13	36	74	109	62	297
302	RET	0	2	0	1	0	0	3
302H	RETIREMENT-VOLUNTARY	4	12	33	66	92	113	320
304A	RETIREMENT-ILIA	0	0	0	1	0	0	1
312A	RESIGNATION-ILIA	6	12	13	17	16	12	76
317	RESIG	815	1,499	2,082	2,457	2,887	1,671	11,411
330	REMOVAL	8	50	125	156	215	129	683
350	DEATH	9	24	45	74	105	50	307
351A	TERMINATION-SPONSOR RELOCATION	0	1	0	0	0	0	1
352G	TERMINATION-APPOINTMENT IN	113	343	540	515	682	424	2,617
353A	SEPARATION - MILITARY	0	3	0	1	0	1	5
355C	TERMINATION-EXPIRATION OF APPT	75	226	359	353	424	160	1,597
357	REMOVAL	1	0	3	1	1	4	10
357A	TERMINATION	69	148	118	125	122	47	629
385	TERM DURING PROB/TRIAL	2	14	7	7	8	4	42
385A	DISCHARGE-TRIAL PERIOD	0	1	0	0	0	0	1
385B	TERMINATION/DURING PROB/TRIAL	244	670	612	505	559	302	2,892
390	SEPAR-APPT IN *	0	0	1	0	0	0	1
# SEPARATED DURING FY*		1,349	3,018	3,974	4,353	5,220	2,979	20,893
% SEPARATED AT THE END OF THE FY*		6.46%	14.45%	19.02%	20.83%	24.98%	14.26%	100.00%

# OF VETS HIRED BETWEEN FY2008 AND FY2013 THAT ARE STILL ON	25,075	8D
% OF VETS HIRED BETWEEN FY2008 AND FY2013 THAT ARE STILL ON	35.32%	8D

Office of Policy and Planning

Question 108. The fiscal year 2014 budget request includes $11 million to be spent on Other Services by the Office of Policy and Planning. Please provide a specific itemized list of how these funds would be spent. To the extent any of these funds will be spent on contracts, please explain the nature of the contract and the expected outcomes.

Response. See spreadsheet below.

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Managing Office	Estimated $ Amount	Description of Work Performed	Estimated number of contractors	Length of Contract	Metrics to be used to determine if the contract will be renewed	Expected Outcomes
Enterprise Program Management Office	$1,800,000	The Program Management Center of Excellence (PMCOE) will further develop and promulgate program management standards, doctrine and policy. The PMCOE, as the central coordinating mechanism for development of key capabilities, templates, and best practices will address all disciplines of program management. Those disciplines include general program management, requirements, cost estimation, acquisition strategy, systems engineering, enterprise architecture, test and evaluation, and construction management. Further, the PMCOE will support the institutionalization of the Department's acquisition program management framework (APMF) and be leveraged to support the development of a subordinate end to end requirements gathering, prioritization, and approval process.	8	12 Months	Percent complete of phase II PMCOE capability, demand for subject matter experts, need for additional best practices artifacts to support VA capabilities required to change how VA operates as a Department, support of the APMF.	Matured PMCOE capability; increased participation in knowledge sharing across VA; implementation of PMCOE collaboration tool; subject management expert support to increase program management skillset capability and knowledge across VA.
Enterprise Program Management Office	$1,100,000	Provide oversight of the planning and execution of key programs within the VA benefits, health and corporate portfolios to ensure effective oversight, integration and sustainment of new capabilities into the routine operations of the Department. In this capacity, the support will enable performance monitoring against plans and support resolution of risks and issues in meeting program objectives.	5	12 Months	1) Number of programs in the oversight process at the time of contract renewal relative to Federal staffing will determine if VA needs contractor support. 2) Performance of the incumbent contractor in the previous period will determine if the work will be renewed or re-competed.	Development of program documents, establishment and approval of baselines for VA's highest priority programs. Performance will be monitored to ensure risks and issues are identified and managed to increase opportunities for program success in providing improved services that benefit Veterans.
Enterprise Program Management Office	$500,000	Training personnel to understand the Baldrige criteria in order to develop application packages, provide support to Carey examiner during consensus week, and provide technical editing support, provide feedback reports to applicants for continuous improvement purposes.	2	12 months	Participant feedback on product quality, cost compared to other options.	Quality feedback reports for applicants to use to continuously improve management systems and resultant service offerings to Veterans.
VA/DoD Collaboration	$450,000	To provide the Office of Interagency Collaboration and Integration (OICI) project management support, technical support, performance measurement, and process improvements/business process reengineering support for the implementation and oversight of the Integrated Disability Evaluation System (IDES).	5	12 months	Contractor will be evaluated on the quality and timeliness of deliverables and management support as set forth in the contract.	Successful completion of deliverables and support as set forth in the contract.

Office	Amount	Task Description	Date	Duration	Review	Outcome
Corporate Analysis & Evaluation	$500,000	Automation of programming system which currently uses spreadsheets and other "flat files" to perform the complex tasks of annual programming. The effort requires development of system requirements, market research, and a recommended implementation plan to include the following tasks: 1) automate input functions for capability requirements proposal; 2) automate input functions for special interest analysis (SIA); 3) engineer functionality to produce a future years Veterans plan (FYVP) document from CRP and SIA automated input; 4) engineer ability to save all CRP and SIA data in a relational database (RDB); and 5) engineer easy data-downloads from RDB to standard Microsoft tools.	4-Feb	12 Months	Frequent review of prototype development; weekly progress reviews throughout life of project; multiple, testable deliverables for prototype, interim operating capability, and final operating capability.	Prototype, testable system after 6 weeks; interim operating capability in 10 weeks; and final operating capability in 12 weeks.
Office of Policy	$950,000	The purpose of this task is to assist in: • Supporting OOP's internal business process and VA's governance process; • Executing strategic studies environmental scanning and analysis processes; • Executing VA's quadrennial strategic planning process; and • Executing VA's policy analysis process.	10-Aug	12 Months	An assessment will be made at the end of the contract to determine the maturity level of Federal staff capabilities. The outcomes of that assessment will determine if follow-on contract is required. This assessment will be conducted annually with each contract.	1) A forward-leaning concepts analysis capability that identifies long-range issues and drives innovation and transformation; 2) a planning capability focused on strategic outcomes that influence policies, programs and resources; and 3) a proactive analysis capability that is externally engaged and internally
Data Governance & Analysis	$200,000	A special supplement to the current population survey (CPS) on Veterans on such topics as demographics, VA status, VA health, education, etc. Most importantly, this is the only survey to capture Veteran employment statistics.	2	7 months	BLS and Census are the only viable source for the CPS Veteran-status data.	Better understanding of Veteran employment situations.
Data Governance & Analysis	$70,000	Match VA administrative records to the IRS tax data to generate statistics relating to Veteran migration at the state and county levels. The data matching also yield valuable demographic and socio-economic statistics on Veterans.	1	3 months	IRS is the only viable source for tax return information and associated personal information (e.g., address, income).	Tabulated data relating Veteran migration and demographics by various level of geography to support VetPop and Veteran migration analysis.
Data Governance & Analysis	$350,000	A global information systems analyst to: 1) provide technical and professional services to supplement staff's efforts on discrete studies; 2) compile, create, and modify GIS layers and related tools; 3) enhance the integrated Web-based mapping capability with analysis system datasets and fully integrate the geospatial analysis dashboard (GAD) and geospatial analysis tools (GAT) into the analysis system and intranet portal; 4) develop interactive Web applications using ArcGIS API for Flex to leverage ArcGIS server resources in combination with Adobe Flex components; and 5) display interactive maps presenting data on Veteran population and VA programs.	9	12 Months	Work products are: 1) accurate in presentation, technical content, and adherence to accepted elements of style; 2) clear and concise, all diagrams easy to understand and relevant to supporting narrative; 3) satisfy the requirements of the statement of work; 4) text and diagrammatic files are editable by the Government; 5) submitted in hard copy (where applicable) and in media mutually agreed upon prior to submission; and 6) submitted on or before the due date.	The enhancement of Geographic Information Systems platform and the integration of SAS and GIS technologies; and the improvement of data dissemination and data analysis by deploying new mapping capabilities in the ArcGIS intranet and internet portal.
Data Governance & Analysis	$350,000	Expand and support an existing USVETS multidimensional database and analysis system; provide statistical application system (SAS) programming support for the National Center for Veterans Analysis and Statistics.	9	12 months	Timely delivery of quality products and services as described in performance work statement.	1) An integrated view of Veteran users and non-users of VA benefits or services. 2) Statistical analysis and reports on Veterans to support VA planning, policy development and decision making.

Question 109. For fiscal year 2014, the budget request includes over $25 million for the Office of Policy and Planning and would support 114 employees. For each office within the Office of Policy and Planning, please identify the positions and pay-grades for employees that would be assigned to that office during fiscal year 2013 and fiscal year 2014 and the number of contractors that are expected to be assigned to each such office.

Response.

2013

Title	Series	Grade
Office of the Assistant Secretary		
Assistant Secretary	301	SES
Executive Assistant to the Assistant Secretary	301	GS 15
Scheduler/Program Support to Assistant Secretary	301	GS 11

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Title	Series	Grade
Principal Deputy Assistant Secretary	301	SES
Scheduler/Program Support to Principal Deputy Assistant Secretary	301	GS 11
Senior Policy Advisor	343	GS 15
Operations		
Director of Operations	343	GS 15
Human Capital Manager	301	GS 14
Administrative Officer	301	GS 13
Communications Specialist	343	GS 9
Budget Officer	343	GS 13
Office of VA/DOD Collaboration		
Executive Director	301	SES
Scheduler/Program Support	301	GS 11
Integrated Disability Evaluation System Service (IDES)		
Director IDES	301	GS 15
Management Analyst	343	GS 14
Management Analyst	343	GS 14
Pathways Intern	399	GS 9
Joint Executive Council/Senior Oversight Committee Service (JEC/SOC)		
Director JEC/SOC	301	GS 15
Special Assistant	301	GS 15
Management Analyst	343	GS 14
Management Analyst	343	GS 9/11
Management Analyst	343	GS 14
Management Analyst	343	GS 14
Management Analyst	343	GS 11
Management Analyst	343	GS 9
Corporate Analysis and Evaluation Service		
Executive Director	343	SES
Programming Service		
Director	343	GS 15
Budget Analyst	560	GS 14
Operations Research Analyst	1515	GS 14
Budget Analyst	560	GS 14
Operations Research Analyst	1515	GS 14
Management Analyst	343	GS 14
Analysis & Evaluation Service		
Director	343	GS 15
Operations Research Analyst	1515	GS 14
Operations Research Analyst	1515	GS 14
Operations Research Analyst	1515	GS 14
Management Analyst	343	GS 13
Operations Research Analyst	1515	GS 14
Operations Research Analyst	1515	GS 14
Office of Policy		
Deputy Assistant Secretary	343	SES
Program Support	301	GS 9
Policy Analysis Service		
Director	343	GS 15
Management Analyst	343	GS 14
Management Analyst	343	GS 11
Management Analyst	343	GS 13
Management Analyst	343	GS 9/11
Management Analyst	399	GS 13
Management Analyst	301	GS 9
Strategic Studies Group		
Director	343	GS 15
Management Analyst	343	GS 14
Management Analyst	343	GS 14

Title	Series	Grade
Management Analyst	343	GS 12
Management Analyst	343	GS 11
Strategic Planning Service		
Director	343	GS 15
Management Analyst	343	GS 14
Management Analyst	343	GS 14
Management Analyst	343	GS 14
Management Analyst	343	GS 13
Management Analyst	343	GS 11
Management Analyst	343	GS 11
Office of Data Governance and Analysis		
Deputy Assistant Secretary	343	SES
National Center for Veterans Analysis and Statistics		
Executive Director	301	SES
Program Support	301	GS 11
Analysis and Statistics Service		
Director	1530	GS 15
Statistician	1530	GS 14
Management Analyst	343	GS 14
Statistician	343	GS 13
Management Analyst	343	GS 14
Statistician	1530	GS 14
Statistician	1530	GS 14
Management Analyst	343	GS 13
Statistician	343	GS 13
Reports and Information Service		
Director	343	GS 15
Management Analyst	343	GS 14
Management Analyst	343	GS 14
Management Analyst	343	GS 14
Management Analyst	343	GS 14
Management Analyst	343	GS 12
Pathways Intern	399	GS 9
Management Analyst	343	GS 14
Management Analyst	343	GS 12
Management Analyst	343	GS 12
Office of the Actuary		
Chief Actuary	1510	SL
Deputy Chief Actuary	1510	GS 15
Actuary	1510	GS 14
Economist	110	GS 14
Actuary	1510	GS 14
Actuary	1510	GS 14
Actuary	1510	GS 14
Management Analyst	343	GS 14
enterprise Program Management Office		
Executive Director	301	SES
Management Analyst	343	GS 11
Deputy Director	301	GS 15
Executive Program Manager	301	SES
Program Management Policy Service		
Director	343	GS 15
Management Analyst	343	GS 14
Management Analyst	343	GS 14
Management Analyst	343	GS 14
Management Analyst	343	GS 13
Management Analyst	343	GS 14
Management Analyst	343	GS 14
Management Analyst	343	GS 14

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Title	Series	Grade
Operational Management Review		
Director	343	GS 15
Management Analyst	343	GS 11
Management Analyst	343	GS 13
Management Analyst	343	GS 14
Pathways Intern	399	GS 9
Management Analyst	343	GS 14
Management Analyst	343	GS 14
Management Analyst	343	GS 14
Resource Management Service		
Director	343	GS 15
Management Analyst	343	GS 14
Management Analyst	343	GS 14
Management Analyst	343	GS 13
Management Analyst	343	GS 11
Management Analyst	343	GS 13
Management Analyst	343	GS 14

2014

Title	Series	Grade
Office of the Assistant Secretary		
Assistant Secretary	301	SES
Executive Assistant to the Assistant Secretary	301	GS 15
Scheduler/Program Support to Assistant Secretary	301	GS 11
Principal Deputy Assistant Secretary	301	SES
Scheduler/Program Support to Principal Deputy Assistant Secretary	301	GS 11
Senior Policy Advisor	343	GS 15
Operations		
Director of Operations	343	GS 15
Human Capital Manager	301	GS 14
Administrative Officer	301	GS 13
Communications Specialist	343	GS 9
Budget Officer	343	GS 13
Office of VA/DOD Collaboration		
Executive Director	301	SES
Scheduler/Program Support	301	GS 11
Integrated Disability Evaluation System Service (IDES)		
Director IDES	301	GS 15
Management Analyst	343	GS 14
Management Analyst	343	GS 14
Management Analyst	343	GS 11
Joint Executive Council/Senior Oversight Committee Service (JEC/SOC)		
Director JEC/SOC	301	GS 15
Special Assistant	301	GS 15
Management Analyst	343	GS 14
Management Analyst	343	GS 9/11
Management Analyst	343	GS 14
Management Analyst	343	GS 14
Management Analyst	343	GS 11
Management Analyst	343	GS 9
Corporate Analysis and Evaluation Service		
Executive Director	343	SES
Programming Service		
Director	343	GS 15
Budget Analyst	560	GS 14
Operations Research Analyst	1515	GS 14
Budget Analyst	560	GS 14

2014—Continued

Title	Series	Grade
Operations Research Analyst	1515	GS 14
Management Analyst	343	GS 14
Analysis & Evaluation Service		
Director	343	GS 15
Operations Research Analyst	1515	GS 14
Operations Research Analyst	1515	GS 14
Operations Research Analyst	1515	GS 14
Management Analyst	343	GS 13
Operations Research Analyst	1515	GS 14
Operations Research Analyst	1515	GS 14
Office of Policy		
Deputy Assistant Secretary	343	SES
Program Support	301	GS 9
Policy Analysis Service		
Director	343	GS 15
Management Analyst	343	GS 14
Management Analyst	343	GS 11
Management Analyst	343	GS 13
Management Analyst	343	GS 9/11
Management Analyst	399	GS 13
Management Analyst	301	GS 9
Strategic Studies Group		
Director	343	GS 15
Management Analyst	343	GS 14
Management Analyst	343	GS 14
Management Analyst	343	GS 12
Management Analyst	343	GS 11
Strategic Planning Service		
Director	343	GS 15
Management Analyst	343	GS 14
Management Analyst	343	GS 14
Management Analyst	343	GS 14
Management Analyst	343	GS 13
Management Analyst	343	GS 11
Management Analyst	343	GS 11
Office of Data Governance and Analysis		
Deputy Assistant Secretary	343	SES
National Center for Veterans Analysis and Statistics		
Executive Director	301	SES
Program Support	301	GS 11
Analysis and Statistics Service		
Director	1530	GS 15
Statistician	1530	GS 14
Management Analyst	343	GS 14
Statistician	343	GS 13
Management Analyst	343	GS 14
Statistician	1530	GS 14
Statistician	1530	GS 14
Management Analyst	343	GS 13
Statistician	343	GS 13
Reports and Information Service		
Director	343	GS 15
Management Analyst	343	GS 14
Management Analyst	343	GS 14
Management Analyst	343	GS 14
Management Analyst	343	GS 14
Management Analyst	343	GS 12
Management Analyst	343	GS 9
Management Analyst	343	GS 14

2014—Continued

Title	Series	Grade
Management Analyst	343	GS 12
Management Analyst	343	GS 12
Office of the Actuary		
Chief Actuary	1510	SL
Deputy Chief Actuary	1510	GS 15
Actuary	1510	GS 14
Economist	110	GS 14
Actuary	1510	GS 14
Actuary	1510	GS 14
Actuary	1510	GS 14
Management Analyst	343	GS 14
enterprise Program Management Office		
Executive Director	301	SES
Management Analyst	343	GS 11
Deputy Director	301	GS 15
Executive Program Manager	301	SES
Program Management Policy Service		
Director	343	GS 15
Management Analyst	343	GS 14
Management Analyst	343	GS 14
Management Analyst	343	GS 14
Management Analyst	343	GS 13
Management Analyst	343	GS 14
Management Analyst	343	GS 14
Management Analyst	343	GS 14
Operational Management Review		
Director	343	GS 15
Management Analyst	343	GS 11
Management Analyst	343	GS 13
Management Analyst	343	GS 14
Management Analyst	343	GS 9
Management Analyst	343	GS 14
Management Analyst	343	GS 14
Management Analyst	343	GS 14
Resource Management Service		
Director	343	GS 15
Management Analyst	343	GS 14
Management Analyst	343	GS 14
Management Analyst	343	GS 13

Additionally, OPP has contracts in place with third parties that involve their employees working in VA facilities. However, VA does not control those companies' independent business decisions regarding staffing requirements. Thus, VA is unable to give a number of contractor's employees assigned to OPP.

Question 110. According to the fiscal year 2014 budget request, approximately $7.3 million is expected to be spent in "contract dollars" managed by offices within the Office of Policy and Planning. Please describe, in detail, the contracts for the Office of VA/DOD Collaboration, the Office of Corporate Analysis and Evaluation, the Office of Policy, the Office of Data Governance, and the Enterprise Program Management Office. Please include a description of the work performed under the contracts, the total number of on-site and offsite contracted employees working under the contract, the length of the contract, the metrics to be used to determine if the contract would be renewed, and the expected outcomes.

Response. See spreadsheet below.

Managing Office	Estimated $ Amount	Description of Work Performed	Estimated number of contractors	Length of Contract	Metrics to be used to determine if the contract will be renewed	Expected Outcomes
Enterprise Program Management Office	$1,800,000	The Program Management Center of Excellence (PMCOE) will further develop and promulgate program management standards, doctrine and policy. The PMCOE, as the central coordinating mechanism for development of key capabilities, templates, and best practices will address all disciplines of program management. Those disciplines include general program management, requirements, cost estimation, acquisition strategy, systems engineering, enterprise architecture, test and evaluation, and construction management. Further, the PMCOE will support the institutionalization of the Department's acquisition program management framework (APMF) and be leveraged to support the development of a subordinate end to end requirements gathering, prioritization, and approval process.	8	12 Months	Percent complete of phase II PMCOE capability, demand for subject matter experts, need for additional best practices artifacts to support VA capabilities required to change how VA operates as a Department, support of the APMF.	Matured PMCOE capability; increased participation in knowledge sharing across VA; implementation of PMCOE collaboration tool; subject management expert support to increase program management skillset capability and knowledge across VA.
Enterprise Program Management Office	$1,100,000	Provide oversight of the planning and execution of key programs within the VA benefits, health and corporate portfolios to ensure effective oversight, integration and sustainment of new capabilities into the routine operations of the Department. In this capacity, the support will enable performance monitoring against plans and support resolution of risks and issues in meeting program objectives.	5	12 Months	1) Number of programs in the oversight process at the time of contract renewal relative to Federal staffing will determine if VA needs contractor support. 2) Performance of the incumbent contractor in the previous period will determine if the work will be renewed or re-competed.	Development of program documents, establishment and approval of baselines for VA's highest priority programs. Performance will be monitored to ensure risks and issues are identified and managed to increase opportunities for program success in providing improved services that benefit Veterans.
Enterprise Program Management Office	$500,000	Training personnel to understand the Baldrige criteria in order to develop application packages, provide support to Carey examiner during consensus week, and provide technical editing support, provide feedback reports to applicants for continuous improvement purposes.	2	12 months	Participant feedback on product quality, cost compared to other options.	Quality feedback reports for applicants to use to continuously improve management systems and resultant service offerings to Veterans.
VA/DoD Collaboration	$450,000	To provide the Office of Interagency Collaboration and Integration (OICI) project management support, technical support, performance measurement, and process improvements/business process reengineering support for the implementation and oversight of the Integrated Disability Evaluation System (IDES).	5	12 months	Contractor will be evaluated on the quality and timeliness of deliverables and management support as set forth in the contract.	Successful completion of deliverables and support as set forth in the contract.

Corporate Analysis & Evaluation	$500,000	Automation of programming system which currently uses spreadsheets and other "flat files" to perform the complex tasks of annual programming. The effort requires development of system requirements, market research, and a recommended implementation plan to include the following tasks: 1) automate input functions for capability requirements proposal; 2) automate input functions for special interest analysis (SIA); 3) engineer functionality to produce a future years Veterans plan (FYVP) document from CRP and SIA automated input; 4) engineer ability to save all CRP and SIA data in a relational database (RDB); and 5) engineer easy data-downloads from RDB to standard Microsoft tools.	4-Feb	12 Months	Frequent review of prototype development; weekly progress reviews throughout life of project; multiple, testable deliverables for prototype, interim operating capability, and final operating capability.	Prototype, testable system after 6 weeks; interim operating capability in 10 weeks; and final operating capability in 12 weeks.
Office of Policy	$950,000	The purpose of this task is to assist in: • Supporting OOP's internal business process and VA's governance process; • Executing strategic studies environmental scanning and analysis processes; • Executing VA's quadrennial strategic planning process; and • Executing VA's policy analysis process.	10-Aug	12 Months	An assessment will be made at the end of the contract to determine the maturity level of Federal staff capabilities. The outcomes of that assessment will determine if follow-on contract is required. This assessment will be conducted annually with each contract.	1) A forward-leaning concepts analysis capability that identifies long-range issues and drives innovation and transformation; 2) a planning capability focused on strategic outcomes that influence policies, programs and resources; and 3) a proactive analysis capability that is externally engaged and internally
Data Governance & Analysis	$200,000	A special supplement to the current population survey (CPS) on Veterans on such topics as demographics, VA status, VA health, education, etc. Most importantly, this is the only survey to capture Veteran employment statistics.	2	7 months	BLS and Census are the only viable source for the CPS Veteran-status data.	Better understanding of Veteran employment situations.
Data Governance & Analysis	$70,000	Match VA administrative records to the IRS tax data to generate statistics relating to Veteran migration at the state and county levels. The data matching also yield valuable demographic and socio-economic statistics on Veterans.	1	3 months	IRS is the only viable source for tax return information and associated personal information (e.g., address, income).	Tabulated data relating Veteran migration and demographics by various level of geography to support VetPop and Veteran migration analysis.
Data Governance & Analysis	$350,000	A global information systems analyst to: 1) provide technical and professional services to supplement staff's efforts on discrete studies; 2) compile, create, and modify GIS layers and related tools; 3) enhance the integrated Web-based mapping capability with analysis system datasets and fully integrate the geospatial analysis dashboard (GAD) and geospatial analysis tools (GAT) into the analysis system and intranet portal; 4) develop interactive Web applications using ArcGIS API for Flex to leverage ArcGIS server resources in combination with Adobe Flex components; and 5) display interactive maps presenting data on Veteran population and VA programs.	9	12 Months	Work products are: 1) accurate in presentation, technical content, and adherence to accepted elements of style; 2) clear and concise, all diagrams easy to understand and relevant to supporting narrative; 3) satisfy the requirements of the statement of work; 4) text and diagrammatic files are editable by the Government; 5) submitted in hard copy (where applicable) and in media mutually agreed upon prior to submission; and 6) submitted on or before the due date.	The enhancement of Geographic Information Systems platform and the integration of SAS and GIS technologies; and the improvement of data dissemination and data analysis by deploying new mapping capabilities in the ArcGIS intranet and internet portal.
Data Governance & Analysis	$350,000	Expand and support an existing USVETS multidimensional database and analysis system; provide statistical application system (SAS) programming support for the National Center for Veterans Analysis and Statistics.	9	12 months	Timely delivery of quality products and services as described in performance work statement.	1) An integrated view of Veteran users and non-users of VA benefits or services. 2) Statistical analysis and reports on Veterans to support VA planning, policy development and decision making.

Office of Operations, Security, and Preparedness

Question 111. For fiscal year 2014, the Office of Operations, Security, and Preparedness requests total resources of $31 million and 133 employees. Please provide a list of the positions that would be filled with that funding and the pay-grades for those positions.

Response. The Office of Operations, Security, and Preparedness (OSP) request of $31 million is the total fiscal year (FY) 2014 budget request for the Office. The personnel services portion of that request is $17.6 million to support 133 full-time employee equivalents.

Grade	TITLE	Organization	POSITION
	OSP Front Office		
Honorable	Assistant Secretary (A/S)	OSP	Assistant Secretary
GS-12	Special Assistant to A/S	OSP	Staff Assistant
	Office of Resource Management		
GS-15	Director, Resource Management	Resource Management	Director, ORM
GS-13	Staff Assistant to Director	Resource Management	Staff Assistant
GS-12	Program Analyst	Resource Management	Program Analyst
GS-14	Budget Analyst	Resource Management	Budget Officer
GS-14	Administrative Officer	Resource Management	Admin Officer
GS-12	Staff Assistant	Resource Management	Admin Officer
GS-14	Resource Manager	Resource Management	Management Analyst
	Office of Emergency Management (OEM)		
SES	Deputy Assistant Secretary OEM	Emergency Management	DAS OEM
GS-14	Senior Staff Assistant	Emergency Management	Support
GS-11	Staff Assistant	Emergency Management	Support
GS-12/13	Management Analyst (Public Health)	Emergency Management	Support
	Planning, Exercise, Training, and Evaluation Service (PETE)		
GS-15	Dir - Emergency Management Spec	OEM/PETE	
	Planning		
GS-14	Lead Emergency Mgt. Spec	OEM/PETE	Planning
GS-11/12/13 ...	Emergency Management Spec (Planner/Liaison Officer (LNO)).	OEM/PETE	Planning
GS-13	Program Analyst - Geographic Information System (GIS).	OEM/PETE	Planning
....	Intern	OEM/PETE	Planning
GS-11/12/13 ...	Emergency Management Spec (DHS LNO)	OEM/PETE	Planning
GS-9/11/12	Program Analyst - GIS	OEM/PETE	Planning
GS-11/12/13 ...	Management Analyst (Planner/LNO)	OEM/PETE	Planning
	Exercise, Training, and Evaluation		
GS-14	Team Lead/Exercises	OEM/PETE	Planning
GS-11/12/13 ...	Emergency Management Spec (Exercise)	OEM/PETE	Planning
GS-12/13	Emergency Management Spec (Continuity) ..	OEM/PETE	Planning
GS-12/13	Emergency Management Spec (Training)	OEM/PETE	Planning
GS-12/13	Emergency Management Spec (Evaluator) ...	OEM/PETE	Planning
	VA Integrated Operations Center (IOC)		
GS-15	Director/(Supv.) VA IOC (FY 12)	OEM	IOC
GS-14	(Supv.) Readiness Operation Spec	OEM	IOC
GS-13	Readiness Operation Spec (Team Lead)	OEM	IOC
GS-9/11/12	Readiness Operation Spec	OEM	IOC
GS-9/11/12	Readiness Operation Spec	OEM	IOC
GS-9/11/12	Readiness Operation Spec	OEM	IOC
GS-9/11/12	Readiness Operation Spec	OEM	IOC
GS-9/11/12	Readiness Operation Spec	OEM	IOC
GS-9/11/12	Readiness Operation Spec	OEM	IOC
GS-9/11/12	Readiness Operation Spec	OEM	IOC
GS-12/13	Program Analyst		IOC
GS-12/13	Program Analyst	OEM	IOC
GS-12/13	Program Analyst	OEM	IOC
GS-12/13	Readiness Operations Specialist (National Operations Center Liaison).	OEM	IOC

Grade	TITLE	Organization	POSITION
	Operations & National Security		
GS-15	Director (Supv.) RO Spec	OEM	COOP/COG
GS-14	Emergency Management Spec	OEM	National Security
	Operations		
GS-14	Readiness Operation Spec (Site B Director)	OEM	COOP/COG
GS-13	Readiness Operation Spec (Deputy Director for Site B).	OEM	COOP/COG
GS-11	Readiness Operation Spec	OEM	COOP/COG
GS-9/11/12	Readiness Operations Spe	OEM	COOP/COG
GS-9/11/12	Readiness Operations Spec	OEM	COOP/COG
GS-12	Readiness Operation Spec. (Director Site C)	OEM	COOP/COG
	National Security Service		
GS-14	Special Security Officer	OEM	National Security
GS-13	Special Security Representative	OEM	National Security
GS-13	Special Security Representative	OEM	National Security
GS-13	Special Security Representative (ROS)	OEM	COOP/COG
	Personnel Security & Identity Management (PSIM)		
ES	Director, Personnel Security and Identity Management.	PSIM	PSIM
GS-12	Staff Assistant to Director	PSIM	PSIM
GS-15	Director, HSPD-12	PSIM	HSPD-12
GS-14	Deputy Director, HSPD-12	PSIM	HSPD-12
GS-13	Physical Security Specialist	PSIM	HSPD-12
GS-13	Program Analyst	PSIM	HSPD-12
GS-11	Director, PIV Office	PSIM	HSPD-12
GS-343-11	Program Analyst	PSIM	HSPD-12
GS-7	Program Specialist	PSIM	PIV Office
GS-7	Program Specialist	PSIM	PIV Office
GS-7	Program Specialist	PSIM	PIV Office
GS-7	Program Specialist	PSIM	PIV Office
GS-7	Program Specialist	PSIM	PIV Office
GS-7	Program Specialist	PSIM	PIV Office
GS-15	Director, Personnel Security and Suitability	PSIM	PSS
GS-14	Acting Director/Deputy Director, PSS	PSIM	PSS
GS-12/13	Security Specialist	PSIM	PSS
GS-12/13	Security Specialist	PSIM	PSS
GS-12	Security Specialist	PSIM	PSS
GS-12	Security Specialist	PSIM	PSS
GS-11	Security Specialist	PSIM	PSS
	Office of Security & Law Enforcement (OSLE)		
SES	Director for S&LE	OSLE	OSLE Lead
GS-13	Program Analyst	OSLE	Operations
GS-13	Administrative Officer	OSLE	Operations
GS-11	Staff Assistant	OSLE	Operations
GS-15	Director, Police Service	OSLE	Police Lead
GS-07	Program Support Assistant	OSLE	Operations
	LEO/Investigations		
GS-14	Chief	Oversight & Investigations	Lead
GS-13	Criminal Investigator	Oversight & Investigations	Crim Inv
....	Criminal Investigator	Oversight & Investigations	Crim Inv
GS-13	Criminal Investigator (Watch officer)	Oversight & Investigations	Crim Inv
GS-13	Criminal Investigator	Oversight & Investigations	Crim Inv
GS-13	Criminal Investigator	Oversight & Investigations	Crim Inv

Grade	TITLE	Organization	POSITION
GS-12/13	Criminal Investigator	Oversight & Investigations	Crim Inv

Intelligence & Crime Analysis

Grade	TITLE	Organization	POSITION
GS-14	Chief	Intell & Crime Analysis	Lead
GS-12/13	Criminal Investigator (Watch officer)	Intell & Crime Analysis	Crim Inv
GS-13	Criminal Investigator (Watch officer)	Intell & Crime Analysis	Crim Inv
GS-13	Criminal Investigator (Watch officer)	Intell & Crime Analysis	Crim Inv
GS-12/13	Criminal Investigator	Intell & Crime Analysis	Crim Inv

Executive Protection (EX Pro)

Grade	TITLE	Organization	POSITION
GS-14	Chief	Executive Protection	Lead
GS-13	Criminal Investigator	Executive Protection	EX Pro
GS-13	Criminal Investigator	Executive Protection	EX Pro
GS-13	Criminal Investigator	Executive Protection	EX Pro
GS-11	Criminal Investigator	Executive Protection	EX Pro
GS-13	Criminal Investigator	Executive Protection	EX Pro
GS-13	Criminal Investigator	Executive Protection	EX Pro
GS-12	Criminal Investigator	Executive Protection	Security
GS-12	Criminal Investigator	Executive Protection	Security
GS-12	Security Specialist	Executive Protection	EX Pro
GS-12	Security Specialist	Executive Protection	EX Pro
WL-9	Motor Vehicle Operator	Executive Protection	EX Pro

Infrastructure Security & Policy

Grade	TITLE	Organization	POSITION
GS-14	Chief	Policy & Infrastructure Protection ..	Lead
GS-13	Security Specialist	Policy & Infrastructure Protection ..	Security
GS-12	Security Specialist	Policy & Infrastructure Protection ..	Security
GS-12/13	Criminal Investigator	Policy & Infrastructure Protection ..	EX Pro

Identity, Credentials, and Access Management (ICAM)

Grade	TITLE	Organization	POSITION
ES	Director,ICAM	ICAM	ICAM
GS-11	Staff Assistant	ICAM	ICAM
GS-14	Administrative Officer	ICAM	ICAM
GS-12	Staff Assistant	ICAM	ICAM
GS-14	Program Analyst	ICAM	ICAM

Identity Management

Grade	TITLE	Organization	POSITION
GS-15	Director—Identity Management	Identity Mgt	Identity Mgt
GS-11	Staff Assistant	Identity Mgt	Identity Mgt
GS-14	Program Analyst	Identity Mgt	Identity Mgt
GS-14	Program Analyst	Identity Mgt	Identity Mgt
GS-11/12/13 ...	Program Analyst	Identity Mgt	Identity Mgt
GS-11/12/13 ...	Program Analyst	Identity Mgt	Identity Mgt
GS-7/9/11	Program Support	Identity Mgt	Identity Mgt
GS-7/9/11	Program Support	Identity Mgt	Identity Mgt

Access Management

Grade	TITLE	Organization	POSITION
GS-15	Director- Access Management	Access Mgt	Access Mgt
GS-11	Staff Assistant	Access Mgt	Access Mgt
GS-14	Program Analyst	Access Mgt	Access Mgt
GS-14	Program Analyst	Access Mgt	Access Mgt
GS-11/12/13 ...	Program Analyst	Access Mgt	Access Mgt
GS-11/12/13 ...	Program Analyst	Access Mgt	Access Mgt
GS-7/9/11	Program Support	Access Mgt	Access Mgt
GS-7/9/11	Program Support	Access Mgt	Access Mgt

On-Board/Monitor/Off-Board

Grade	TITLE	Organization	POSITION
GS-15	Director-On-Board/Off-Board	On-Board/Off-Board	On-Board/Off-Board

Grade	TITLE	Organization	POSITION
GS-11	Staff Assistant	On-Board/Off-Board	On-Board/Off-Board
GS-14	Program Analyst	On-Board/Off-Board	On-Board/Off-Board
GS-11/12/13 ...	Program Analyst	On-Board/Off-Board	On-Board/Off-Board
GS-7/9/11	Program Support	On-Board/Off-Board	On-Board/Off-Board

Question 112. For fiscal year 2014, the Office of Operations, Security, and Preparedness requests $10.6 million for Other Services. Please provide a specific itemized list of how these funds would be spent. To the extent any of these funds will be spent on contracts, please explain the nature of the contract and the expected outcomes.

Response. OSP uses contract support in the following areas: Department of Homeland Security/Federal Protective Service Contract Guards for the Government Services Administration leased spaces in the Capital Region ($3.2 million) and Program support for the Homeland Security Presidential Directive–12 (HSPD–12) program management office ($6 million). OSP also pays for support for Continuity of Operations sites and Continuity of Government sites, which are located outside of the National Capital Region ($750,000). OSP also has internal VA Service Level Agreements totaling $525,000 and some maintenance contracts.

Question 113. According to the fiscal year 2014 budget request, the Office of Operations, Security, and Preparedness now expects to spend $10.2 million on Other Services during fiscal year 2013, which is $6.2 million higher than the amount originally requested for fiscal year 2013 ($4.1 million).

A. Please explain what led to the expected increase in Other Services during fiscal year 2013.

Response. Beginning in FY 2013, OSP assumed overall management responsibility for the VA Personal Identity Verification (PIV) card program, which had previously resided in the Office of Information and Technology (OI&T). This increase in Other Services ($6.2 million) is a direct result of that action. OSP is funding that program utilizing reimbursable funding from the other Offices and Administrations.

B. Please provide an explanation of how these funds are expected to be expended during fiscal year 2013.

Response. These funds ($6.2 million) will be used for contract support at the 200+ PIV card issuing stations across the Department as well as in the Project Management Office at headquarters.

Question 114. According to the fiscal year 2014 budget request, the Office of Operations, Security, and Preparedness now expects to spend $1.8 million on supplies and materials in fiscal year 2013, which is $1.6 million higher than VA originally requested for fiscal year 2013.

A. Please explain what led to the expected increase in supplies and materials during fiscal year 2013.

Response. Beginning in FY 2013, OSP assumed overall management responsibility for the VA PIV card program, which had previously resided in OI&T. This increase in Supplies and Materials ($1.6 million) is a direct result of that action. OSP is funding that program utilizing reimbursable funding from the other Offices and Administrations.

B. Please provide an explanation of how these funds are expected to be expended during fiscal year 2013.

Response. This $1.6 million increase will be used to purchase consumable supplies for PIV card issuing stations across the agency. These supplies are mainly PIV card blanks that are centrally managed which are used to issue new or replacement cards to agency employees, contractors, and affiliates.

Office of Public and Intergovernmental Affairs

Question 115. For fiscal year 2014, the Office of Public and Intergovernmental Affairs requests total resources of $25.7 million and 101 employees. Please provide a list of the positions that would be filled with that funding and the pay-grades for those positions.

Office of Public and Intergovernmental Affairs

Central Staff Listing

Assistant Secretary	EX		Director, Digital Media	GS-15
Executive Director	ES		Program Specialist	GS-13
Special Assistant	GS-15		Public Affairs Specialist	GS-15
Executive Assistant	GS-14		Public Affairs Specialist	GS-11
Program Support Assistant	GS-11		Public Affairs Specialist	GS-11
Total	5		Public Affairs Specialist	GS-14
			Public Affairs Specialist	GS-12
Director, Resource Mgmt	GS-14		Public Affairs Specialist	GS-13
Staff Assistant	GS-12		Public Affairs Specialist	GS-11
Program Analyst	GS-12		Public Affairs Specialist	GS-11
Total	3		Audiovisual Specialist	GS-7
			Audiovisual Specialist	GS-5
Director, NVOO	GS-15		Total	12
Program Specialist	GS-14			
Public Affairs Specialist	GS-14		Presidential Innovation Fellow	1
Public Affairs Specialist	GS-14			
Total	4		Director, Media Relations	GS-15
			Deputy Director (SES)	GS-14
Director, NVSP&SE	GS-15		Public Affairs Specialist	GS-14
Deputy Director	Nurse V		Public Affairs Specialist	GS-14
Public Affairs Specialist	GS-14		Public Affairs Specialist	GS-13
Operations Officer	GS-14		Public Affairs Specialist	GS-14
Staff Assistant	GS-9		Public Affairs Specialist	GS-14
Program Specialist	GS-9		Public Affairs Specialist	GS-14
Total	6		Program Support Assistant	GS-7
			Public Affairs Specialist	GS-7
Director, Paralympic Program	GS-15		Total	12
Program Specialist	GS-13			
Total	2		Director, Field Operations	GS-15
			Deputy Director Field Operations	GS-14
DAS, IGA	ES		Total	2
Staff Assistant	GS-14			
Program Specialist	GS-14		Director, New York ROPA	GS-14
Program Analyst	GS-12		Public Affairs Specialist	GS-13
Program Support Assistant	GS-10		Public Affairs Specialist	GS-13
Executive Support Assistant	GS-9		Total	3
Total	6			
			Director, DC ROPA	GS-14
Director, Tribal Gov't	ES		Public Affairs Specialist	GS-13
Program Specialist	GS-14		Jr. Public Affairs Specialist	GS-12
Program Specialist	GS-14		Total	3
Program Specialist	GS-13			
Program Specialist	GS-13		Director, Atlanta ROPA	GS-14
Program Specialist	GS-13		Public Affairs Specialist	GS-13
Total	6		Program Support Assistant	GS-7
			Total	3
Director, NVIO	ES			
Deputy Director	GS-15		Director, Chicago ROPA	GS-14
Program Specialist	GS-15		Public Affairs Specialist	GS-13
Management Analyst	GS-14		Public Affairs Specialist	GS-11
Program Analyst	GS-14		Total	3
Program Analyst	GS-14			
Program Analyst	GS-14		Director, Denver ROPA	GS-14
Staff Assistant	GS-14		Public Affairs Specialist	GS-13
Program Analyst	GS-13		Public Affairs Specialist	GS-11
Program Specialist	GS-13		Total	3
Administrative Officer	GS-12			
Management Analyst	GS-12		Director, LA ROPA	GS-14
Program Support Assistant	GS-7		Public Affairs Specialist	GS-13
Program Support Assistant	GS-7		Public Affairs Specialist	GS-11
Total	14		Total	3
DAS, OPA	ES		Director, Dallas ROPA	GS-14
Senior Advisor	GS-15		Public Affairs Specialist	GS-13
Speechwriter	GS-15		Public Affairs Specialist	GS-11
Speechwriter	GS-15		Total	3
Speechwriter	GS-15			
Speechwriter	GS-14			
Press Secretary	GS-14			
Deputy Press Secretary	GS-13			
Program Support Assistant	GS-10			
Total	9		Grand Total	152

Question 116. For fiscal year 2014, the Office of Public and Intergovernmental Affairs requests $9.5 million for purposes of the Paralympics program.

A. During fiscal year 2013, how much is expected to be dispersed through this grant program, what percentage of those funds are expected to be used to pay the salary costs for employees of the U.S. Olympic Committee/U.S. Paralympics, and how much is expected to be spent on non-salary administrative costs by the U.S. Olympic Committee?

Response. For FY 2014, OPIA requests $9.5 million for purposes of the Paralympics program. During FY 2013, the Paralympic program is expected to disperse $7.5 million through the Paralympic grant, with 13 percent expected to be used to pay the salary costs for employees of the U.S. Olympic Committee/U.S. Paralympics, and no funds expected to be spent on non-salary administrative costs by the U.S. Olym-

pic Committee. The U.S. Olympic Committee does not intend to use Paralympic grant funds for the allowed 5 percent administrative costs and intends to use non-governmental sources of funding for non-salary administrative costs.

B. During fiscal year 2014, how much is expected to be dispersed through this grant program, what percentage of those funds are expected to be used to pay the salary costs for employees of the U.S. Olympic Committee/U.S. Paralympics, and how much is expected to be spent on non-salary administrative costs by the U.S. Olympic Committee?

Response. During FY 2014, the Paralympic program is expected to disperse $7.5 million through the Paralympic grant, with 13 percent expected to be used to pay the salary costs for employees of the U.S. Olympic Committee/U.S. Paralympics, and no funds expected to be spent on non-salary administrative costs by the U.S. Olympic Committee. The U.S. Olympic Committee does not intend to use Paralympic grant funds for the allowed 5 percent administrative costs and intends to use non-governmental sources of funding for non-salary administrative costs.

Question 117. According to the fiscal year 2014 budget request, the Office of Public and Intergovernmental Affairs now expects to spend $4.4 million on Other Services during fiscal year 2013, which is $2.9 million higher than the amount requested for fiscal year 2013 ($1.5 million), and that office requests $1.5 million for Other Services for fiscal year 2014.

A. Please explain what led to the expected increase in Other Services during fiscal year 2013.

Response. OPIA received $2.5 million to execute an outreach initiative known as "VA-Outreach." The goal of the initiative is to increase Veterans access to VA health care, benefits, and services.

B. Please provide an itemized list of how these funds are expected to be expended during fiscal year 2013 and fiscal year 2014. To the extent any of these funds will be spent on contracts, please explain the nature of the contract and the expected outcomes.

Response.

FY 2013 Other Services $4.4 million

Contracts/Name	Amount (Est.)	Description
VA Outreach Initiative	$2,500,000	The goal of the initiative is to increase Veterans access to VA health care, benefits, and services. "VA Outreach" is a national marketing and advertising outreach campaign with the goal of bringing new Veterans to VA.
Barbaricum LLC	$231,000	To establish, maintain and distribute a customized executive daily news summary.
Young & Rubicam Inc.	$166,000	Vendor to provide graphic design services, custom computer programming services and administrative and general management consulting services is support of VA's Executive Order 13175, Consultation and Coordination with Indian Tribal Governments.
Rhinegold	$965,000	HVIO will have a continuing need for outreach support in FY 14. That support will include purchasing paid internet advertising, developing and distributing public service announcements (PSAs), partner development and support, and distribution of materials promoting awareness and use of the National Call Center for Homeless Veterans (NCCHV), and other communications and public relations support in support of the effort to end homelessness among Veterans by 2015. Part of the effort on this contract serves the VHA Homeless Office.
VA History Office and Archives	$300,000	DVA seeks to establish an agency-wide VA History Office and Archives to preserve its heritage and material culture and to develop history outreach programs to benefit VA, Veterans, Congress and other stakeholders, and the American public.
Misc. Contracts	$250,000	Rent, Transit Subsidy, UPS Service, Service Level Agreements, Copier Maintenances
TOTAL	$4,412,000	

FY 2014 Other Services $1,506m

Contracts	Amount (Est.)	Description
Barbaricum LLC	$238,000	To establish, maintain and distribute a customized executive daily news summary.
Rhinegold	$965,000	HVIO will have a continuing need for outreach support in FY 14. That support will include purchasing paid internet advertising, developing and distributing public service announcements (PSAs), partner development and support, and distribution of materials promoting awareness and use of the National Call Center for Homeless Veterans (NCCHV), and other communications and public relations support in support of the effort to end homelessness among Veterans by 2015. Part of the effort on this contract serves the VHA Homeless Office.
Misc Contracts	$250,000	Rent, Transit Subsidy, UPS Service, Service Level Agreements, Copier Maintenances
TOTAL	$1,453,000	

Question 118. According to the fiscal year 2014 budget request, the Office of Public and Intergovernmental Affairs requests $462,000 for travel for fiscal year 2014. How many trips is that level of funding expected to support and what is the average expected cost per trip?

Response. OPIA's request of $462,000 for travel in FY 2014 is expected to support an estimation of 270 trips with an average estimation of $1,702.00 cost per trip.

Question 119. In response to a question for the record regarding the fiscal year 2013 budget request, VA provided the Committee with information on advertising outreach activities for 2009 through 2013. For the five-year period ending in 2013, VA reported spending $83.7 million. Please provide the Committee with updated amounts for 2013 and how much is expected to be spent on advertising in fiscal year 2014.

Response. In FY 2013, OPIA received $15 million from VHA to support media buys for regional advertising and the development of an outreach Web site prior to the start of the national Ad Council advertising campaign that will be launched in October 2013. OPIA also received approval for $2.5 million in FY 2012 carry-over funds to support creative advertising development, and social media advertising.

In FY 2014, the Ad Council campaign will be the lead advertising effort under OPIA. The budget for the campaign during FY 2014 is estimated at $1.3 million.

[Note: All three VA administrations maintain separate advertising and outreach budget data on their efforts conducted in FY 2013.]

Question 120. VA's response to prehearing questions for the fiscal year 2013 budget hearing stated that one of the missions of the National Veterans Outreach Office (NVO) was to "evaluate and develop metrics to measure the effectiveness of outreach programs."

A. Please describe the metrics that have been developed by NVO for the purposes of evaluating VA outreach activities.

Response. The metric established for outreach is new access to one or more of VA's programs. "Access" is defined as a Veteran, family member, or a Service-member who enrolls, registers, and/or uses one or more VA benefits and services. The access baseline is the number of unique individuals who accessed VA in FY 2012. "New access" is defined as an individual accessing VA in FY 2013 who was not found in any VA database in FY 2012. FY 2012 baseline data and FY 2013 access data are both extracted from VBA, VHA, NCA and VA's e-Benefits portal.

In order to track and measure VA access, a reporting process was established and approved by the VA Chief of Staff in December 2012. On a monthly basis, VHA, VBA, and NCA provide data within their respective areas of responsibility to the VA Office of Policy and Planning (OPP) to process and determine new clients accessing VA.

B. What metrics will VA use to determine whether programs are duplicative in nature? If that determination is made, what steps will be taken to change or terminate the outreach?

Response. NVO leadership and team members confer regularly with other VA Staff Offices and with all three VA Administrations to review the status of current programs and review proposals for new projects. Through this detailed process, potential for duplicity is identified and plans developed to ensure programs that may be duplicative in nature are not executed by NVO.

C. Have any outreach programs or campaigns been terminated early by VA because they have been deemed ineffective?

Response. Thus far, NVO has not terminated any outreach programs or campaigns due to ineffectiveness. All of NVO's outreach programs or campaigns have sufficient built-in flexibility to enable reinforcing efforts along a proven path of success and also have off-ramp capabilities to preclude following a path that is not producing the intended result(s) or effect(s).

D. How does VA evaluate whether veteran participation in services offered by VA is a result of outreach activities undertaken by VA?

Response. NVO presently uses the database tracking system discussed in Question 120 to determine how outreach is impacting new user access to VA benefits and services. Starting in October 2013, VA and the Ad Council are launching a national advertising campaign targeting Veterans and their families to increase their awareness and usage of all VA benefits, programs, and services. The campaign's messaging will direct the targeted audience to access a specially-created web page for more information about VA. Access to this web page will be tracked as one method of measuring the effectiveness of the advertising campaign.

Additionally, the Ad Council uses the leading monitoring, audience and valuation services available in the industry to capture the data pertaining to the markets where the public service announcements aired during the campaign. The donated media support will be monitored and reported to VA approximately two months after the close of each quarter across the following:

- Local broadcast, network cable, and local cable television
- Radio (traditional and streaming)
- Print (magazine and newspaper)
- Web banners
- Outdoor
- Public Relations

The Ad Council will also provide preliminary monthly reports to VA to assist with directional analysis. This information will include reports from:

- Local broadcast detections, dollar values, and specific placement
- Network cable detections and specific placement
- Banner placements and click-through rates

Office of Congressional and Legislative Affairs

Question 121. According to the 2012 PAR, during 2012 VA "[i]mproved relations with Congress by improving responsiveness and communicating more effectively."

A. Please explain the statistics or information that were the basis for this conclusion.

Response. The Office of Congressional and Legislative Affairs (OCLA) is responsible for maintaining open communications with Congress through briefings, meetings, office calls, hearings, site visits, written communications, reports, and responses to Congressional Member offices and Congressional Committee requests for information. OCLA also supports Congressional offices' Veterans constituent casework and is responsible for VA interaction with the U.S. Government Accountability Office (GAO). OCLA coordinates all VA-GAO meetings, correspondence, and reports.

During FY 2012, OCLA supported 72 congressional hearings (57% increase over FY 2011), coordinated 688 briefings (52% increase over FY 2011), responded to 1,404 questions for the record, processed over 19,703 constituent casework inquires, supported 43 GAO Entrance Conferences, 41 Exit Conferences (41% increase over FY 2011), 65 Draft Reports (35% increase over FY 2011), and 72 Final Reports (53% increase over FY 2011). FY 2012 was the first year OCLA measured the number of formal responses to requests for information. In FY 2012, OCLA responded to 2,750 congressional requests for information.

B. During fiscal year 2012, what was the average time it took to fulfill briefing requests by the Senate Committee on Veterans' Affairs?

Response. During FY 2012, OCLA coordinated 688 briefs to Members of Congress and staff. This was a 52 percent increase over the 454 briefs conducted in FY 2011. Briefs were coordinated based on the priority set by the requesting committee and the Department.

C. During fiscal year 2012, what was the average time it took to fulfill briefing requests by the House Committee on Veterans' Affairs?

Response. During FY 2012, OCLA coordinated 688 briefs to Members of Congress and staff. This was a 52 percent increase over the 454 briefs conducted in FY 2011. Briefs were coordinated based on the priority set by the requesting committee and the Department.

D. To date in fiscal year 2013, how many requests from the Senate or House Committees on Veterans' Affairs have gone unfulfilled for more than 2 weeks and for more than 4 weeks?

Response. During FY 2013, OCLA coordinated 999 briefings to Members of Congress, congressional committees, and staff. This was a 45 percent increase over FY 2012. The priority for briefings was set by the requesting Member or congressional committee, and the Department.

During FY 2013, OCLA developed and maintains a Workload Dashboard that identifies all of the congressional action items the office is currently working.

As of October 17, 2013, the OCLA Dashboard listed the following outstanding items:

- 133 Congressional Requests for Information
- 86 Executive Congressional Correspondence items addressed to the Secretary
- 732 Questions for the Record
- 17 Hearing Deliverables
- Additionally, OCLA is also working:
    - 427 Congressional Constituent Casework Inquires
    - 17 GAO actions
    - 20 Requests for Technical Assistance on Legislation
    - 35 Briefings within the next 30 days

The total current daily volume of work constitutes over 1,400 action items. Given this extensive volume of work, OCLA reviews and prioritizes its efforts to support both the Department and Congress. Unfortunately, with such a large workload, there will be items that will take longer to complete than we would like.

Question 122. For fiscal year 2014, the Office of Congressional and Legislative Affairs requests $6 million and 45 employees. Please provide a list of the positions that would be filled with that funding and the pay-grades for those positions.

Response. The 45 positions and their corresponding pay-grades are as follows:

Assistant Secretary	EX
Director Congressional Affairs	SES
Associate Deputy Assistant Secretary	SES
Director of Operations	GS-15
Director, Benefits Legislative Service	GS-15
Director, Health Legislative Service	GS-15
Director, Legislative Service	GS-15
Director, Corporate Enterprise Legislative Service	GS-15
Director, Congressional Reports and Correspondence	GS-15
Special Assistant	GS-15
Special Assistant	GS-15
2 Administrative Officers	GS-14
Executive Correspondence Analyst	GS-14
13 Congressional Relations Officers	GS-12/13/14
GAO Liaison Officer	GS-14
6 Program Analysts	GS-9/11
Assistant Director, Congressional Liaison Service	GS-14
Senior Congressional Liaison Representative	GS-13
Congressional Liaison Officer	GS-13
3 Congressional Liaison Representatives	GS-12
Staff Assistant	GS-11
3 Congressional Liaison Assistant	GS-7/8/9
Program Assistant	GS-8

Question 123. In connection with VA's fiscal year 2013 budget request, the Office of Congressional and Legislative Affairs outlined the measures and metrics used to evaluate the performance of that office.

A. In terms of those measures and metrics, please assess the performance of the Office of Congressional and Legislative Affairs during fiscal year 2012.

Response. During FY 2012 OCLA continued to carry out its Strategic Plan to "Enhance relationships with Congress by improving responsiveness and communicating more effectively" though a pro-active strategy designed to provide accurate, relevant, and timely information to Congress. OCLA also achieved full operational capability

of its congressional knowledge management system that provides a database to catalog the Department's congressional activities.

OCLA's workforce, of whom 50% are Veterans, accomplished the following in FY 2012:

- Supported 72 Hearings (57% increase over FY 2011)
- Coordinated 688 Briefings (52% increase over FY 2011)
- Coordinated responses to 1,404 Questions for the Record
- Responded to 2,750 Requests for Information (first year for this performance measure)
- Supported 57 Congressional oversight travel visits
- Supported 43 GAO Entrance Conferences
- Supported 41 GAO Exit Conferences (41% increase over FY 2011)
- Coordinated the Department's responses to 65 GAO Draft Reports (35% increase over FY 2011)
- Supported 72 GAO Final Reports (53% increase over FY 2011)
- Coordinated 19,703 Congressional Constituent Inquires
- Submitted 75% of questions for the record on time (Target goal was 85%)
- Submitted 88% of testimony on time (Target goal is 90%)
- Submitted 68% of Title 38 reports on time (Target goal is 85%)

B. In terms of those measures and metrics, what performance outcomes are expected during fiscal year 2013?

Response. OCLA achieved the following outcomes in FY 2013:

- Supported 62 Hearings
- Coordinated 999 Briefings (45% increase over FY 2012)
- Coordinated responses to 310 Questions for the Record
- Responded to 3,544 Requests for Information (29% increase over FY 2012—first year this performance measure was kept)
- Supported 63 Congressional oversight travel visits
- Supported 51 GAO Entrance Conferences (19% increase over FY 2012)
- Supported 36 GAO Exit Conferences
- Coordinated the Department's responses to 31 GAO Draft Reports
- Supported 35 GAO Final Reports
- Coordinated 24,949 Congressional Constituent Inquires (27% increase over FY 2012)
- Submitted 13% of questions for the record on time (Target goal was 85%)
- Submitted 75% of testimony on time (Target goal is 90%)
- Submitted 24% of Title 38 reports on time (Target goal is 85%)

C. In terms of those measures and metrics, what performance outcomes are expected during fiscal year 2014 if the requested level of funding is provided?

Response. OCLA will continue to advance responsive and effective congressional communications (i.e., proactive approach to briefings, meetings, hearings, site visits, and constituent service) to increase the information exchanged regarding the Department of Veterans Affairs among Members of Congress and staff.

If the requested level of funding is provided, OCLA would look to efficiencies, technology, and effective prioritization to maintain its level of performance and achieve the following outcomes in FY 2014:

- 100% Support of all Hearings set by Congress
- Conduct approximately 700 Briefings
- Respond to approximately 1,200 Questions for the Record
- Respond to approximately 3,750 Requests for Information
- Support 59 Congressional oversight travel visits
- Support approximately 60 GAO Entrance Conferences
- Support approximately 20 GAO Exit Conferences
- Coordinate the Department's response to approximately 60 GAO Draft Reports
- Support approximately 25 GAO Final Reports
- Coordinate approximately 19,000 Congressional Constituent Inquires
- OCLA would strive to meet its target goals of:
  - 90% Percentage of questions for the record submitted on time
  - 90% Percentage of testimony submitted on time
  - 85% Percentage of Title 38 reports submitted on time

Office of Acquisition, Logistics, and Construction

Question 124. In response to questions about the fiscal year 2013 budget request, VA indicated that the Office of Acquisition, Logistics, and Construction planned to spend $5 million during fiscal year 2013 on an "Acquisition Improvement Initiative," which was described as developing the acquisition workforce.

A. How much has VA expended on that initiative to date?

Response. VA has spent $3,979,384 on the Acquisition Improvement Initiative as of August 31, 2013, and is spending an additional $916,000 in September 2013, for a total of $4,895,384.

B. Please describe this initiative in more detail and outline any measureable outcomes that have resulted from this initiative.

Response. The Office of Acquisition, Logistics and Construction (OALC) is committed to continuing the improvement of the acquisition process. To ensure that these improvements are sustainable, OALC embarked on an aggressive path to increase the capacity and capability of the acquisition workforce. OALC has begun to increase the size of the acquisition workforce and improve the training of all employees that have a significant impact to the process, to include the Major Construction and Leasing Program Managers and Resident Engineers.

OALC increased the capacity of the acquisition workforce supporting major construction and leasing by hiring 19 contracting officers since fiscal year (FY) 2012. This represents an 80 percent increase in contracting expertise. OALC has also invested in training and technology to ensure sustained improvement. The legacy program management software is currently being replaced by a state-of-the-art system and nationwide training is ongoing. OALC has also invested in additional program management and coaching focused on the acquisition process. The table below details the distribution of the Acquisition Improvement Initiative funds:

Program Management Software Services (TRIRIGA)	$2,310,000
Program Management and Coaching Training	$1,185,384
Salary & Benefits	$1,425,000
	$4,920,384

Question 125. For fiscal year 2014, the Office of Acquisition, Logistics, and Construction requests total resources of $87 million and 492 employees, an increase of 146 FTE over the fiscal year 2012 level.

A. Please provide a list of the positions added since fiscal year 2012.
Response.

Proposed Positions Over the FY 2012 Level

Resident Engineers	42
Project Managers/Program Managers	34
Realty Specialists	3
Planners	18
Contracting Specialists	23
Architect/Engineers	3
Management Support	23
Total	146

B. Have those positions been and will those positions generally be filled through hiring new employees or transferring employees from other VA offices?
Response.

Actual Hired Positions

Resident Engineers	20
Planners	4
Contracting Specialists	19
Total	43

To date, 43 positions have been hired with 77 percent of the positions being new hires from outside VA. The majority of the 106 open positions are currently projected to be filled from outside VA.

Question 126. According to the fiscal year 2014 budget request, the Office Acquisition, Logistics, and Construction now expects to spend $19.6 million on Other Services during fiscal year 2013, which is $5.7 million higher than the amount requested

for fiscal year 2013 ($13.9 million), and that office requests $7 million for Other Services for fiscal year 2014.

A. Please explain what led to the expected increase in Other Services during fiscal year 2013.

Response. Updated hiring plans reduced the requirement for personal services funds in FY 2013. $5.6 million from personal services was moved to other services and is targeted for contract needs. In FY 2014, hiring is expected to reach planned levels, and other services funding will decrease proportionately. Due to delays in hiring, OALC will pursue contracts to support efforts of the Construction Review Council (CRC) and other improvements to address issues noted in the GAO report, GAO–13–556T.

B. Please provide an itemized list of how these funds are expected to be expended during fiscal year 2013 and fiscal year 2014. To the extent any of these funds will be spent on contracts, please explain the nature of the contract and the expected outcomes.

Response. See charts below.

Q. 126.B. ITEMIZED LIST OF OTHER SERVICE EXPENDITURES FOR FY 2013 AND FY 2014 - OALC/CFM			
Revised 9-10-13.			
FY 2013	FY 2014	Description	Comments
$384,050	$397,607	DHS security services	Security costs for GSA rented space.
$1,009,373	$704,000	Permanent change of station expenses.	Shipment of household goods.
$19,625	$50,000	Recurring maintenance & repair	Recurring maintenance & repair.
$149,091	$378,000	Training	Employee development.
$3,395,048	$3,148,220	Historic Preservation obligations	Historic Preservation related obligations.
$2,000	$10,000	UPS	United Parcel Service obligations.
$4,658	$5,000	Financial Disclosure	OALC/CFM's portion of VA's finanancial disclosure obligation.
$121,000	$121,000	HCIP	Human Capital Investment Program reimbursement.
$40,000	$0	BIRT Report Writer Support for TRIREGA	Training and support for the BIRT Report Writing language, specifically the creation of BIRT reports in IBM's TRIRIGA Capital Asset Management Module.
$265,000	$0	Training Developer Scripting	Web based training content and platform development to make fiscal concepts/processes accessable to field staff.
$5,610	$8,676	PIV	Personal Identify Verification Card reimbursement.
$170,000	$170,000	NIBS	FY 2013 NIBS membership cost and sponsorship of buildingSMART Alliance.
$332,000	$384,000	Financial Service Center MOU	Memo of Understanding between VA centralized accounting and finance center and CFM for necessary support.
$627,199	$300,000	Interagency Agreement Historic American Buildings Survey (HABS)	Documentation of VA's most significant historic properties, National Historic Landmarks, in compliance with Section 110 of the National Historic Preservation Act to document the official Historic American Building and Landscape Surveys submitted to the Library of Congress.
$285,255	$300,000	Technical Writer contract	Develop complex and highly specific technical Performance Work Statements (PWS) for firm, fixed-price, post-production support on an existing Government Off The Shelf product; provide technical draft & editorial capability to document CFM fiscal, and operational processes.
$218,000	$218,000	Competency contract	Contract to continue development of competencies which are general to Construction Management and apply to all roles and positions.
$30,000	$30,000	Federal Facilities Council (FFC)	National Academy of Sciences contract in support of FFC activities to identify advancing technologies, processes, and management practices to improve the planning, design, construction, management, operation & evaluation of federal facilities.
$570,758	$623,600	US Army Corps Engineers IAA	The Army Corps of Engineers was engaged to provide second look at the Orlando Medical Center construction project. Tasks included schedule analysis and a cost to complete study. VA used the results of these tasks to establish risks and options for the Orlando facility.
$441,802	$175,000	FOIA Contracts	Freedom Of Information Act processing support.
$887,900	$887,000	Integrated Master Schedule	Integrated master schedule development and implementation.
$1,185,384	$238,000	CFM Coaching contract	Develop coaching and education for CFM's construction project managers to be more effective leaders in the construction project team. The expected outcome is increased team communications and better team work environments leading to facilities delivered on time and within budget.
$43,773	$69,610	Miscellaneous	Multiple small contracts for less than $10,000 each.
$121,000	$124,000	Human Capital Investment Plan Reimbursement.	Reimbursement for HRA services to CFM for support of recruitment, hiring and employee development training programs.
$35,000	$35,000	LYNX Photo Management	Secure construction photo management software support annual renewal.

FY 2013	FY 2014	Description	Comments
$29,364	$29,364	Cost Distribution for Office of Human Resources	Reimbursement for cost distribution for Office of Human Resources.
$50,000	$0	Pershing Hall contract	Evaluate the location of the Pershing Hall artifacts and collections and determine the condition and make recommendations on future curation needs. This will bring VA into compliance with federal historic preservation laws and regulations.
$200,000	$200,000	GSA Support to Construction Excellence Peer Review	GSA Support for Construction Excellence Peer Review.
$30,103	$31,434	Defense Finance & Accounting Service (DFAS)	Interagency agreement to process VA and CFM payroll.
$96,346	$302,000	OALC Front Office	Mission support service contract(s).
$650,189	$882,000	Plans & Programs Construction Review Council (CRC) and Program Management (PM) Support contracts	This effort will provide support to CFM in the implementation and reporting of the capital program improvement plan. The contract will provide support documentation and tracking of improvements in the construction process.
$161,096	$161,096	Electronic Librarian	Senior Library Expert to plan, design, deploy, and manage electronic library systems for multiple users.
$1,292,202	$1,300,000	Performance Metrics	Professional consultant services to update Performance Measurements and to automate the data collection and reporting systems.
$110,000	$110,000	Customer Satisfaction Survey	Development of customer satifisfaction survey and analysis of results.
$2,304,911	$485,000	Construction Project Management - TRIRIGA	This effort continues the sustainment of the TRIRIGA software for construction management. The software will provide a collaborative construction management tool for VA. The utilization of this product will improve contract administration and project oversight.
$834,745	$1,000,000	Corporate and Regional Matrixed Budget System (CRMBS) Post Production Support contract	Provide post-production support on an existing Government-Off-The-Shelf product to include bug-fixes, security updates, routine maintenance and updates to ensure compliance with US Congress Rehabilitation Act to make their electronic and information technology accessible to people with disabilities.
	$1,000,000	Resource Management System (RMS) Software as a Service (SaaS)	Replacement to CFM's Corporate and Regional Budget Matrix System (CRMBS). This system coordinates funding w/ procurement requests, it manages many different types of funding, hierarchical approvals and stores support documentation.
$491,488	$1,898,000	VA Facilities Management School MOU	Memorandum of Understanding (MOU) with the Department of Veterans Affairs Acquisition Academy (VAAA), to develop multi-modal delivery of comprehensive curricula of educational programs and courses relevant to VA's infrastructure and the total healthcare environment.
$72,392	$73,000	Seismic Instrumentation Maintenance IAA	Services supplied by US Geological Survey (USGS) to provide digital seismic recording instrumentation for buildings located in high and very high seismic hazard regions. USGS will provide instrumentation layouts for performing sensor system installations and will manage the acquired data from each structure. The resulting building instrumentation and acquired data will be integrated into the USGS Advanced National Seismic System.
$190,000	$215,000	Advisory Council Historic Preservation Liaison	Renewal of Interagency Agreement to provide dedicated support to VA on complex and controversial historic preservation issues.
$427,799	$627,000	General Counsel MOU	Cost to reimburse GC for staff.
$400,000	$400,000	OIG Software Costs	Cost to reimburse OIG for software.
$17,684,161	$17,090,607		

Note: $2M in budget authority non pay was redirected to other Department level priorities. Unused reimbursements will be returned to the customer offices.

Question 127. According to the 2012 PAR, in April 2012 VA established a Construction Review Council (CRC). The stated purpose of the CRC is to "oversee the Department's development and execution of its real property capital asset programs." The PAR also notes that VA has started "initiatives to advance the timely delivery of first-rate facilities."

A. Please provide a list of the members of the CRC, including their positions and for which VA agency or department they work. If a member of the CRC is not an employee of VA, please include the agency, Cabinet level department, company, or association for which they work.

Response. The following positions are members of the CRC and are VA employees:

• Secretary, Department of Veterans Affairs
• Deputy Secretary, Department of Veterans Affairs
• Under Secretary of Health
• Under Secretary of Memorial Affairs
• Under Secretary of Benefits
• Principal Executive Director, Office of Acquisitions, Logistics and Construction (OALC)
• Executive Director, Construction and Facilities Management
• Assistant Secretary for Management
• Director, Office of Asset and Enterprise Management
• Assistant Secretary for Human Resources and Administration
• Assistant Secretary for Information Technology
• Assistant Secretary for Policy and Planning
• Assistant Secretary for Congressional and Legislative Affairs
• General Counsel
• Assistant Deputy Under Secretary for Health for Policy and Planning, Veterans Health Administration
• The relevant Veterans Integrated Service Network and VA medical center Directors as well as relevant construction program executives and senior resident engineers will participate as required.

B. What is the duration of the CRC, and for how long do the members of the CRC serve?

Response. The CRC does not have a termination date. Members on the Council are by position; therefore, the incumbent will serve on the panel.

C. Please describe, in detail, the initiatives (referenced above) VA has undertaken to improve or "advance timely delivery of first-rate facilities to better serve our Nation's veterans."

Response. The CRC defined four areas of concentration in order to advance timely delivery of first-rate facilities to better serve our Nation's Veterans. They are:

• Requirements—Adequately develop requirements during the planning process of a construction project.
• Design—Improve design quality to minimize added costs and/or delays during construction.
• Budget—Effectively coordinate design, construction and activation costs
• Project Management—Streamline program management and automation enterprise-wide tools.

The OALC initiatives to address these areas include:

• Develop policy to align with the Strategic Capital Investment Planning (SCIP) process and the move to a 35 percent design, to adequately develop requirements before requesting major construction funding.
• Examine the current peer review process, adequacy of current design guide, errors and omission rates, and guide specifications, to ensure all are current and effective, increase quality of the design, and allow fewer changes during construction.
• Establish mechanisms, such as activations funding, to coordinate the various funding streams required for major construction, to ensure funding for medical equipment and Office of Information and Technology equipment, to support the construction schedule.
• Field the construction project management software package (TRIRIGA) across the enterprise.

Question 128. The 2012 PAR indicates that VA has seen a "cost savings or avoidance" of $82 million through selling property, space management, and other initiatives. It also notes that VA has reduced its vacant buildings by 23 percent over the last five years.

A. As of the start of fiscal year 2013, how many vacant or underutilized properties does VA have in its inventory? Please break this out by building or property type (hospital, clinic, office building, etc.).

Response. At the end of FY 2012/beginning of FY 2013, VA had approximately 974 vacant or underutilized buildings, of which 418 (43%) were historic buildings. Of the 974, approximately 228 were vacant and 746 were underutilized.

The 974 buildings account for approximately 10.5 million Square Feet (SF) of space in vacant or underutilized buildings. Of that total, 4.1 million SF is located in vacant buildings and 6.4 million SF is located in underutilized buildings.

End of FY 2012 Vacant/Underutilized Buildings

Usage Type	# Vacant Buildings	Sq Ft Vacant Buildings	# Underutilized Buildings	Sq Ft Underutilized Buildings	Total # Buildings	Total Sq Ft
Dormitories/Barracks	2	110,200	0	0	2	110,200
Hospital	14	1,315,299	32	706,071	46	2,021,370
Housing	58	294,004	52	233,414	110	527,418
Industrial	2	2,278	57	243,619	59	245,897
Laboratories	1	133,730	10	223,307	11	357,037
Office	26	469,980	89	1,137,132	115	1,607,112
Other Institutional Uses	8	168,282	56	823,400	64	991,682
Outpatient Health care Facility	1	74,551	3	22,319	4	96,870
Service	16	145,115	193	1,342,195	209	1,487,310
Warehouses (Storage/Sheds)	21	177,237	143	787,358	164	964,595
All Other	79	1,186,290	111	859,117	190	2,045,407
Grand Total	228	4,076,966	746	6,377,932	974	10,454,898

B. In fiscal year 2014, how many vacant or underutilized properties does VA expect to have in its inventory? Please break this out by building or property type (hospital, clinic, office building, etc.).

Response. VA projects it will have approximately 941 vacant or underutilized buildings at the end of FY 2013/beginning of FY 2014. Of the 941, approximately 206 would be considered vacant and 735 underutilized. In terms of SF, there will be 3.8 million SF in vacant buildings and 6.2 million SF in underutilized buildings, for a total of 10.0 million SF in the portfolio.

The reduction in vacant and underutilized buildings from end of FY 2012 is the result of disposing of un-needed assets;, however, there are challenges in further reducing VA inventory in this area. Of the projected 941 vacant or underutilized assets, 409 (44%) are considered historic buildings, limiting VA's ability to dispose or reuse these assets in many cases.

Competing stakeholder interests in some of these vacant or underutilized assets also has hampered disposal or reuse efforts. VA is looking at further opportunities to reduce our vacant and underutilized footprint, as mentioned earlier. Having tools in place, such as a fully restored Enhanced-Use Lease (EUL) authority or Civilian Property Realignment Act (CPRA), as proposed by the President of the United States, would help overcome some of these challenges and allow VA to more effectively reduce its inventory of vacant and underutilized assets.

Projected End of FY 2013 Vacant/Underutilized Buildings

Usage Type	# Vacant Buildings	Sq Ft Vacant Buildings	# Underutilized Buildings	Sq Ft Underutilized Buildings	Total # Buildings	Total Sq Ft
Dormitories/Barracks	1	85,000	0	0	1	85,000
Hospital	14	1,315,299	32	706,071	46	2,021,370
Housing	55	283,430	52	233,414	107	516,844
Industrial	1	555	56	241,019	57	241,574
Laboratories	1	133,730	8	213,034	9	346,764
Office	22	424,172	89	1,137,132	111	1,561,304
Other Institutional Uses	6	163,892	55	719,161	61	883,053
Outpatient Health care Facility	1	74,551	3	22,319	4	96,870
Service	15	129,055	190	1,309,696	205	1,438,751
Warehouses (Storage/Sheds)	17	166,571	139	780,740	156	947,311
All Other	73	1,050,377	111	859,117	184	1,909,494
Grand Total	206	3,826,632	735	6,221,703	941	10,048,335

C. For each of fiscal years 2012, 2013, and 2014, how much has VA spent or does VA expect to spend on maintenance of vacant or underutilized property?

Response. VA does not track actual costs at the building level; however it does use a proration methodology to report building level costs to the Federal Real Property Profile (FRPP) annually. For FY 2012, VA estimates it spent approximately $23.4 million on the 974 vacant and underutilized assets in its portfolio. A further breakdown of those costs is an estimated $6 million on the 228 vacant buildings and $17 million on the 746 underutilized assets.

The average cost for vacant buildings is $1.48/SF and is consistent with previous estimates on maintaining vacant assets. Underutilized buildings are still in use, therefore incur greater operating expenses than a purely vacant building. The average cost for maintaining underutilized buildings is $2.72/SF

The average cost per SF to maintain a vacant or underutilized building would likely remain constant over the next several years. Given current disposal plans, the overall estimated cost to operate vacant and underutilized buildings would range from $22 to $24 million annually in FY 2013 and FY 2014.

Question 129. Public Law 111–82 authorized VA to enter into leases for seven Health Care Centers (HCCs). The law provided $150 million to cover the startup costs and the first year's rent; however, VA has only obligated $40 million for construction costs.

A. How much in total will be needed to construct theses HCCs and when will they start treating veterans? Please breakdown this funding by individual HCC.

Response. VA obligates the build-out funds and first year's rent upon contract award. To date, four of the seven HCCs have been awarded and approximately $52.7 million has been obligated. Please see the table below for specific amounts related to each project. VA's request for authorization and actual costs expended are linked to the medical build-out requirements along with the rent payments, not necessarily the developer's cost to construct the facility. Please see below for a breakout of each HCC and anticipated or actual costs, which are dependent on the contract award (projects highlighted in gray have been awarded). Also included for each clinic is the anticipated date for first patient day.

	Butler, PA	Charlotte, NC	Fayetteville, NC	Loma Linda, CA	Monterey, CA	Montgomery, AL	Winston-Salem, NC
Annual Lease Cost—							
Year 1($)	5,755,683	14,232,000	7,662,113	16,249,000	6,183,000	3,723,855	10,986,664
Build-Out($)	2,813,953	16,225,000	8,936,545	14,905,000	5,445,000	3,214,237	9,604,089
Size (in net usable square feet)	168,000	295,000	259,600	271,000	99,000	111,407	280,000
Date of Contract Award (Planned(P) & Actual(A))	May-12(A)	Aug-13(P)	Sep-12(A)	Aug-13(P)	Aug-13(P)	May-13(A)	May-13(A)
Anticipated Date to Start Treating Veterans	TBD*	Jan-16	Aug-15	Feb-16	Jan-16	Nov-15	Nov-15

*VA's Office of the Inspector General (OIG) completed an investigation of Westar and its related companies and principals and found that Westar made fraudulent misrepresentations in its offer during the procurement process. Due to these findings, VA issued a stop work order on June 21, 2013, and a ''Show Cause'' letter to Westar on July 12, 2013. The lease was terminated for default effective as of August 9, 2013. VA reopened the Butler HCC lease procurement on September 30, 2013, and expects a new lease award by May 2014.

B. What is VA doing to track costs of the HCCs to ensure there is effective management of and supervision over the HCC leasing project?

Response. VA's lease acquisition process utilized on the HCCs follows a number of methods to ensure effective cost management. Leases adhere to the Competition in Contracting Act to ensure that maximum competition is pursued, which yields the most competitive pricing possible on each contract. Each lease is conducted as a "best-value" procurement, meaning that both price and technical factors are evaluated and weighed prior to VA making the final award determination. In order to track and manage funds expended on the HCCs, VA is maintaining clear, consistent contract files that include spreadsheets of all obligations pertaining to each project. Each project is effectively managed by an acquisition team that includes a Real Estate Project Manager and Contracting Officer from OALC; representatives from leadership and engineering at the parent VA medical centers, and, as needed, technical support from architect and engineer firms and legal support from VA's Office of General Counsel. VA also assigns two to three resident engineers for each of the HCCs to oversee the project during the post-award design and construction phases, to ensure that the contract is executed in a quality and timely manner.

Question 130. The 2012 PAR highlights the Warrior to Workforce Program implemented by the Office of Acquisition, Logistics, and Construction. The Warrior to Workforce Program is a three-year pilot program that trains service-connected disabled veterans to become contract specialists.

A. What metrics will VA use to determine if this program will be expanded beyond the three-year pilot?

Response. The Warriors to Workforce (W2W) program has garnered positive recognition for the great benefits derived by both the Veterans in the program as well as VA. The W2W program has earned both the Secretary's Award and the Chief Acquisition Officer's Council Award, for its innovative approach to training wounded Veterans. Many metrics have been collected and evaluated; below are some of the more meaningful outcomes:

• 100 percent completion of the positive education requirement for the 1102 series; average college business course grade point average was 3.7 (4.0 scale) (Targeted metric was 95 percent). Peak performance training resulted in 154 percent improvement in attention; 58 percent brain speed improvement for working memory; 32 percent improvement on short term memory recall, and many other notable achievements (Targeted metric was >30 percent improvement).

• 22 percent of the cohort will receive a Bachelor's of Science in Business by May 2013; 65 percent of the cohort will receive a Bachelor's degree within the next year.

• VA acquisition organizations have embraced the W2W program which is demonstrated by an overwhelming willingness to host a W2W intern during their first on-the-job training period (which falls within the 2-year Acquisition Intern Program).

Additionally, the VA Acquisition Academy (VAAA) established a continuous improvement process for the W2W program to measure learning, validate program effectiveness and incorporate lessons learned. VAAA monitors 28 key program metrics to assess program success and measurable benefit to the organization. Notable metrics demonstrating results include:

• W2W intern retention is 96 percent, as of May 14, 2013, compared to 90 percent retention for the overall VA acquisition workforce (Targeted metric was >80 percent).

• W2W courses rate 4.3 out of 5.0 for overall effectiveness (Targeted metric was 4.0 on a Lickert scale).

• Interns receive an average of 96 percent on course exams for the Federal Acquisition Certification in Contracting (Targeted metric was >80 percent).

• 100 percent of interns received at least 95 percent "Acceptable" and "Mastery" ratings for performance in training activities (Targeted metric was >90 percent).

The W2W Program has a broad reaching impact on groups including the wounded Veteran participants and their families, Federal acquisition organizations and America's Veteran population. The specific short and long-term impacts, including lasting effects, on each of these groups are outlined below:

• The Veteran participant and their families:
  • Are provided a long-term professional career with valuable skills (Peak Performance Training) that will benefit them professionally and personally; and
  • Obtain a sense of purpose, pride, esteem, and stability to be passed on to spouses and children.

• The Federal Acquisition Organizations:
  • Receive an influx of well-rounded professionals ready to hit the ground running; and
  • Benefit from succession planning efforts to supply a pipeline of acquisition professionals for VA and other government agencies.

• America's Veterans:
  • Receive world-class service by expertly training acquisition professionals who understand Veteran needs and issues; and
  • Are provided increased career opportunities through expanded programs for Veteran development.

As a result of the positive results from the completion of the W2W program year one and the previously demonstrated success and metrics of the 2-year Acquisition Intern Program (AIP), OALC intends to launch additional intern cohorts as outlined in questions 2 and 3 below. The intention is to expand participation by other executive agencies (NOTE: GSA participated in the pilot program). Additionally, OALC is piloting a W2W cohort focused on a program management career track. This cohort, launched in January 2013, and sponsored and funded by VA's Office of Infor-

mation and Technology, uses the same successful program design and focuses on the competencies required to become a program manager.

B. How much is expected to be spent on the Warrior to Workforce Program for fiscal year 2014?

Response. Our budget forecasts $2.2 million for FY 2014; which includes one acquisition-focused, and one program management-focused cohort, for a total of 48 W2W participants in the program for FY 2014. The funding covers staff cost, participants on-the-job training, curriculum delivery, contractual services, and administrative costs (supplies, printing, reproduction, materials, and equipment).

Cost effectiveness is central to the design and delivery of the W2W program. Some examples include:

• Participants utilize their Veteran benefits to fund the college courses received in the program, resulting in a significant cost savings for their training during program year one.

• The program utilizes existing online courseware to supplement the interns' development at no additional cost.

• The program provides a supplement to existing proven career development programs (such as the VA Acquisition Internship School's Acquisition Intern Program for the inaugural W2W cohort).

C. Please describe the program in detail, including the number of veterans currently in or who have completed the program, the courses the veterans take, and any internships required.

Response. Twenty-eight interns have completed their first year and have moved into the AIP. There are 20 interns currently in the first year of the program management career track. OALC anticipates hiring another acquisition W2W cohort in FY 2014, and is in discussions with VA's Office of Information and Technology, to sponsor another FY 2014 program management cohort. Implementation of these additional acquisition and program management cohorts would train an additional 48 Veterans.

VA launched the W2W program on December 5, 2011, to integrate wounded Veterans into the acquisition workforce and uphold President Lincoln's promise, "to care for him who shall have borne the battle, and for his widow, and his orphan" by serving and honoring the men and women who are America's Veterans. The mission of the program, supporting Executive Order 13518—Employment of Veterans, is to assist in the reintegration of wounded Veterans by preparing them for a career as a Contract Specialist (GS–1102) or as a Program Manager (GS–0343). As President Obama said in his address to Congress and the Nation, "We ask these men and women to leave their careers, leave their families, and risk their lives to fight for our country. The last thing they should have to do is fight for a job when they come home." Ideal candidates are Veterans who have: (1) service-connected disabilities and (2) little or no post high school education. The W2W program addresses both the employment challenges facing wounded Veterans and the workforce development challenges of the acquisition community. The program design allows for participation from other government agencies.

The W2W program took an innovative approach to hiring the wounded Veterans (including one GSA participant). The program utilizes the Veteran's Recruitment Authority to access and target Veterans most in need of career and development opportunities. VAAA also collaborated with VA Veterans Employment Coordination Service and Vocational Rehabilitation and Employment Program, DOD Wounded Warrior Transition Programs and Veterans Service Organizations in identifying wounded Veteran candidates.

The W2W program is a 3-year holistic training program providing Veterans an opportunity to apply military experiences and skills to the contract specialist career field. In the program;'s first year, participants receive academic education, peak performance training, an introduction to acquisition or project/program management, and participate in mission service activities. Upon successful completion, participants transition to the 2-year Acquisition Intern or Program Management Fellows Programs.

College Coursework, Foundational Curriculum, And Peak Performance Training	Acquisition Intern Program Curriculum
	PM Fellows Program Curriculum

YEAR 1
(10-11 Months)   **YEARS 2 & 3**
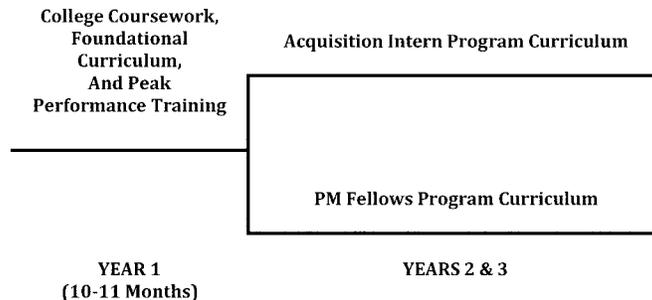
The initial year consists of 4 main components: Business Education, Foundational Curriculum, Peak Performance Training, and Mission Service. The purpose of these components is to build on the skill sets imparted by the military, and prepare the W2W interns for either the 2-year AIP, or the 2-year Program Management Fellows Program.

Business Education consists of accredited college-level courses to prepare the interns for either the contracting or project/program management career. The Foundational training consists of introductory technical courses to introduce the interns to the technical specialty of the career field and to prepare them in other office fundamentals (including Microsoft Office applications and essential business competencies). The Peak Performance training consists of highly intensive, customized workshops and one-on-one sessions with training coaches focused on mental and physiological conditioning to perform at peak levels under pressure and stress. The Mission Service component is designed to give the interns a chance to participate in efforts to serve Veterans and gain a better understanding of VA's mission, vision, and core values.

The courses within the Business Education component vary slightly by the participant's track (acquisitions or project/program management):

Acquisition

(Business curriculum targeted to meet the positive education requirements of the 1102 career field):
- Business Writing
- Business Mathematics
- Introduction to Business and Decision-Making
- Computer Applications for Business
- Accounting Principles I
- Business Management and Organization
- Accounting Principles II
- Corporate Finance I
- Business Law I
- Business Communications: Written and Oral

Project/Program Management (PM)

(Combination of Business and Information Technology curriculum):
- Business Writing
- Business Mathematics
- Computer Applications for Business
- Computer Programming I
- Information Systems
- Operating Environments
- Intro to Business Decision Making
- Principles of Accounting I
- Data base Design
- Business Law
- Systems Analysis and Design
- Corporate Finance

Interns also have over 200 online courses to complete during the first year as foundational curriculum in many topic areas including technical and business competency, and computer skills. Examples of foundational curriculum experienced by W2W acquisition interns include: Negotiation Essentials, VA Contract Security, Performance Based Services Acquisition, Simplified Acquisition Procedures, Overview of

Acquisition Ethics, Influencing Key Decision Makers, Getting Started with Microsoft Word, Moving and Getting Around in Excel, Interpersonal Communications, Workplace Conflict, Business Etiquette and Customer Interactions. Examples of foundational curriculum experienced by W2W program management interns include: Introduction to Project Management Using Project, Monitoring Schedule, Building a Schedule with Project, Communicating Project Information with Project, Influencing Key Decision Makers, Getting Started with Microsoft Word, Moving and Getting Around in Excel, Interpersonal Communications, Workplace Conflict, Business Etiquette and Customer Interactions.

Interns also participate in Peak Performance training that strengthens key mental skills (e.g., Goal Setting, Stress-Energy Management) to assist with challenges associated with Post Traumatic Stress Disorder and Traumatic Brain Injury. This approach boosts their attention, memory, flexibility, and problem solving to perform at a peak level under pressure and stress.

The final component is Mission Service. The interns plan and participate in a wide range of Mission Service activities throughout the program in an effort to gain a better understanding of VA's mission, vision, and core values. Mission Service activities expose the interns to the Veteran community through hands-on experience with VA services and fellow Veterans. Interns take an active role in selecting and coordinating Mission Service activities, providing a valuable opportunity for development of teamwork and leadership skills.

The interns are hired as a GS–5 for their transition year, and placed on a career ladder to GS–11. Interns in both the Acquisition track and the Project/Program Management track complete the transition year and move into their respective 2-year technical training. The technical training delivers the training and experience for either the Federal Acquisition Certification—Contracting or the Federal Acquisition Certification—Project/Program Management.

The main goal of the W2W program is to transition the Veteran into the business workplace and to provide training leading to a productive career within VA. It serves VA by providing a valuable source of VA-trained employees who bring valuable skills learned in the military (i.e. integrity, discipline, teamwork, etc).

Question 131. The fiscal year 2014 budget request for Construction, Major Projects, includes a request of $44 million for the Advanced Planning Fund. This appropriated fund is comprised of "no year money" and is used to develop the early stages of construction projects for the Veterans Health Administration, the National Cemetery Administration, the Veterans Benefits Administration, and VA central office staff offices.

A. What is the unobligated balance of the Advanced Planning Fund?

Response. The balance is $141. million as of the September 30, 2013. The table below reflects the anticipated balance in the Advanced Planning Fund at the end of FY 2014.

Unobligated Balance as of September 30, 2013)	$141,106
FY 2014 Request	$44,000
Subtotal of Available Funds	$185,106
Less: Expected FY 2014 Obligations	$182,042
Balance Remaining	$3,064

B. For fiscal year 2012, please provide a detailed description and amount for each project funded through the Advanced Planning Fund.

Response. See table for 2012 below.

Location/Description	FY 2012 Obligations
Alameda, CA—OPC	$694,963
Biloxi, MS—Mental Health Ctr Renovations	$209,583
Biloxi, MS—PM & RS /Prosthetics	$209,583
Bronx, NY—Spinal Cord Injury (SCI)	$869,398
Canandaigua, NY—New Construction CLC and Domiciliary	$380,180
Dallas, TX—Clinical Expansion of Mental Health	$402,033
Dallas, TX—Long Term SCI	$901,173
East Central Florida—New Cemetery (MP/SD/DD)	$1,664,339

Location/Description	FY 2012 Obligations
Fayetteville, AR—Parking Garage	$261,258
Ft. Sam Houston, TX—National Cemetery (Master Plan)	$332,571
Las Vegas, NV—New Adminstration Building	$865,480
Lexington, KY (Leestown)—Clinical Campus Realignment (Master Plan)	$610,409
Livermore, CA—Realignment & Closure	$5,349,373
Long Beach, CA—Seismic Corrections Buildings 7 and 126	$694,012
Los Angeles, CA (West LA)—Construct Essential Care Tower/B500 Seismic Correction	$574,000
Louisville, KY—New VAMC	$932,782
Omaha, NE—New Clinical Addition	$461,885
Orlando, FL—SimLEARN (Medical Center)	$1,870,734
Palo Alto, CA—80 Bed Psychiatric Facility	$300,000
Palo Alto, CA—Ambulatory Care/Polytrauma Rehab	$52,128
Pittsburgh, PA—Research Building	$32,924
Portland, OR—Retrofit & Renovation Siesmic Studies	$264,855
Riverside NC Master Plan Environmental Studies	$80,000
Southern Colorado, NC (MP/SD/DD)	$353,360
St Louis, MO (JC Division)—Bed Tower Master Plan (NEPA and 106)	$107,701
Tallahasee—New Cemetery (MP/SD/DD)	$1,283,441
Tampa, FL—Polytrauma Expansion	$367,227
Walla Walla, WA—Multispecialty Clinic	$158,099
West LA—12 Bldgs Seismic Upgrade (B206 & 258)	$384,862
West LA—New Bed Tower & Bldg 500 Seismic Correction	$500,000
Total	$21,168,353
Other:	
Various Planning/Design/Assessment Activities:	$19,250,859
Updated Design Guides and Criteria	—
Facility Condition Assessments	—
Peer Review	—
Master Planning	—
Post Occupancy Evaluation	—
Transferred funds from APF to support: Miami, FL—Renovation-Surgical Suite & Operating Rooms	$14,000,000
Grand Total	$54,419,212

C. For fiscal year 2013, please provide a detailed description and amount for each project expected to be funded through the Advanced Planning Fund.
Response. See table for 2013 below.

Location/Description	FY 2013 Obligations
Alameda, CA—Outpatient Clinic (OPC)	$323,141
Biloxi, MS—B1 & B2 Renovations & PM-RS/Prosthetics	$306,347
Bronx, NY—Spinal Cord Injury (SCI)	$1,091,888
Dallas, TX—Clinical Expansion of Mental Health	$118,230
Livermore, CA—Realignment & Closure	$26,117
Long Beach, CA—Seismic Correction Buildings 7 & 126 Phase 2	$141,108
Los Angeles, CA (West LA)—Capital Improvement Plan (Master Plan)	$1,788,441
Louisville, KY—New VAMC	$15,940,404
Manhattan, NY—Medical Center-Flood Recovery	$5,815,299
National Cemetery of the Alleghenies	$866,854
Omaha, NE—Replacement Facility	$628,380
Palo Alto, CA—80 Bed Psychiatric Facility	$433,180
Palo Alto, CA—Ambulatory Care/Polytrauma Rehab	$8,127,955
Perry Point, MD—Replace Community Living Center	$107,617
Portland, OR—Retrofit & Renovation	$11,068
Reno, NV—Seismic & Life Safety Corrections B-1	$4,298,543
San Juan, PR—Seismic Correction (Parking Structure)	$16,455
St Louis, MO (JC Division)—Bed Tower	$41,100
Tallahasee—New Cemetery	$79,527
Walla Walla, WA—Multispecialty Clinic	$335,661
West LA—12 Bldgs Seismic Upgrade (B206 & 258)	$1,788,441
West LA—New Bed Tower & Bldg 500 Seismic Correction	$4,600,816

Location/Description	FY 2013 Obligations
Total	$46,886,572
Other:	
Various Planning/Design/Assessment Activities:	$12,399,045
Cost Estimating, Environmental & Historic Preservation Services	—
Updated Design Guides and Criteria	—
NCA Facility Condition Assessments	—
Regional Strategic Master Plans	—
Post Occupancy Evaluations	—
Grand Total	$59,285,617

D. For fiscal year 2014, please provide a detailed description and amount for each project expected to be funded through the Advanced Planning Fund.
Response. See table for 2014 below.

Location/Description	FY 2014 Estimate
Alameda, CA—Outpatient Clinic (OPC)	$5,000,000
Dallas, TX—Clinical Expansion of Mental Health	$548,387
Dallas, TX—Long Term SCI	$500,000
Dallas/Ft. Worth—Gravesite Expansion	$2,000,000
Livermore, CA—Realignment & Closure	$3,500,000
Ft. Sam Houston, TX—National Cemetery	$1,800,000
W. Los Angeles, CA—Seismic Corrections (blgs B156,B157,B258)	$4,700,000
Louisville, KY—New VAMC	$19,475,000
Manhattan, NY—Medical Center-Flood Recovery	$1,350,000
North Little Rock, AR—VBA Building Replacement Facility	$900,000
Ohio Western Reserve, OH—National Cemetery	$1,500,000
Omaha—New Cemetery	$500,000
Omaha, NE—Replacement Hospital	$15,000,000
Portland, OR—Retrofit & Renovation	$5,000,000
Southern Colorado National Cemetery	$2,000,000
Sacramento Valley, CA—NC	$2,000,000
Barrancas, FL—NC	$2,000,000
Jacksonville, FL—NC	$2,000,000
S.Florida, FL—NC	$2,000,000
Palo Alto, CA—Building 6 Seismic Replacement	$4,000,000
Pittsburgh, PA—Bridge	$50,000
Perry Point, MD—Replace Community Living Center	$900,000
Long Beach, CA—Buildings 128 & 133	$100,000
San Francisco, CA—Seismic Retrofit B 1, 6 & 8/Replace B12	$350,000
San Juan, PR—Seismic Correction (Parking Structure)	$3,500,000
Seattle, WA—B101 Mental Health Services—Request for Equit Adj	$450,000
Puerto Rico, PR—Gravesite Expansion	$2,000,000
Reno, NV—Seismic & Life Safety Corrections B-1	$4,300,000
St Louis, MO (JC Division)—Bed Tower	$8,218,525
Tampa, FL—New Bed Tower Schematics & DDs (Polytrauma Expansion)	$4,600,000
West LA—New Bed Tower & Bldg 500 Seismic Correction	$19,000,000
Williamette, OR—NC Columbarium Expansion	$2,000,000
Western New York—New Cemetery	$800,000
Total	$122,041,912
Other:	
Various Planning/Design/Assessment Activities:	$60,000,000
Cost Estimating, Environmental & Historic Preservation Services	—
Updated Design Guides and Criteria	—
NCA Facility Condition Assessments	—
Regional Strategic Master Plans	—
Post Occupancy Evaluations	—
Grand Total	$182,041,912

Question 132. The Office of Small and Disadvantaged Business Utilization's (OSDBU) stated mission "is to advocate for the maximum practicable participation of small business in VA acquisitions, with special emphasis on service-disabled veteran-owned (SDVOSB) and veteran-owned small business (VOSB)." Within OSDBU is the Center for Veterans Enterprise (CVE) that is charged with verifying veteran businesses looking to take advantage of veteran specific VA contracting preferences.

A. Many veterans have expressed the opinion that CVE's mission of approving or denying eligibility for veteran set asides is in direct conflict with the OSDBU mission of advocating for VOSBs and SDVOSBs. How does VA respond to that charge?

Response. VA has unique legislation in support of meeting Veteran-owned small business and service-disabled Veteran-owned small business procurement goals. This legislation is found in section 8127 of title 38. The Executive Director is not the manager of the Center for Veterans Enterprise (CVE). He has direct supervisory authority over the Director of CVE.

The Executive Director, OSDBU implements and executes all of the functions and duties of the office under section 644 and 637 of title 15 of the United States Code with respect to VA. Of particular note, are the responsibilities of developing strategies to assure that a fair proportion of the total purchases and contracts for property and services for VA in each industry category are placed with small-business concerns pursuant to sections 637(d)(1) and 644(a)(3). One avenue to increase the number of awards to small businesses, specifically SDVOSBs/VOSBs, is the verification program established by 38 U.S.C. § 8127. Section 8127 directs the Secretary to verify the Veteran status, ownership and control of all SDVOSBs/VOSBs to participate in the unique contracting program created in the legislation. The Secretary has directed that the Executive Director, OSDBU oversee CVE as a part of his duties under sections 637(d)(1) and 644(a)(3).

The VA VOSB Verification program provides VOSBs with access to VA procurement opportunities they would not have if they are not verified. VA contends that there is no conflict between advocating for Veterans and enabling VOSBs to participate in the Veterans First contracting program.

B. In order to avoid the appearance of competing missions within OSDBU, has VA looked at whether CVE should be moved to another office or established as a standalone office under the Secretary? Please explain.

Response. VA believes that the missions of verification and acquisition support are not competing missions, rather they are complementary missions. As such, VA has not explored moving CVE to either another office nor as a standalone office under the Secretary. The verification mission fits best with the mission of OSDBU, and VA believes it is best suited to be under the supervision of the Executive Director of OSDBU.

Question 133. The chart "Summary of Employment and Obligations" for the Office of Acquisitions and Logistics Supply Fund does not include FTE information for OSDBU.

A. Please provide the Committee with the FTE requirements for OSDBU for fiscal year 2014 and the preceding three years.

Response. OSDBU has a standing authorization of 42 FTE since FY 2012. Prior to that, the authorization was for 40 FTE.

B. Please provide the Committee with a detailed budget for OSDBU and CVE.

Response. Due to the nature of OSDBU's source of funding in the Supply Fund, OSDBU has traditionally negotiated its budget based on the current year's funding level and adjusted the request for the rapidly changing circumstances. The flexibility of the Supply Fund has been beneficial to Veterans, as the OSDBU needs can be quickly addressed, and more accurate projections made with the request coming much closer to the need.

OSDBU FY 2012 Expenditures

FTE	42
Obligations:	
Personal services	$4,252,488
Travel	$64,752
Transportation of things	—
Rents, communications and utilities	$359,492
Printing and reproduction	$4,594
Other services	$15,604,719*
Supplies and materials	$196,988

OSDBU FY 2012 Expenditures—Continued

Equipment	$5,640
Total obligations	$20,488,672**
Total budget	$33,000,000

*See breakdown of other services on page 5.
**$12,511,328 carried over to FY 2013.

OSDBU expects that the FY 2013 budget will be approved by July 31, 2013.

Question 134. Last year, CVE announced the creation of a pre-decisional letter to better assist veterans make the necessary changes to their businesses prior to receiving full verification decisions. The goal was to decrease the number of veterans who entered the appeals process after an initial denial.

A. Since its creation, how many veterans have taken advantage of the pre-decisional letter to make the necessary changes?

Response. The Pre-Decisional Findings (PDF) program was piloted from February to April 2013, and launched at full scale on May 1, 2013. Data on the program is very limited, due to the fact that it is a brand new program. It is important to note that not all businesses are eligible for the program. Those businesses, whose compliance issues are categorized among the list of correctible issues, not requiring full re-evaluation, are allowed to clarify their issues and/or make adjustments to their documentation within a specified time period with the intent to avoid denial. Those with more complex issues that would require a complete re-evaluation are offered the option to withdraw their application rather than to receive a denial letter. This allows them to take the time that they need to address the issues and resubmit, rather than receiving a determination, and then having only the 30 days allowed by regulation to submit the request for reconsideration.

In the first 27 days from the full scale launch on May 1, 2013, 31 Veterans have taken advantage of the program. Pulling in all results from both the pilot and the launch, 80 firms have taken advantage of the program through May 27, 2013. Of those firms, 71 percent were approved, ten percent were denied, and 19 percent withdrew their applications.

B. What metrics have been established to determine whether the new process has been effective in decreasing the number of veteran businesses entering the appeal process?

Response. The PDF process has helped to decrease the number of Veteran businesses entering the request for reconsideration (R4R) process. This process enables applicants to correct non-compliant aspects of their businesses established by the initial determination. CVE has developed a number of metrics to gage the program. One of the objectives of the PDF program is to reduce the number of requests for reconsideration and the time required to process them. The average number of R4Rs submitted monthly has declined from 92 in January 2013 to 40 in May (as of May 28, 2013). The average time to process R4Rs has declined from 146 days in January to 66 days in May.

Fewer denials directly affects the number of requests for reconsideration submitted, shortening the average processing time. At the end of FY 2012, the initial determination approval rate was 58 percent. At the end of May 2013, the initial approval rate is 83 percent. It is important to note that prior to the introduction of PDF, all of the firms that are now participating would have received an initial denial. Note that because the sample size is so small (about three percent of all initial determinations made in FY 2013 to date), the impact on the overall approval rate will become more significant over time.

OSDBU FY 2012 Expenditures (+ breakdown of other services)

FTE	42
Obligations:	
Personal services	$4,252,488
Travel	$64,752
Transportation of things	—
Rents, communications and utilities	$359,492
Printing and reproduction	$4,594
Other services	$15,604,719*
Supplies and materials	$196,988

OSDBU FY 2012 Expenditures (+ breakdown of other services)—Continued

Equipment	$5,640
Total obligations	$20,488,672**
Total budget	$33,000,000
*Breakdown of other services:	
Verification support	$9,925,585
Outreach Support	$5,263,156
Acquisition Support	$365,607
Training and security	$50,371
**$12,511,328 carried over to FY 2013.	

OFFICE OF INSPECTOR GENERAL

Question 135. For fiscal year 2014, the Office of Inspector General requests $11 million for Other Services. Please provide an itemized list of how those funds would be utilized.

Response. The fiscal year (FY) 2014) request for Other Services includes the following contractual services, interagency agreements, employee training, VA cross-cutting services, and other procured services:

• Contract for the Consolidated Financial Statement Audit.
• Interagency Agreement for Human Resources/Payroll Processing Services—Department of Treasury and Department of Agriculture.
• Contract for the *Federal Information Security Management Act* Review.
• Employee Training.
• VA Franchise Fund Services—IT processing, financial services, background investigations, and records storage.
• Employee Relocation Services.
• Annual assessment for Council of the Inspectors General for Integrity and Efficiency.
• Building Security Services—Department of Homeland Security and VA.
• Investigative Data Base Access, Forensic Services, Communications Agreements.
• Other VA Administrative Services, including workers compensation, unemployment compensation, and EEO services.

Question 136. With the requested level of resources for fiscal year 2014, how many benefits inspections would the Office of Inspector General plan to conduct?

Response. The Office of Inspector General (OIG) will conduct 18 inspections of VA Regional Office operations in FY 2014. Our independent inspections provide recurring oversight focused on disability compensation claims processing and the performance of Veterans Service Center operations.

We also plan to conduct the following two national reviews of key Veteran Benefits Administration (VBA) initiatives in meeting the VA Secretary's goals of processing claims in an average of 125 days and with 98 percent accuracy by FY 2015:

• Review of VBA's Statistical Technical Accuracy Review (STAR) Program—We will sample claims reviewed by STAR to determine the effectiveness of the program in assessing disability claims processing accuracy and identifying areas for improvement. The STAR program is VBA's quality assurance program. In our March 2009 report, Audit of Veterans Benefits Administration Compensation Rating Accuracy and Consistency Reviews, we found that while VBA identified a national compensation claim rating accuracy of 87 percent for the 12-month period ending February 2008, we projected that VBA officials understated the error rate by about 10 percent. This difference equated to approximately 88,000 additional claims where veterans' monthly benefits may be incorrect. In FY 2013, the risk of increased inaccurate ratings could occur due to VBA's reliance on Disability Benefits Questionnaires and provisional decisions on the oldest disability compensation claims in VBA's inventory.

• Review of the Veterans Benefits Management System (VBMS)—We plan to audit claims processed using VBMS to determine whether the automated system is resulting in higher quality and more consistent disability benefits decisions. This review is expected to complement the results of a current ongoing audit of cost, schedule, performance, and information security in VBMS development.

VETERANS HEALTH ADMINISTRATION

Question 137. If VA cannot provide care for a veteran at a VA Medical Center (VAMC), the VAMC will provide that care to the veteran in the veteran's local community through purchased care. In fiscal year 2014, VA is expected to spend $1.1 billion on purchased care. However, there are several Inspector General (IG) reports that have criticized various aspects of the Veterans Health Administration's (VHA) purchased care program, such as improper payments and some facilities having problems with managing purchased care.

A. How much does VA expect to be spent on purchased care in fiscal year 2015?

Response. In 2015, VHA estimates spending $6,177,600,000 on Non-VA care.

B. What actions has VHA taken to meet the requirements of the Improper Payments Elimination and Recovery Act of 2010?

Response. The VHA Chief Business Office (CBO) has implemented multiple corrective actions to reduce improper payments and meet Improper Payments Elimination and Recovery Act requirements. Improvements to reduce improper payments include:

• Implementation of the Quality Corrective Action Program (QCAP) was completed in December 2012. This internal program is designed to identify quality initiatives through various audit findings and reviews. The QCAP facilitates the development of appropriate corrective action teams and processes and tracks and trends results with the use of an automated tool.

• Implementation of the Fee Basis Claims System (FBCS) was completed in March 2012. FBCS is a graphical user interface based system that is layered on top of the VistA Fee system. The national implementation of FBCS included an initial 3-week training course on FBCS procedures that was provided to site Non-VA Care Fee staff during rollout. Supplemental online training was also provided. Ongoing FBCS training has been incorporated to share any recently installed patches and updates to process changes.

• National rollout of the FBCS Optimization launched in August 2012. FBCS Optimization is the next stage in a nationwide effort to improve and standardize the processes associated with the use of FBCS for claims processing across VHA in support of the Non-VA Care Program Offices in the field.

• Establishment of a Field Assistance Program in 2011 was expanded in 2012 to provide enhanced site visits designed to improve local operations by assessing site Non-VA Care claims processes and assisting with the development of effective internal controls. Findings are tracked at all sites to measure trends and identify lessons learned to share with all sites for training course development.

• The VHA Chief Business Office developed a duplicate payment report, accessed through a user-friendly tool called SnapWeb, which identifies potential improper duplicate payments. The report was available beginning in April 2012.

• The Non-VA Care Program Academy is the primary training program provided to VISN and VA medical center Fee employees nationwide. The Non-VA Care Program Academy is organized into a four-tiered, progressive level of curriculums designed to improve performance, enhance internal controls, and be in compliance with program policies.

• The National Non-VA Care Program Office Intranet site was expanded in December 2012 to include updated training materials, procedure guides, notices, and FBCS alerts. This information is available to the field to alert staff to any changes and provide status of multiple projects related to Non-VA Care.

• In January 2011, a contract was awarded to assist VA in establishing an enhanced program integrity function to reduce fraud, waste, and abuse through implementation of industry standard applications and processes.

C. How much did VHA pay in duplicate payments in the last fiscal year and how much of those duplicate payments did VHA recover?

Response.

Duplicate Payments FY 2012 = $1,213,070
Duplicate Payments Recovered in FY 2012 = $776,450

D. Some VAMCs have inappropriately authorized millions in non-VA care but did not have sufficient funding to pay for those services. Why, after several IG investigations on this matter, does this continue? What is VHA's plan to address this?

VHA Response: The Chief Business Office Purchased Care (CBOPC) has instituted a comprehensive in-house auditing capability to cost-effectively audit claims for all CBOPC programs and ensure compliance with applicable regulations and other guidance. We will also be focusing on improving processes within the financial management of the Non-VA Medical Care program to improve the financial integrity of the program throughout its lifecycle. Additionally, CBOPC provides guidance to

the field concerning the need to obligate funds prior to authorizing care on an on-going basis through several venues to include:

- Policy and Procedure Guides
- Recorded training sessions on the use of estimation tools
- National conference call announcements
- Field Assistance Site Visits
- On-going audits to reduce improper payments

In addition, guidance to the field is provided in Fiscal regulations published by the Office of Finance, available on-line and at local Finance offices.

Sections of the NNPO Web site contain links to cost estimation and obligation of funds guidance to include:

- 1601F Program Guide series Authorizations outlining the need to obligate the funds prior to issuance of the authorizations and a specific section titled, Fee Basis Obligations.
- Fee Internal controls and Continuous Monitors, Internal Controls and Continuous Monitors Attachment A.
- Obligation of Funds is outlined in M–1 Part 1, Chapter 18 and in M–1 Part 1 Chapter 21.
- FBCS training modules outline the authorization and obligation process.
- An outpatient and inpatient cost estimation tool was developed and training provided to field staff.
- Routine National Conference calls update the field on regulatory changes, training events and review procedures related to obligation of funds prior to services rendered.

If a facility requires additional funding in support of Non-VA Medical Care activities, this is addressed at the local level, where additional funds are secured from the respective VISN Office and/or the Office of Finance, VA Central Office as per the Office of Finance guidance.

Question 138. An IG report, titled *Audit of Non-VA Inpatient Fee Care Program*, suggested VHA could find potential cost savings, about $134 million over five years, by consolidating the Fee Programs claim processing system. The Under Secretary for Health, Dr. Petzel, agreed there would be potential savings if the claims processing systems were consolidated.

A. Has VHA consolidated its fee processing system into regional centers, similar to how VHA manages medical revenue collections?

Response. No, VA has not regionalized in a similar fashion to the revenue centers; however, work on a centralized claims processing system, known as HCP, or Health Claims Processing has begun. The system is currently under development. VHA-wide implementation is expected to be complete in Fall 2015. Additionally, we have initiated an Improvement Roadmap (as of Sept 2012) that is focused on reducing improper payments, training, communications, and other programmatic fixes over a 6–12 month timeframe. The larger effort to consolidate fee processing systems and personnel will be approached through the completion of the HCP system and the design and implementation of a new organizational model that consolidates that claims processing from the present 140+ locations to 3–5 centers.

B. If not, why has this consolidation not been completed and when does VA expect to complete the consolidation?

Response. The effort is not completed because of the current focus on completing the Improvement Roadmap, which builds a solid foundation for the new organizational model. Due to the anticipated size and scope of the reorganization effort, it is expected that the planning and implementation will be spread over several years. There are over 140+ processing sites currently with over 2,500 personnel involved across those sites. Consolidating these sites must take a well-planned and implemented approach to prevent disruption to the critical services that this program provides to our Veterans. Implementing the Improvement Roadmap is a key first step in standardizing business process and reducing improper payments before the consolidation begins.

Question 139. Staffing at VAMCs make up a large portion of VHA's funding obligations. However, VHA did not develop a mental health staffing plan until after several IG Combined Assessment Program and Community Based Outpatient Clinic reviews indicated problems with nurse staffing and the Committee requested that VHA develop one.

A. Does VA have a staffing model in place for all clinical providers?

Response. VHA continues to develop a staffing model for all clinical providers. In June 2012, the Under Secretary for Health established the Specialty Care Physician Productivity and Staffing Plan Task Force to develop a methodology for VHA spe-

cialty care physician staffing and productivity. Productivity coupled with access measures provide a framework for determining specialty physician staffing. This model was prototyped for the seven specialties of Cardiology, Gastroenterology, Dermatology, Neurology, Orthopedics, Urology, and Ophthalmology. VHA will establish productivity standards for five specialties in FY 2013 and the remaining specialties by the end of FY 2015.

B. Has VHA sought guidance from DOD Health Affairs or private health care providers, such as Kaiser Permanente, regarding how they developed their staffing models? If so, how did that guidance influence the development of VHA's staffing model.

Response. VA recently established a partnership with DOD and is leading a joint study to better understand physician productivity and how to effectively design and implement staffing plans to improve clinical outcomes.

C. Of the funding VHA is appropriated for staffing, how much will be used to pay for union representation/union time?

Response. VHA does not have a tracking mechanism to provide this data.

Question 140. The Committee has held several hearings highlighting the problem veterans have accessing mental health care at VHA. In response to an IG report that found VHA's measures for access to care are unreliable, VHA announced an increase of 1,900 mental health provider and administrative staff positions to address the problem. According to testimony VA submitted for the Committee's March 20, 2013, mental health hearing, as of March 5, 2013, a total of 1,089 new providers and 230 administrative staff have been hired.

A. How will VHA ensure that these new providers are deployed where veterans' needs are the greatest?

Response. As part of an ongoing comprehensive review of mental health operations, VA considered a number of factors to determine additional staffing levels distributed across the system, including:

• Veteran population in the service area,
• Mental health needs of Veterans in that population, and
• Range and complexity of mental health services provided in the service area.

VHA's Mental Health Operations collaborated with VISNs and facilities to distribute the additional staffing based on this review and with the goal of ensuring that facilities had sufficient mental health staff to meet Veteran needs. In some areas, however, because of recruitment challenges, sites elected to develop regional telemental health programs or to develop Non-VA contracts to supplement staffing levels. VA continues to review the adequacy of staffing levels based on timeliness of care, quality of care, and patient and provider satisfaction.

B. What changes has VHA made to make sure the metrics used to measure access provide an accurate picture?

Response. VA has developed two new measures of Veterans' waiting times: (1) a new patient metric based on "create" date, and (2) an established patient metric using the prospective waiting time and based on the Agreed Upon Date (AUD). The data is currently being reported for these two new metrics as of December 31, 2012.

VA is also developing internal metrics based on measuring the time from the date of referral to mental health care to the time of the completed appointment. These metrics will be piloted in late FY 2013 for deployment in FY 2014. In addition, VA identified several metrics to assist clinic managers with reviewing access issues within their clinics. A "Clinic Access Index" group identified and defined key data elements needed by mid-level managers to improve the function of clinic operations. The database has been built and is available for use by all VA staff. Educational efforts are being developed to teach managers how to use the database. VA has also developed a Veteran survey to assess Veterans' perceptions of access barriers. The survey is currently being mailed to Veterans with results expected by the mid-fall of 2013.

Question 141. This budget request would provide a 92 percent, or $3.6 billion, increase for mental health care since fiscal year 2008. However, even with this significant spending increase, veterans have had significant problems with accessing care they need and deserve.

A. How does VHA measure success of this program to ensure the significant increase in funding is spent wisely?

Response. In September 2008, VA published the Uniform Mental Health Services (UMHS) VHA Handbook 1160.01 in VA medical centers and clinics. The handbook specified the range of services that must be available nationally to ensure that Veterans have access to a consistent set of services regardless of where they are seeking care. As a result of the handbook, the number and types of required services expanded and ensured that VA would provide outreach to Veterans in non-tradi-

tional clinics such as medical settings, primary care, and geriatric settings. VA has measured the success of this program in a number of ways including evaluating the increase in numbers of Veterans served across programs and by each service, the increase in the number of services provided, as well as the number of staff hired and trained in evidenced based therapies.

In FY 2012, VA developed the Mental Health Information System in partnership with the mental health site visit protocol to comprehensively evaluate implementation of the UMHS handbook using administrative data, performance measure data, interviews with Veterans, mental health staff, facility/VISN leadership, and other stakeholders, as well as observations and other data to assess the status of implementation. As a result, VA developed quality improvement initiatives for areas that were not functioning as intended and developed a best practice SharePoint to allow facilities to share successful initiatives. In FY 2013, VHA is continuing the site visit process on a 3-year cycle while continuing to develop additional metrics including outcome metrics for leadership and mental health staff to use in evaluating the efficacy of mental health programs.

B. To what extent does VHA consider patient outcomes as part of its metrics in evaluating VHA's mental health care program?

Response. VA has committed to developing and using outcome metrics for use in evaluating its mental health program in FY 2013. The initial set of measures is currently being validated, as the measures are based on administrative data. VA will collect symptom improvement and functional measures for new patients to mental health starting in fiscal year 2014.

Question 142. Recently, VHA has changed the way it delivers care with the development of the Patient Aligned Care Team (PACT) model. This model of care uses a team of professionals that includes doctors, nurses, medical assistants, and clerks. The intent of this team approach is to provide a more comprehensive model of care to veterans. These care team professionals are to be physically located close together to be able to consult easily with each other. More recently, VHA has included mental health professionals within the PACT.

A. The budget request provides a limited list of metrics VHA uses to "measure the progress toward the goals that we have set for these teams." Please submit to the Committee the complete list of metrics and the goals PACTs must meet.

Response. The metrics and goals (targets) for PACT are listed below:

1. Continuity with Veterans assigned to a primary care provider: Veterans are able to see their own primary care provider for regularly scheduled or urgent visits. Target >=77%

2. Same day access with primary care provider: Veterans are able to see their primary care provider the same day they call for an appointment and want the appointment that day. Target >=70%

3. Appointment in Primary Care within 7 days of desired date: Veterans can schedule an appointment within 7 days of the date they choose to be seen. Target >=92%

4. Ratio of non-traditional primary care encounters: Ratio of the combination of shared medical appointments, telephone encounters, and secure messaging for the assigned panel of primary care patients. Target >=20%

5. Primary care patients enrolled in home telehealth. Ratio of primary care patients for the assigned panel of patients enrolled in home telehealth for chronic disease management. Target >=1.6%

6. Primary Care staffing ratio. Ratio of support staff FTE assigned to a primary care provider FTE to care for the assigned panel of primary care patients. Target >=3.0

B. The budget request indicates that half of all PACTs will be trained by the end of this year. Which sites have fully trained PACTs and when will all of the PACTs be trained?

Response. The attachment below contains the current training numbers of PACT team members to date. During FY 2012–13, there have been 9,855 total participants attending one of the training sessions although VHA calculated only those who either completed, or are currently active, somewhere along the longitudinal training continuum. Three Networks (4, 10, and 23) opted out of the Learning Center training and are managing their own training activities. For example, VISN 4 conducted a PACT Collaborative with the participation of all their PACTs in FY 2012.

Integrated PACT Training
Current Status – May 2013

VISN	Total PC Staff*	Participants Trained FY11	Participants completed, or involved in, longitudinal training model FY12-FY13	Percent trained to date
*Not Assigned		818	23	
VISN 1	1007	339	357	69%
VISN 2	554	286	347	100%+
VISN 3	778	273	201	61%
VISN 4	1176	241	0	N/A
VISN 5	498	230	24	51%
VISN 6	1408	663	221	63%
VISN 7	1350	315	461	58%
VISN 8	2115	503	762	60%
VISN 9	1165	265	79	29%
VISN 10	906	224	0	N/A
VISN 11	1207	434	174	50%
VISN 12	1009	445	102	54%
VISN 15	900	287	327	68%
VISN 16	1746	420	622	60%
VISN 17	1026	187	210	39%
VISN 18	1077	292	230	48%
VISN 19	781	655	60	92%
VISN 20	1173	387	116	43%
VISN 21	1131	325	198	46%
VISN 22	1147	486	224	62%
VISN 23	1267	219	4	N/A
TOTAL	**23421**	**8294**	**4742**	**56%**

*_Reflects sum of_:

- Number of providers, all divisions – Primary Care provider panel cube
- Primary care direct FTE vacancies (PCMM)
- All support staff FTE (PCMM)
- All support staff vacancy FTE (PCMM)

Limitations and other considerations related to this data include:

• Numbers do not reflect special population PACTs, specific extended team members, or mental health integration team members.

• Support staff numbers are available as FTEs (not reflecting the number of part-time employees).

Conclusions:

• The actual number of targeted participants is higher than reflected in the table.

• The total of those needing training is a constantly moving target due to turnover and introduction of new members throughout the multi-year training roll-out.

• The longitudinal model and participant caps require more time to reach all PACT members.

• We will train a significant majority of all PACTs by the end of FY 2014.

C. With the recent inclusion of mental health into the PACT, what has VHA done to ensure mental health providers assigned to a PACT are physically located with the rest of the PACT? Please provide a list of sites where a mental health provider is embedded with the PACT.

Response. All VA medical centers and CBOCs with more than 5,000 enrolled Veterans are required to have co-located mental health providers embedded within and collaborating with other members of PACT as members of the interdisciplinary team. Implementation is assessed with three related mechanisms:

1. Self report in the quarterly UMHS Handbook survey.

2. Self report in the annual Primary Care-Mental Health Integration survey with a subset of facilities visited to validate self-reports.

3. During Office of Mental Health Operations site visits, leadership and front line staff are asked about co-located mental health staff presence in primary care.

The attachment below contains a list of sites currently reporting mental health providers embedded within the PACT.

Integrated PACT Training

Current Status – May 2013

VISN	Total PC Staff*	Participants Trained FY11	Participants completed, or involved in, longitudinal training model FY12-FY13	Percent trained to date
*Not Assigned		818	23	
VISN 1	1007	339	357	69%
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VISN 23	1267	219	4	N/A
TOTAL	**23421**	**8294**	**4742**	**56%**

*Reflects sum of:

- Number of providers, all divisions – Primary Care provider panel cube

- Primary care direct FTE vacancies (PCMM)

- All support staff FTE (PCMM)

- All support staff vacancy FTE (PCMM)

Question 143. The President's budget includes $85 million in medical services in both fiscal years 2014 and 2015 to cover costs associated with the Affordable Care Act's (ACA) mandate that all Americans have health insurance by 2014.

A. Please describe the metrics used to determine the amount of funding needed to cover the costs of ACA.

Response. VA has conducted an analysis of the number of Veterans thought to be leaving the VA health care system, the number of Veterans to be accrued to the system, and the estimated costs for providing their care. The metrics used to estimate the amount of funding needed to cover ACA costs were: the health care utilization profiles designed to identify and sort Veteran enrollees into a spectrum of high users of VA health care services down to non-users of VA health care services; the resulting utilization rate; the disenrollment rate by profile; the expected utilization pattern for Veterans joining VA; and the average cost associated with their utilization.

B. For each of fiscal years 2014 and 2015, how many veterans does VA estimate will leave VA for other options of care?

Response. The Affordable Care Act (ACA) expands affordable, comprehensive health care coverage options for some Veterans, both through the Health Insurance Marketplaces and through expansion of Medicaid in states that choose to expand their programs to all individuals below 138 percent of the poverty level. VA assumes that currently enrolled Veterans who become eligible for Medicaid will generally choose to stay with VA. VA also assumes that some Veterans who would have enrolled in VA (under current Medicaid eligibility rules) and live in a state that expands its Medicaid program may choose to enroll in Medicaid instead of VA. ACA also provides premium tax credits for eligible individuals to purchase health care coverage through the Health Insurance Marketplaces. However, in order to receive the premium tax credit, a Veteran may not be enrolled in the VA health care system.

C. For each of fiscal years 2014 and 2015, how many veterans does VA estimate will enroll in VHA to satisfy the individual mandate in ACA?

Response. Starting in FY 2014, the individual shared responsibility provision under ACA calls for each individual to have minimum essential coverage (MEC), qualify for an exemption, or make a payment when filing his or her Federal income tax return. Under the law, VA health care benefits meet the definition of MEC. Additionally, under ACA, states have the option to expand their Medicaid programs but are not required to do so. VA continues to monitor state decisions to determine the impact on VA beneficiaries in each of these locations. VA anticipates a modest net increase in enrollment as a result of ACA. As previously stated, VA expects that there will be some increase in enrollment; VA also expects that there will be some people who will leave VA's system. VA has conducted an analysis of how many Veterans may enroll in VHA to satisfy the individual mandate in ACA. The estimated net number of Veterans projected to enroll with VA as a result of ACA is 66,000 for FY 2014.

Question 144. Under the medical services account, VHA estimates it will spend $582 million in fiscal year 2014 and $95 million in fiscal year 2015 to activate facilities. And, within the Medical Facilities account, VHA projects it will spend $160 million in fiscal year 2014 and $26 million in fiscal year 2015 to activate facilities.

A. Please provide a full list of the facilities that will be activated with these funds, with the amount of funding estimated for each facility broken down into non-recurring and recurring costs.

Response. Please see attached. The final 2015 funding level for this activity will be determined during the 2015 budget process when updated data and metrics on this program's funding needs are available.

Fiscal Year 2014

VISN	Location	State	Description	Project	Recurring	Non-Recurring	Total
1	Boston	MA	Outpatient Clinic	Lease	$17,320,522	$457,026	$17,777,548
2	Syracuse	NY	Addition For SCI Center (Overview - OV).	528-708	$349,158	$5,988,729	$6,337,887
4	Butler	PA	Health Care Center	Lease	$536,294	$10,817,135	$11,353,429
4	Pittsburgh	PA	Medical Center Consolidation (OV).	646-500	$0	$2,672,993	$2,672,993
6	Wilmington	NC	Outpatient Clinic	Lease	$2,554,203	$1,574,230	$4,128,433
6	Greenville	NC	Outpatient Clinic	Lease	$3,209,783	$4,724,993	$7,934,775
6	Fayetteville	NC	Health Care Center	Lease	$4,576,215	$21,859,321	$26,435,536
6	Winston-Salem	NC	Health Care Center	Lease	$0	$17,497,991	$17,497,991
6	Charlotte	NC	Health Care Center	Lease	$0	$18,112,576	$18,112,576
7	Greenville	SC	Outpatient Clinic	Lease	$0	$824,282	$824,282
7	Hinesville	SC	Community-Based Outpatient Clinic.	Lease	$3,452,265	$805,961	$4,258,226
7	Savannah	GA	Community-Based Outpatient Clinic.	Lease	$3,261,329	$1,713,770	$4,975,099
7	Anderson	SC	Outpatient Clinic	Lease	$0	$729,953	$729,953
7	Montgomery	AL	Health Care Center	Lease	$0	$5,908,871	$5,908,871
7	Atlanta	GA	Specialty Care	Lease	$0	$2,081,864	$2,081,864
7	Huntsville	AL	Outpatient Clinic	Lease	$0	$1,922,599	$1,922,599
7	Birmingham	AL	Clinical Annex/Outpatient Clinic	Lease	$0	$1,931,412	$1,931,412
7	Atlanta	GA	Modernize Patient Wards (OV)	508-057	$35,277,925	$1,206,019	$36,483,944
8	Jacksonville	FL	Satellite Outpatient Clinic	Lease	$2,442,952	$9,900,225	$12,343,177
8	Mayaguez	PR	Satellite Outpatient Clinic	Lease	$0	$4,764,179	$4,764,179
8	Tampa	FL	Primary Care Annex	Lease	$1,763,264	$2,898,748	$4,662,012
8	Tallahassee	FL	Outpatient Clinic	Lease	$0	$9,814,345	$9,814,345

Fiscal Year 2014—Continued

VISN	Location	State	Description	Project	Recurring	Non-Recurring	Total
8	Orlando	FL	New Medical Facility (OV)	673-950	$39,160,665	$38,741,513	$77,902,178
8	Lee County	FL	Outpatient Clinic (Bay Pines)	516-400	$262,829	$7,501,365	$7,764,194
8	Bay Pines	FL	Inpatient/Outpatient Improve-ments.	516-005	$91,716	$0	$91,716
8	Gainesville	FL	Correct Patient Privacy Defi-ciencies.	573-070	$27,054,777	$2,021,224	$29,076,002
8	Tampa	FL	Polytrauma and Bed Tower (OV)	673-900	$2,004,046	$4,923,043	$6,927,089
8	San Juan	PR	Seismic Corrections Bldg. 1 (OV)	672-085	$0	$517,532	$517,532
10	Mansfield	OH	Satellite Outpatient Clinic	Lease	$2,172,849	$1,091,263	$3,264,111
11	Fort Wayne	IN	Community Based Outpatient Clinic.	Lease	$1,077,374	$1,777,600	$2,854,974
11	Peoria	IL	Community Based Outpatient Clinic.	Lease	$783,178	$492,343	$1,275,521
11	Toledo	OH	Community Based Outpatient Clinic.	Lease	$1,068,704	$3,066,828	$4,135,533
11	Grand Rapids ..	MI	Community Based Outpatient Clinic.	Lease	$2,611,478	$7,601,926	$10,213,404
11	South Bend	IN	Community Based Outpatient Clinic.	Lease	$0	$4,652,872	$4,652,872
12	Crown Point	IN	Outpatient Clinic	Lease	$0	$4,134,828	$4,134,828
12	Green Bay	WI	Outpatient Clinic	Lease	$63,594,064	$12,429,484	$76,023,548
15	Columbia	MO	Operating Suite Replacement	589-006	$182,127	$381,606	$563,734
15	St. Louis (JB) ...	MO	Med Facility Improv & Cem Ex-pansion (OV).	657-313	$284,297	$4,229,655	$4,513,952
16	Lafayette	LA	Community Based Outpatient Clinic.	Lease	$3,463,671	$2,689,598	$6,153,269
16	Lake Charles ...	LA	Community Based Outpatient Clinic.	Lease	$2,292,328	$2,286,639	$4,578,967
16	Fayetteville	AR	Clinical Addition	564-302	$1,786,503	$11,212,702	$12,999,205
16	Biloxi	MS	Restoration Of Hospital/Consoli-dation (OV).	520-317	$24,587,218	$9,480,317	$34,067,536
16	New Orleans	LA	Restoration/Replacement Medical Facility (OV).	629-401	$9,434,412	$45,842,871	$55,277,284
17	San Antonio	TX	Ward Upgrades And Expansion (OV).	671-047	$0	$709,106	$709,106
17	Temple	TX	IT Building	674-117	$0	$297,744	$297,744
17	Corpus Christi	TX	Outpatient Clinic	Lease	$107,978	$1,302,693	$1,410,671
17	McAllen	TX	Outpatient Clinic	Lease	$237,414	$1,069,566	$1,306,980
17	Fort Worth	TX	Outpatient Clinic	Lease	$727,239	$10,724,819	$11,452,058
17	Harlingen	TX	Outpatient Clinic	Lease	$425,635	$0	$425,635
17	Austin	TX	Outpatient Clinic	Lease	$14,586,597	$5,937,983	$20,524,580
17	San Antonio	TX	Polytrauma Center, & Renovation of Exist Bldg. 1.	671-048	$5,988,569	$2,378,476	$8,367,045
18	Mesa	AZ	Satellite Outpatient Clinic	Lease	$13,356,817	$1,448,934	$14,805,751
19	Colorado Springs.	CO	Community-Based Outpatient Clinic Relocation.	Lease	$1,731,810	$7,264,216	$8,996,027
19	Billings	MT	Satellite Outpatient Clinic	Lease	$4,127,973	$3,830,120	$7,958,093
19	Denver	CO	Replacement Medical Center Fa-cility (OV).	554-501	$7,735,419	$54,455,961	$62,191,381
20	Salem	OR	Community-Based Outpatient Clinic.	Lease	$5,486,592	$1,623,365	$7,109,957
20	Eugene	OR	Community-Based Outpatient Clinic.	Lease	$15,156,885	$4,470,620	$19,627,505
20	Seattle	WA	Correct Seismic Deficiencies B100, NT & NHCU.	663-406	$8,742,076	$8,495,652	$17,237,728
20	Walla Walla	WA	Multi Specialty Care (Overview)	687-400	$610,045	$1,093,449	$1,703,494
21	San Francisco ..	CA	Research Lease	Lease	$0	$1,798,163	$1,798,163
21	Palo Alto	CA	Seismic Corrections, Bldg. 2	640-413	$30,980	$79,303	$110,283
21	Palo Alto	CA	Centers for Ambulatory Care and Polytrauma Rehabilitation (OV).	640-424	$0	$6,256,052	$6,256,052
22	Los Angeles	CA	Seismic Corrections - 12 Bldgs.	691-406	$0	$2,918,298	$2,918,298
22	Las Vegas	NV	Primary Care Clinic #1	Lease	$86,161	$369,431	$455,591
22	Las Vegas	NV	Primary Care Clinic #2	Lease	$86,161	$332,488	$418,648

Fiscal Year 2014—Continued

VISN	Location	State	Description	Project	Recurring	Non-Recurring	Total
22	Las Vegas	NV	Primary Care Clinic #3	Lease	$86,161	$332,488	$418,648
22	Las Vegas	NV	Primary Care Clinic #4	Lease	$86,161	$465,317	$551,478
22	Bakersfield	CA	Community-Based Outpatient Clinic.	Lease	$0	$696,990	$696,990
22	Loma Linda	CA	Health Care Center	Lease	$0	$13,690,064	$13,690,064
22	Las Vegas	NV	New Medical Facility (OV)	593-202	$32,248,745	$1,407,631	$33,656,376
22	Long Beach	CA	Seismic Corrections/Clinical, B-7 & 126.	600-402	$1,360,206	$2,157,870	$3,518,076
			Total		$369,661,768	$428,889,232	$798,551,000

Fiscal Year 2015

VISN	Location	State	Description	Project	Recurring	Non-Recurring	Total
2	Rochester	NY	Outpatient Clinic	Lease	$0	$2,594,855	$2,594,855
4	Butler	PA	Health Care Center	Lease	$345,228	$0	$345,228
6	Greenville	NC	Outpatient Clinic	Lease	$1,540,621	$0	$1,540,621
6	Fayetteville	NC	Health Care Center	Lease	$2,629,763	$0	$2,629,763
6	Winston-Salem	NC	Health Care Center	Lease	$1,220,410	$4,718,419	$5,938,828
6	Charlotte	NC	Health Care Center	Lease	$1,787,028	$4,884,145	$6,671,173
7	Hinesville	SC	Community-Based Outpatient Clinic	Lease	$1,175,860	$0	$1,175,860
7	Savannah	GA	Community-Based Outpatient Clinic	Lease	$1,120,466	$0	$1,120,466
7	Anderson	SC	Outpatient Clinic	Lease	$297,703	$196,835	$494,538
7	Montgomery	AL	Health Care Center	Lease	$1,049,303	$1,593,356	$2,642,659
7	Atlanta	GA	Specialty Care	Lease	$1,785,517	$561,385	$2,346,901
7	Huntsville	AL	Outpatient Clinic	Lease	$3,464,333	$518,438	$3,982,771
7	Birmingham	AL	Clinical Annex/Outpatient Clinic	Lease	$3,912,878	$520,815	$4,433,693
8	Tampa	FL	Primary Care Annex	Lease	$730,925	$0	$730,925
8	Tallahassee	FL	Outpatient Clinic	Lease	$580,497	$2,646,486	$3,226,983
8	Bay Pines	FL	Inpatient/Outpatient Improvements	516-005	$47,574	$0	$47,574
8	Tampa	FL	Polytrauma and Bed Tower (OV)	673-900	$1,204,852	$443,826	$1,648,295
8	San Juan	PR	Seismic Corrections Bldg. 1 (OV) ...	672-085	$0	$418,665	$418,665
11	Fort Wayne	IN	Community Based Outpatient Clinic	Lease	$290,519	$0	$290,519
11	Grand Rapids ..	MI	Community Based Outpatient Clinic	Lease	$1,128,712	$0	$1,128,712
11	South Bend	IN	Community Based Outpatient Clinic	Lease	$3,031,720	$1,254,670	$4,286,390
15	St. Louis (JB) ..	MO	Med Facility Improv & Cem Expansion (OV).	657-313	$299,499	$1,414,548	$1,714,046
16	Lafayette	LA	Community Based Outpatient Clinic	Lease	$933,996	$0	$933,996
16	Lake Charles ...	LA	Community Based Outpatient Clinic	Lease	$618,137	$0	$618,137
16	Biloxi	MS	Restoration Of Hospital/Consolidation (OV).	520-317	$7,051,589	$0	$7,051,589
16	New Orleans	LA	Restoration/Replacement Medical Facility (OV).	629-401	$9,795,425	$13,599,164	$23,394,589
18	Mesa	AZ	Satellite Outpatient Clinic	Lease	$4,721,649	$0	$4,721,649
19	Colorado Springs.	CO	Community-Based Outpatient Clinic Relocation.	Lease	$847,931	$0	$847,931
19	Billings	MT	Satellite Outpatient Clinic	Lease	$1,708,731	$0	$1,708,731
19	Denver	CO	Replacement Medical Center Facility (OV).	554-501	$8,982,484	$832,040	$9,814,525
20	Salem	OR	Community-Based Outpatient Clinic	Lease	$1,479,486	$0	$1,479,486
20	Eugene	OR	Community-Based Outpatient Clinic	Lease	$5,765,526	$0	$5,765,526
20	Seattle	WA	Correct Seismic Deficiencies B100, NT & NHCU.	663-406	$9,945,330	$127,171	$10,072,500
20	Walla Walla	WA	Multi Specialty Care (Overview)	687-400	$685,808	$351,214	$1,037,022
21	Monterey	CA	Health Care Center	Lease	$0	$1,136,277	$1,136,277
21	Palo Alto	CA	Centers for Ambulatory Care and Polytrauma Rehabilitation (OV).	640-424	$100,875	$5,060,925	$5,161,800
22	Bakersfield	CA	Community-Based Outpatient Clinic	Lease	$264,985	$187,947	$452,932
22	Loma Linda	CA	Health Care Center	Lease	$2,079,918	$3,691,593	$5,771,511
22	Long Beach	CA	Seismic Corrections/Clinical, B-7 & 126.	600-402	$622,331	$0	$622,331

Fiscal Year 2015—Continued

VISN	Location	State	Description	Project	Recurring	Non-Recurring	Total
			Total		$83,247,227	$46,752,773	$130,000,000

B. Please describe the activation costs that fall within the Medical Services account and those costs that fall within the Medical Facilities account.

Response. Activation costs are funded by the two appropriations based upon what those appropriations are used to purchase. For example, if the activation cost was the result of purchasing medical equipment or hiring new clinical staff, the Medical Services appropriation would be required. If the activation cost was to expand a sidewalk and install a wheelchair ramp to make the facility more accessible to Veterans with limited mobility, the Medical Facilities appropriation would be required.

Question 145. The Medical Support and Compliance account contains funding for VHA central office, Veterans Integrated Service Networks (VISN) headquarters offices, and management of the medical centers. However, unlike last year's budget request, this year's request does not display funding for these three accounts separately.

a. How much does VA expect to spend in fiscal years 2014 and 2015 for VISN headquarters functions?

Response. In the 2014 Congressional submission, VA anticipated spending $308 million in 2014 and $297.1 million in 2015. In the 2015 Congressional submission, the 2014 estimate is revised to $291.6 million and the 2015 estimate remains at $297.1 million.

b. How much funding will be saved as a result of implementing VHA's staffing reorganization of VISN headquarters?

Response. VA's 21 Veterans Integrated Service Networks (VISNs) are being restructured around a standard staffing structure for each VISN. As the result of this initiative, VA estimates savings of $25 million each in FY 2014 and FY 2015 in the Medical Support and Compliance account.

c. When does VHA plan to start the second part of the reorganization, a review of the number of VISNs? Please provide a detailed description of the criteria VHA will use to evaluate whether 21 VISNs are needed.

Response. The Under Secretary for Health convened a workgroup on April 4, 2013, chartered with reviewing the number and composition of VISNs that currently comprise make up the Veterans Health Administration. As part of that charter, the workgroup was responsible for developing the criteria and methodology that would be used to review the size and composition of the VISNs. A copy of the workgroup charter follows.

Department of
Veterans Affairs

Memorandum

Date: **APR 0 4 2013**

From: Under Secretary for Health (10)

Subj: Workgroup to Review Composition of Networks

To: Deputy Under Secretary for Health for Operations and Management (10N)
Deputy Under Secretary for Health for Policy and Services (10P)
Principal Deputy Under Secretary for Health (10A)

1. This memorandum establishes a workgroup to review the number and composition of Veterans Integrated Service Networks (VISN). The workgroup will review current boundaries of VISNs based on analysis of Veteran population and health care utilization trends. The workgroup shall also review the overall number of VISNs and may consider the combination of certain VISNs or further segmentation of certain VISNs.

2. The workgroup shall be chaired by the Deputy Under Secretary for Health for Operations and Management (10N) and co-chaired by the Deputy Under Secretary for Health for Policy and Services (10P). The Chair and Co-Chair may designate an acting chairperson and co-chairperson.

3. Proposed workgroup composition shall be comprised of the following individuals:
Network Director VISN 4 (10N4)
Network Director VISN 19 (10N19)
Network Director VISN 21 (10N21)
Assistant Deputy Under Secretary for Health for Policy and Services (10P)
Assistant Deputy Under Secretary for Health for Policy and Planning (10P1)
Assistant Deputy Under Secretary for Health for Clinical Operations (10NC)
Assistant Deputy Under Secretary for Health for Administrative Operations (10NA)

The workgroup may identify any individuals it deems necessary to serve as adjunct group members for the purposes of completing its mission. Additionally, the workgroup may identify any additional resources it deems necessary for the completion of its mission.

4. The workgroup shall establish a methodology document for conducting its review and analysis. The workgroup shall present the proposed methodology to the Under Secretary for Health for approval. Once approved, the workgroup shall apply the study methodology to analyze the number and composition of VISNs.

5. The workgroup shall develop recommendations to the Under Secretary for Health regarding the optimal number of VISNs, their boundary structures, and an ongoing review cycle for composition and number of VISNs.

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Workgroup to Review Composition of Networks

6. The workgroup is requested to complete its analysis not later than September 30, 2013.

Robert A. Petzel, M.D.

Question 146. Section 111 of Honoring America's Veterans and Caring for Camp Lejeune Families Act directs VA to develop a plan for recovery and collection of amounts for the Department of Veterans Affairs Medical Care Collections Fund (MCCF). This section provides a method to develop and implement a better process and system of controls to ensure accurate and full collections by VHA. Please provide details on VHA's efforts to implement section 111.

Response. Public Law 112–154, Section 111 requires the VA to develop and implement a plan no later than 270 days after the date of enactment to ensure recovery and collection from Veterans' health insurance for medical care and services provided through VA's Fee Basis authorities. VA has completed all actions associated with the requirements of Section 111 as described below:

• *Improved identification of billable fee claims:* The VHA Chief Business Office chartered a workgroup to reengineer business processes that support maximizing the cost recovery of billable fee services. The team implemented Standard Operating Procedures to improve identification of billable fee claims as part of this effort.

• *Training:* Training on the identification of billable Fee claims was provided to Fee and revenue operations staff using both written guidebooks and fact sheets.

• *Fee Revenue Goals:* Utilizing VA's Integrated Collections Forecasting Model (ICFM), goals for Fee revenue were established beginning in FY 2012.

• *Monitors:* Comprehensive monitoring to benchmark performance and outcomes was deployed in FY 2012.

• *Policies and Procedures for MCCF Recovery:* Deployment of seven industry best practice Consolidated Patient Account Centers is the cornerstone of ensuring long term success in MCCF Recovery. As part of this effort, policies and procedures were implemented for all revenue cycle functional areas and are continually monitored for updates.

Question 147. The issue of third party payers and MCCF have been the subject of a number of government reports over the years. These reports were critical of VHA's third party billing and collection practices. Because funds deposited in MCCF are retained by the medical centers and can be used to treat veterans, it is critical that VHA is able to collect all that is owed by third parties.

A. Please provide the Committee with the total amount VA sought in third party billings and the total amount collected from third parties for the last six fiscal years.

Response.

Fiscal Year	Total Third Party Billings
2007	$3,325,052,175
2008	$4,107,259,321
2009	$5,290,964,587
2010	$5,490,122,279
2011	$5,775,314,495
2012	$5,556,546,698

B. Please provide the Committee with the percentage increase in billings and collections for each fiscal year compared to the previous fiscal year's billing.

Response.

Fiscal Year	Total Third Party Billings	Percent (%) Change from Prior Fiscal Year	Total Third Party Collections	Percent (%) Change from Prior Fiscal Year
2007	$3,325,052,175	—	$1,261,345,593	—
2008	$4,107,259,321	23.52%	$1,497,448,632	18.7%
2009	$5,290,964,587	28.82%	$1,843,201,251	23.1%
2010	$5,490,122,279	3.76%	$1,904,031,955	3.3%
2011	$5,775,314,495	5.19%	$1,799,951,647	-5.5%
2012	$5,556,546,698	-3.79%	$1,847,530,762	2.6%

C. Please provide the Committee with the collection rate for claims over $1,000 for the last six fiscal years.

Response.

Fiscal Year	Collection rate for Claims over $1000
2007	44.5%
2008	42.2%
2009	40.9%
2010	39.2%
2011	35.8%
2012	36.5%

D. Please provide the Committee with the collection rate for claims under $1,000 for the last six fiscal years.

Response.

Fiscal Year	Collection rate for Claims under $1000
2007	50.3%
2008	45.1%
2009	41.3%
2010	39.5%
2011	35.5%
2012	35.5%

Question 148. In an explanation of health care benefits provided by the Honoring America's Veterans and Caring for Camp Lejeune Families Act, VA's budget request indicates "[i]n 2015 [VA] expects to start treating family members" and this budget, if adopted, would provide $25 million to treat Camp Lejeune families. The fiscal year 2013 Continuing Resolution (CR), signed into law on March 26, 2013, included the appropriations and legislative language needed for VHA to treat Camp Lejeune family members in fiscal year 2014.

A. Given that the CR provides the funding and language necessary to treat Camp Lejeune families, will VA be able to provide benefits earlier than fiscal year 2015? If not, please describe the barriers to providing treatment earlier than fiscal year 2015.

Response. The earliest VA will be able to reimburse family members for hospital care or a medical service is dependent on the publication of an effective rule to implement the statute

The family member regulations are currently going through Departmental review. Once completed, they will follow the regulatory development process established under the Administrative Procedure Act and will be submitted to the Office of Management and Budget (OMB) for review and approval. Concurrent with the finalization of regulations, VA will need to hire additional personnel to administer the family member program. VA anticipates that personnel will be hired and that other resources needed to implement this program will be in place when the regulations are published.

B. Please describe the regulation drafting process as it pertains to providing treatment to Camp Lejeune families, including a timeline of when VHA began the draft-

ing process, the stages of the process, when the regulations are expected to be final, and what stage in the current regulation process are those regulations.

Response. For family members, VA is expediting its own internal regulatory process. The very earliest VA anticipates being able to provide benefits to family members is by the start of FY 2015. Immediately after enactment of the law, VA assembled a Steering Committee, including subject matter and policy experts from the entire organization, which made policy decisions regarding providing treatment to Camp Lejeune family members.

The U.S. Marine Corps is preparing a memo to clarify the support it and DOD will provide to VA to determine administrative eligibility for Veterans and family members. VA has used subject matter expert briefings, Internet, social media, and traditional media to proactively reach out to stakeholders. Briefings and information papers have been provided to members of the Camp Lejeune Community Action Panel, concerned Veterans and their family members, Veterans Service Organizations, congressional staff, and the media.

Homelessness

Question 149. A letter from VA, dated February 1, 2012, included a timeline of the "VA Homelessness Reduction Strategy: 2009–2015." This timeline included decisions regarding increasing or decreasing budget requests, reallocating funding, and a decision whether to extend the timeline.

A. When does VA expect to make a decision regarding reallocating funding and whether to extend the timeline?

Response. The January 2013 PIT counts, projected to be released by HUD during quarter one of FY 2014, will provide an important snapshot of the Administration's progress in ending veteran homelessness.

Reallocating resources, however, is an ongoing process. VA's success in moving toward ending Veteran homelessness is in part due to ongoing program evaluation and realignment. VA's ongoing program realignment has been a two-pronged approach of focused service adjustments and a realignment of resource investment.

The SSVF Program, for example, is evidence of VA's ongoing efforts to realign program services and investments to end Veteran homelessness. Although still a relatively new program, it is already clear that the SSVF Program has been successful, which warrants continued, if not enhanced, investments. The SSVF Program provides grants to private non-profit organizations and consumer cooperatives to help Veteran families rapidly exit homelessness or to prevent at-risk Veterans from becoming homelessness. The SSVF Program is unique in that it can serve both the Veteran and his or her family member(s). The SSVF Program continues VA's efforts to realign services under a Housing First permanent supportive housing model.

In FY 2012, during the SSVF Program's first full year of operations, the program surpassed expectations, serving approximately 21,500 Veterans and over 35,000 persons. Of those served, 40 percent were at?risk for homelessness and seeking prevention services while the remaining 60 percent were provided rapid re?housing services to transition from homelessness into permanent housing. At the end of FY 2012, VA awarded 151 SSVF grants in 49 states and the District of Columbia for operations in FY 2013.

In recognition that this community-based resource needed to be more geographically available to all communities assisting Veterans and their families, VA announced a SSVF NOFA for an additional $300 million to further grow this program.

B. What criteria will VA use to determine whether to decrease budget requests, reallocate funding, and make a decision whether to extend the timeline?

Response. VA's budget focuses on preserving funding for mission-critical and cost effective services that directly benefit Veterans, their families, and Survivors, prioritizing programs shown to be effective in ending Veteran homelessness. Decisions regarding future prioritization will continue to be informed by data from the PIT Count in addition to data from VA homeless programs.

Question 150. In fiscal year 2012, Congress appropriated $1.023 billion for homeless veterans programs. Please provide the Committee a detailed breakdown of how this funding was utilized within these programs and the number of veterans who accessed these programs.

Response. VA operates the largest system of homeless medical, treatment, and assistance programs in the Nation. The hallmark of VA's programs for homeless Veterans is the provision of comprehensive care and benefits including medical, psychiatric, substance use, rehabilitation, dental care, and expedited claims processing for these Veterans. The following represent many programs included in VA's homeless continuum of care. All programs in this continuum are part of VA's plan to eliminate homelessness and contribute to the overall reduction of the homeless Veteran population.

Supportive Services for Veteran Families (SSVF) Program: In FY 2012, VA obligated approximately $100 million in funding for the SSVF Program for operations occurring in FY 2013. In FY 2012, the SSVF Program served over 35,000 Veterans and their family members based on $60 million in SSVF grants awarded in FY 2011. The SSVF Program makes available grant funds for private non-profit organizations and consumer cooperatives to help very low-income Veteran families rapidly exit homelessness or to assist Veteran families at-risk for homelessness. In addition to providing linkage to VA health care and other services, grantee organizations have the ability to directly address the type of emergent needs that, if unmet, can be deciding factors in a family's struggle to remain stably housed. Funds for emergency rental assistance, security and utility deposits, food and other household supplies, child care, one-time car repairs, and other needs will help to keep Veterans and their families housed—as families. In 2011, VA awarded the first SSVF grants, awarding approximately $60 million to 85 grantees in 40 states and the District of Columbia for operations in FY 2012. In FY 2012, SSVF grantees served over 35,000 Veterans and their family members, placing nearly 86 percent in permanent housing. In FY 2012, $100 million was awarded in SSVF grants to 151 community agencies in 49 states, Puerto Rico, and the District of Columbia for operations in FY 2013. In FY 2013, the SSVF Program anticipates serving at least 42,000 Veterans and their family members. In early FY 2013, a SSVF NOFA was published in the *Federal Register*, announcing the availability of $300 million for FY 2013. The application period closed on February 1, 2013, and VA is currently reviewing applications.

Veterans Homelessness Prevention Demonstration (VHPD) Program: In FY 2012, VA obligated $1.39 million in funding for VHPD and, during this time, VHPD provided services to over 730 Veteran families, of which 26 percent were female and 37 percent were OIF/OEF/OND Veterans. VHPD (also referred to as the HUD-VA Pilot Program) is designed to explore ways for the Federal Government to offer early intervention homeless prevention, primarily to Veterans returning from wars in Iraq and Afghanistan. This demonstration program provides an opportunity to understand the unique needs of a new cohort of Veterans and will support efforts to identify, provide outreach to, and assist them in regaining and maintaining housing stability. This 3-year HUD-VA prevention pilot is a partnership among VA, HUD, the Department of Labor (DOL), and local community agencies. VHPD will serve the following locations: MacDill Air Force Base in Tampa, Florida; Camp Pendleton in San Diego, California; Fort Hood in Killeen, Texas; Fort Drum in Watertown, New York; and Joint Base Lewis-McChord near Tacoma, Washington. As the lead agency, HUD is awarding grants for the provision of housing assistance and supportive services to prevent Veterans and their families from becoming homeless or to reduce the length of time Veterans and their families are homeless. In February 2011, grant agreements were signed by five Continuums of Care—regional or local planning bodies that coordinate housing and services funding for homeless families and individuals. VHPD sites began serving Veterans in March 2011.

The National Call Center for Homeless Veterans (NCCHV): In FY 2012, VA obligated $3.9 million in funding for the NCCHV. The NCCHV received 80,558 total calls in FY 2012, representing an increase of 123 percent over the same time period in FY 2011. The NCCHV was founded to ensure that homeless Veterans or Veterans at risk for homelessness have free, 24/7 access to trained counselors. The hotline is intended to assist homeless Veterans and their families; VA medical centers; Federal, state, and local partners; community agencies; service providers; and others in the community. The NCCHV (877–4AID-VET) was fully implemented on March 1, 2010. The NCCHV received 80,558 total calls in FY 2012. Of the calls received, 14,386 callers identified as being homeless. The NCCHV made 50,608 referrals to VA medical center points of contact in FY 2012, representing an increase of 133 percent over the same period in FY 2011.

Veterans Justice Programs: In FY 2012, VA obligated $18.3 million for Veterans Justice Programs. As part of VA's Plan to End Veteran Homelessness, VA is focused on serving Veterans involved with the criminal justice system, who may be homeless or at-risk for homelessness. Studies have shown that for adult males, incarceration is the most powerful predictor of homelessness. The Health Care for Reentry Veterans (HCRV) Program provides outreach and linkage to post-release services for Veterans in state and Federal prisons. In FY 2012, 10,572 Veterans were served through the HCRV Program. The Veterans Justice Outreach (VJO) Program focuses on Veterans in contact with law enforcement, jails, and courts, including the rapidly expanding Veterans Treatment Courts. In FY 2012, 27,251 Veterans were served in the VJO program.

Grant and Per Diem (GPD) Program: In FY 2012, VA obligated over $208 million in operating funds for the GPD Program and over $26 million in funding for VA

GPD liaisons, who provide services and oversight of GPD-funded programs. During this time, over 41,000 Veterans accessed GPD services. Under the GPD Program, VA offers GPD payments to public or non-profit private entities to develop transitional housing and supportive services for homeless Veterans. The goal of the program is to help homeless Veterans achieve residential stability, increase their skill levels and/or income, and obtain greater self-determination. VA awarded approximately $28.4 million in grants to fund transitional housing projects. Thirty-one of the funded projects are a TIP Housing Model, which will provide time-limited supportive services to homeless Veterans in which the services transition but the Veteran remains in the housing. During this fiscal year, VA activated 34 new transitional housing projects that can house up to 890 homeless Veterans.

Over 41,000 Veterans utilized GPD services in FY 2012. There were 22,148 discharges from GPD in FY 2012 with an average length of stay of approximately 183 days. The average cost per admission in GPD was $6,465. Approximately 56 percent (12,464) of homeless Veterans discharged from GPD moved into independent housing, and approximately 17 percent were discharged to another treatment setting. Twenty-six percent of Veterans discharged were employed at least part-time or were participating in VA's Compensated Work Therapy (CWT) Program.

Health Care for Homeless Veterans (HCHV) Program: In FY 2012, VA obligated approximately $119 million in funding for all programs funded through the HCHV Program. The HCHV Program is a three-pronged approach to eliminating homelessness among Veterans, consisting of contract transitional housing services, outreach, and case management. The HCHV Program is critical to VA's efforts to reach homeless Veterans living on the streets and in need of housing services. The program provides a means to contract with community-based residential treatment service providers to provide emergency housing and same-day placement of homeless Veterans identified in their outreach efforts. HCHV funds assist in supporting 16 CRRCs, which provide "one stop services" to assist homeless Veterans and Veterans and their families at-risk for homelessness. In FY 2012, HCHV outreach staff provided services to 119,878 homeless Veterans. The Contract Residential Treatment component of the HCHV Program ensures that Veterans with serious mental health diagnoses can be placed in community-based residential treatment programs which provide quality housing and services. The HCHV Program provides "in place" residential treatment beds through contracts with community partners and VA outreach and clinical assessments to homeless Veterans who have serious psychiatric and substance use disorders. In FY 2012, the HCHV Program contracted residential programs provided transitional housing to over 11,500 homeless Veterans. The Veterans were supported in 3,399 operational beds at 299 sites, system-wide.

Domiciliary Care for Homeless Veterans (DCHV): In FY 2012, VA obligated $19.98 million to the development of five new DCHV programs. The DCHV mission is to provide time-limited, state-of-the-art, high quality residential rehabilitation and treatment services for homeless and at-risk of homeless Veterans with multiple and severe medical conditions, mental illness, addiction, or psychosocial deficits. DCHVs provide a 24/7 structured and supportive residential environment as part of the rehabilitative treatment process. In FY 2012, there were 2,342 DCHV beds dedicated to the treatment of homeless Veterans, an increase of 41 beds from FY 2011. The DCHV programs served 8,389 unique Veterans in FY 2012. In FY 2012, 54.8 percent of Veterans were discharged to permanent housing. An additional 25 percent of Veterans were discharged to another Mental Health Residential Rehabilitation and Treatment Program (MH-RRTP), health care institution, or transitional housing. Between FY 2007 and FY 2012, the number of homeless Veterans served yearly in all MH-RRTP programs increased by 68 percent from 14,112 to 23,835. In FY 2012, VHA will develop five new DCHV programs in Philadelphia, Atlanta, West Palm Beach, Denver, and San Diego. The Denver DCHV opened at the end of May 2013. The Atlanta DCHV and the Philadelphia DCHV are scheduled to open in November 2013. The San Diego DCHV is scheduled to open by May 2014. The West Palm Beach DCHV is scheduled to open in 2016 after the construction of a new on-station building. VHA has also approved the development of a DCHV in San Juan, Puerto Rico, which is scheduled to open in 2015.

Substance Use Disorder (SUD) Treatment Enhancement Initiative for VA Homeless Programs: In FY 2012, VA obligated approximately $3.5 million for the SUD Treatment Enhancement. VHA's SUD Treatment Enhancement Initiative created community-based Homeless SUD Specialist positions designed to provide case management and referral services to homeless Veterans with SUDs. These specialists assist Veterans in obtaining and maintaining housing, increasing access to substance abuse treatment, and enhancing opportunities for recovery. In FY 2012, this initiative funded a total of 47 SUD Specialists at targeted sites around the country, providing critical services to 8,390 homeless Veterans.

HUD-VASH Program: VA obligated $169.9 million for the HUD-VASH program during FY 2012, housing over 37,000 Veterans in this program. HUD-VASH is a collaborative program between HUD and VA for eligible homeless Veterans to receive a HUD-provided Housing Choice voucher and VA-provided case management and supportive services to support stability and recovery from homelessness. Case management services ensure the Veteran is able to obtain and sustain in permanent housing, thus exiting from homelessness. These case management services also ensure a wide menu of choices so the Veteran may care for his or her physical and mental health and SUDs as well as promote integration into the Veteran's chosen community. As of September 30, 2012, 44,020 HUD-VASH vouchers were in use and 37,591 Veterans were housed through this program.

Homeless Veterans Dental Initiative (HVDI): In FY 2012, 119 participating VA facilities reported that 14,114 Veterans received dental care through the HVDI's total FY 2012 obligations of $27.3 million. HVDI is jointly funded by VHA Homeless Programs and the Office of Dentistry. This initiative enhances the accessibility of quality dental care to homeless Veteran patients to help ensure success in VHA-sponsored and VA partnership homeless rehabilitation programs. The HVDI facilitates the provision of limited outpatient benefits for a one-time course of dental care for VA health care eligible Veterans who are enrolled for at least 60 days in the following programs: GPD, DCHV, CWT—Transitional Residence (CWT-TR), Healthcare for Homeless Veterans Contract Residential Treatment, and Community Residential Care.

Homeless Veteran Supported Employment Program (HVSEP): In FY 2012, VA obligated approximately $25 million for HVSEP and provided employment services to 12,815 Veterans. Homeless and at-risk Veterans need access to employment opportunities to support their housing needs, improve the quality of their lives, and assist in their community reintegration efforts. VA has committed to supporting this critical component to eliminating homelessness through HVSEP. HVSEP, jointly operated by CWT and VHA Homeless Programs, provides vocational assistance, job development, job placement, and ongoing employment supports to improve employment outcomes among homeless Veterans. Vocational and employment services are based on rapid engagement, customized job development, and competitive community placement with ongoing supports for maintaining employment.

National Homeless Registry: In FY 2012, VA obligated $7.2 million in funding for the National Homeless Registry. Although not a program itself, VA's comprehensive National Homeless Registry is intended to track and monitor treatment outcomes in homeless program expansion and prevention initiatives. The Registry serves as a data warehouse and enhances VA's capability to monitor program effectiveness and the long-term outcomes of Veterans who have utilized VA-funded homeless services. The Registry is currently populated with over 500,000 names of current and formerly homeless Veterans who have utilized VA's homeless programs. VHA will continue to refine its Registry to fully capture the scope of the homeless Veteran population, monitor treatment outcomes, and access to VA services.

Question 151. The fiscal year 2013 budget request included $21 million for 200 additional FTE to be Homeless Veterans Outreach Coordinators (HVOC) in VBA. Please provide the Committee with an update on the hiring status of the additional 200 HVOCs, where the additional HVOCs will be located, and when VA expects to have completed the hiring of additional HVOCs.

Response. The FY 2013 President's Budget, submitted to Congress in February 2012, included a request for an increase of $21 million and 200 FTE to serve as Homeless Veterans Outreach Coordinators (HVOCs) at the ROs. Homeless Veterans Outreach is one of several integrated programs woven into the Department's six strategies outlined in its 5-year plan to end homelessness among Veterans—outreach/education, treatment, prevention, housing/supportive services, income/employment/benefits, and community partnership—that encompass a wide continuum of interventions and services.

By the summer of 2012, assessments of the Department's homelessness program indicated that existing outreach efforts were proving successful, as evidenced by a 58 percent increase in the number of claims received from homeless or at-risk Veterans. Concurrently, the C&P inventory pending more than 125 days was increasing rather than diminishing. As a result of this combination of factors, the Secretary decided in the Fall of 2012 to reprioritize the HVOC resources and allow them to be invested toward reducing the claims backlog.

Question 152. The fiscal year 2014 budget request includes $1.393 billion for fiscal year 2014 and $1.0 billion for fiscal year 2015 for homeless veterans programs. The fiscal year 2015 advance appropriation request includes the funding of several programs being eliminated, including Domiciliary Care for Homeless Vets-Initiative,

Substance Abuse/Mental Health Enhancement, Expansion of Homeless Dental Initiative, Homeless Veterans Supported Employment Program, and Homeless Therapy Employment, Compensated Work Thearpy (CWT) & CWT/TR-Sustainment.

A. What metrics were used to determine that these programs were no longer needed in fiscal year 2015?

Response. As VA's plan to end Veteran homelessness nears 2015, VA is gradually reducing funding for certain programs, moving other programs to sustainment, and generally realigning resources to preserve key homeless services for the long term. To this end, funding for several programs will be eliminated from VA's homeless programs budget in FY 2015. The programs and services are still being provided through local VA medical centers and funded through different mechanisms than specific program budget line items. VA's homeless program budget focuses on preserving funding for absolutely necessary and mission-critical services, prioritizing programs shown to be effective in ending Veteran homelessness. The rationale behind these budget decisions is outlined below. As VA considered these budget decisions, VA chose to fund many of these eliminated programs through the Veterans Equitable Resource Allocation (VERA) model. VA funds each VISN using the VERA model, a capitated funding model that allows equitable distribution of patient care, education, and research funding based on patient workload with an adjustment factor for geographic location. In summary, the decision to eliminate these program line items from VA's homeless programs budget was functional and fiscal in nature rather than performance/metrics-driven. The rationale behind these decisions are as follows:

• *DCHV:* Currently, there are 42 DCHV programs across the country. VA's plan to end Veteran homelessness called for the implementation of five new DCHV programs in Philadelphia, Atlanta, West Palm Beach, Denver, and San Diego. By design, DCHV programs throughout the country are funded primarily through VA's VERA model. The funding eliminated in FY 2015 specifically supported the implementation of these five new DCHV programs. It is expected that development and implementation efforts will be completed by FY 2015 and that ongoing operations can be funded through VERA along with all the other DCHV programs.

• *Substance Abuse/Mental Health Enhancement:* This initiative supported the creation of 47 Homeless Program Substance Use Disorder Specialists nationally. Since the inception of the enhancement, VA intended that funding for these positions would be shifted to VERA, consistent with the majority of SUD services offered by VA. These positions theoretically join the existing pool of SUD service providers in VA's system, thus ensuring the sustainability of such services for homeless Veterans.

• *Homeless Dental Initiative:* Homeless Dental Initiative funding is an enhancement to existing VA dental programs serving homeless Veterans. During a time of budget constraints, VA decided to eliminate this funding enhancement because dental services do not in and of themselves end homelessness. In order to preserve funding for and focus on the absolutely necessary and mission-critical services, VA eliminated enhanced dental funding in VA's homeless program budget. Currently, VHA Dental Services allocates approximately $17 million for the dental care of eligible Veterans who are enrolled for at least 60 days in the following programs: GPD, DCHV, CWT-TR, HCHV Contract Residential Treatment, and Community Residential Care.

• *HVSEP:* From its inception, HVSEP was intended to transition from an initiative funded through VA homeless programs to the VERA system by its fourth year of operation. This transition is a strategic decision and is not a reflection on its value as a program. In fact, VHA Homeless Programs Office is currently working on ways to expand employment services to homeless Veterans through its ongoing programs as well as through non-homeless programs such as CWT and through enhanced use of community-based employment resources. This expanded focus on employment is in recognition of the critical role employment plays in helping Veterans' exit or preventing homelessness.

• *CWT and CWT/TR—Sustainment:* CWT and CWT/TR are funded through VERA and, thus, these services will be sustained despite any changes in funding within the VHA Homeless Programs Office.

B. If VA does not meet its goal of reducing the number of homeless veterans from 62,619 in 2012 to 47,000 in 2013, how will this impact the funding requested for fiscal year 2015?

Response. VA has already had significant and measurable success in ending Veteran homelessness. Based on HUD PIT Count, as available at the time of the FY 2014 Budget hearing, from January 2009 to January 2012, the number of Veterans experiencing homelessness on a single night has decreased 17.2 percent (from

75,609 to 62,619), a reduction that occurred in a particularly challenging economic environment. The PIT Count is a count of sheltered and unsheltered homeless persons on a single night in January and is intended to be a snap shot in time. Consequently, it is important to note that in the event VA does not meet the PIT Count benchmark reduction to 47,000 homeless Veterans in FY 2013 (as measured in the January 2014 PIT Count), this does not mean VA is not on track to end Veteran homelessness.

VA and HUD data sources inform the resource allocation and investment process for VA's homelessness programs. Programs such as SSVF and HUD-VASH, which are focused on both homeless prevention and permanent supportive housing, are critical to accelerating VA's progress in connecting Veterans to permanent supportive housing and providing crucial supportive services. For example, VA sees an urgent need for continued reinvestment in the HUD-VASH Program. To achieve more rapid engagement with chronically homeless Veterans, an additional 10,000 vouchers with funding for long term case management services in FY 2015 will likely be needed to serve the most vulnerable homeless Veterans. Finishing the job of ending Veteran homelessness will require continued investment in Veteran-centric housing and health programs, the widespread adoption of evidence-based best practices such as Housing First, and resources that ensure that Veterans receive the proper treatment to achieve the best housing, income, and treatment outcomes.

Finally, despite the comprehensive array of services and programs already proposed in VA's budget, VA cannot directly address all the needs of homeless Veterans and their dependents. If VA is to end Veteran homelessness, VA must continue to cultivate strong and productive relationships within the community. Veterans, their partners, and their dependent children have a number of unmet health care needs directly related to their housing instability, including: emergency cash assistance, temporary housing for family members separate from the Veteran, transportation, affordable housing, move in kits and supplies, and legal services. These are all essential resources that in many cases, VA cannot directly provide to homeless Veterans and their families. Continued coordination with Federal, state, local, faith-based, philanthropic, and Veterans Service Organizations is vital for connecting all Veterans and their families with the housing and supports needed to prevent and end Veteran homelessness.

Question 153. In December 2011, VA signed 38 leases creating a public-private partnership to develop housing units for homeless veterans. Through the Building Utilization Review and Repurposing (BURR) initiative, VA identified unused or underutilized property which would create an additional 4,100 housing units.

A. How many additional units of housing were available through this program in fiscal year 2012 and how many will be available by the end of fiscal year 2013?

Response. The 38 enhanced-use lease (EUL) agreements signed in December 2011 as part of the BURR initiative created public/private partnerships whereby EUL lessee/developers, in exchange for a long-term leasehold interest in underutilized or vacant VA land and/or buildings, are responsible for the design, construction, operation, and on-going maintenance of supportive housing for homeless or at-risk Veterans. During FY 2012, all 38 projects were still in the design and/or construction phase; as a result, no new units went into operations during FY 2012.

VA currently anticipates that 135 units will be placed into operations by the close of FY 2013 as a result of BURR EUL agreements. In addition, 258 units of supportive housing have or will become operational during FY 2013 as a result of three recent EUL agreements signed independently of the BURR initiative.

B. What are the lessons learned from the leases that were executed in 2011 and how will these lessons learned be implemented to improve this program in the future?

Response. The chief lesson learned from the BURR initiative concerns the interdependency between capital and operational financing. In many cases, state housing finance agencies (the entities responsible for dispersing Federal low-income housing tax credits (LIHTCs)) and investors (e.g., LIHTC syndicators) are unwilling to close on capital financing until developers have secured commitments of operational financing (e.g., rental subsidies like project-based HUD-VASH or Section 8 vouchers). Capital financing must be finalized before construction can begin, and construction on these facilities typically takes a minimum of twelve months—often longer. However, the entities responsible for dispersing operational financing and subsidies (e.g., local Public Housing Authorities) are often unable to make commitments of operational support this far in advance. This creates a 'Catch–22' of sorts for developers (like the BURR EUL lessees) who are attempting to leverage LIHTCs to create permanent affordable supportive housing for highly-vulnerable individuals, such as homeless Veterans.

VA has been coordinating with HUD in an effort to identify solutions to this "Catch–22"; currently, both agencies are hopeful that some mitigating measures have been identified. Going forward, VA will continue to coordinate with HUD, in an effort to identify these sorts of issues in advance, and to proactively generate solutions.

C. What are the barriers identified that caused delays in these projects moving forward?

Response. While the factors that have caused delays to some of the BURR projects' schedules are ultimately unique to each project, it is possible to categorize most of these sources of delays under three broad headings: (i) financing, (ii) local opposition, and (iii) unforeseen environmental/historical conditions. (i) Financing delays sometimes take the form of the Catch–22 described in response to Question 153(B) above, but other types of financing-related delays have impacted the BURR EUL projects as well. For instance: two states (Maine and Massachusetts) suspended housing finance programs during 2012, causing developers on three projects to have to await at least a year longer to apply for financing. In other cases, developers submitted applications for competitively-awarded tax credits, and simply were not awarded any—thereby requiring the developers to apply in the following year's cycle. (ii) Due to the nature of the contemplated housing facilities, EUL developer/ lessees frequently face 'Not In My Backyard' ('NIMBY') opposition from local residents and municipalities.. (iii) Finally, the consultation processes required pursuant to Federal environmental and historic preservation regulations, for example (the National Environmental Protection Act and the National Historic Preservation Act (NHPA), respectively) can uncover unforeseen issues which result in delays. For example: compliance with Section 106 of the NHPA often requires VA to perform archaeological surveys at EUL sites before construction can begin. These surveys can be lengthy, and furthermore they sometimes recommend follow-up studies or mitigation measures which are themselves costly and time-consuming.

Veterans Transportation Service

Question 154. The Dignified Burial and Other Veterans' Benefits Improvement Act of 2012 provides VA with authority to transport veterans to or from a VA facility or other locations that provide other services, such as vocational rehabilitation, counseling, and health services.

A. Please provide the Committee with which VA medical facilities are providing transportation through this authority.

Response. Please see table below.

Veterans Transportation Service Initiative
Planned and/or Current Implementation Sites

VISN	Facility	FY12 Veteran Trips	Q1 FY13 Veteran Trips	Mobility Manager	Comments
1	Boston, MA	25,555	4,157	Y	
1	Bedford, MA			N	Recruiting VTS staff
1	West Haven, CT			N	Recruiting VTS staff
1	Manchester, NH			Y	Conducting pre-deployment needs/resources assessment
1	Augusta, ME			Y	Conducting pre-deployment needs/resources assessment
2	Albany, NY			Y	
2	Bath, NY	*Consolidated*		Y	
2	Buffalo, NY	17,793	4,372	Y	
2	Canandaigua, NY			Y	
2	Syracuse, NY			Y	
3	New Jersey, NJ	*Consolidated*		Y	
3	Lyons, NJ	21,563	6,227	N	
5	Cambridge, MD	6,716	2,254	N	
5	Washington, DC	243	102	Y	
6	Fayetteville, NC	1,027	1,006	N	
6	Salisbury, NC	2,661	2,031	N	Reassessing needs/resource requirements
7	Charleston, SC			Y	Conducting pre-deployment needs/resources assessment
7	Atlanta, GA	5	25	Y	Conducting pre-deployment needs/resources assessment
7	Augusta, GA			Y	Recruiting VTS staff
7	Dublin, GA			N	Recruiting VTS staff
7	Tuscaloosa, AL			Y	Recruiting VTS staff
8	Gainesville, FL			Y	Conducting pre-deployment needs/resources assessment
8	Bay Pines, FL	3,850	1,736	N	
9	Mountain Home, TN			Y	Conducting pre-deployment needs/resources assessment
9	Lexington, KY			Y	Recruiting VTS Staff
9	Huntington, WV			N	Recruiting VTS staff
9	Nashville, TN			N	Recruiting VTS staff
9	Louisville, KY			N	Reassessing needs/resource requirements
9	Memphis, TN			N	Recruiting VTS staff
10	Cincinnati, OH	2,324	1,715	Y	
10	Columbus, OH	2,353	1,243	Y	
10	Chillicothe, OH			Y	Conducting pre-deployment needs/resources assessment
10	Cleveland, OH			Y	Conducting pre-deployment needs/resources assessment
10	Dayton, OH			N	Recruiting VTS staff
11	Ann Arbor, MI	14,791	3,217	Y	
11	Battle Creek, MI	8,091	101	Y	
11	Indianapolis, IN		767	Y	
11	Danville, IL	182	924	Y	
11	Saginaw, MI			N	Conducting pre-deployment needs/resources assessment
12	Iron Mountain, MI	6,290	1,283	N	

VISN	Facility	FY12 Veteran Trips	Q1 FY13 Veteran Trips	Mobility Manager	Comments
12	Madison, WI	1,197	2,239	Y	
12	Hines, IL	4,607	2,141	Y	
12	Chicago, IL			N	Recruiting VTS staff
12	Tomah, WI	1,558	905	Y	
15	St. Louis, MO			N	Recruiting VTS staff
15	Marion, IN		956	Y	
15	Poplar Bluff, MO	782	772	Y	
15	Kansas City, MO		300	Y	
15	Topeka, KS			N	Reassessing needs/resource requirements
15	Fresno, CA			N	Recruiting VTS staff
15	Wichita, KS			N	Recruiting VTS staff
16	Muskogee, OK	7,407	1,956	Y	
16	Alexandria, LA	3,920	912	N	
17	Temple, TX	18,560		N	Reassessing needs/resource requirements
17	Dallas, TX	8,696	3,170	Y	
18	Phoenix, AZ	668	550	N	
18	Prescott, AZ	5,395	793	Y	
18	Tucson, AZ	6,072	562	Y	
18	Big Spring, TX	1,999	824	N	
18	Amarillo, TX	4,645	2,155	Y	
18	Albuquerque, NM			N	Postponed implementation to FY 14
19	Salt Lake City, UT	6,250	881	N	
19	Montana, MT	3,289	643	Y	
19	Sheridan, WY			N	Recruiting VTS staff
20	Portland, OR	2,433	1,064	Y	
20	Seattle, WA	1,844	154	Y	
20	Spokane, WA	546	340	Y	
20	Roseburg, OR			Y	Conducting pre-deployment needs/resources assessment
20	Anchorage, AK		123	Y	
20	Walla Walla, WA		119	Y	
21	Mather, CA			Y	Conducting pre-deployment needs/resources assessment
21	Honolulu, HI			N	Recruiting VTS staff
22	Loma Linda, CA	2,116	603	Y	
22	San Diego, CA			N	Recruiting VTS staff
22	Las Vegas, NV			N	Recruiting VTS staff
23	St. Cloud, MN	2,267	585	Y	
23	Minneapolis, MN			Y	Conducting pre-deployment needs/resources assessment
23	Fort Meade, SD			N	Recruiting VTS staff
	Total	**197,695**	**53,907**	**47**	

B. Please provide any analyses conducted to determine the need for this program.
Response:

Challenges

VTS was conceived with the goal of providing safe, reliable, and efficient transportation for Veterans to VA health care, especially those who are mobility impaired; suffered a Traumatic Brain Injury; severe PTSD, or other medical and mental health problems which make self-arranged transportation difficult or who reside in rural areas which lack public transportation. In the two years since, its inception, Veterans have increasingly relied on VTS transportation services. With almost 75% of the VTS sites depending on paid drivers for over 50% of Veterans' rides.

Volunteer Drivers

While 48% of VTS facilities rely exclusively on VA staff to transport Veterans, most facilities use a combination of paid and volunteer drivers. The Disabled Amer-

ican Veterans organization (DAV) has long been a very positive contributor to Veterans receiving needed health care. In 2011, through the Volunteer Transportation Network (VTN) 702,867 Veterans were provided transportation to and from VA health care facilities. However, with increasing numbers of transportation disadvantaged Veterans, the number of volunteer drivers at most VA medical centers does not meet Veterans' transportation needs. Volunteer drivers are generally precluded from transporting Veterans who are not ambulatory, require portable oxygen or have significant medical issues. Additionally, some volunteers, for valid reasons, are reluctant to transport non-ambulatory or very ill Veterans. Across the country, VTS transportation requests surpass the capacity of the VTN.

Beneficiary Travel Program

VA's Beneficiary Travel (BT)Program, as part of VA Medical Care Benefits, provides mileage reimbursement at $0.415 per mile, common carrier (plane, boat, taxi, bus etc.) transportation, and when medically indicated special mode (ambulance, wheelchair van etc.) transport to low-income or disabled Veterans for travel to receive treatment, care or services at VA or VA authorized medical facilities. VA may also provide or reimburse for the actual cost of bridge tolls, road and tunnel tolls, parking, and authorized luggage fees when supported by a receipt. BT eligibility is based upon receipt of VA service connection and/or low income (VA pension thresholds). Approximately 3.3 million of 5.5 million current VHA users are eligible for BT; however, only 1.3 million of those utilize the benefit. Some eligible Veterans choose not to use the benefit for personal reasons; however, others have noted inability to drive to appointments, limited or no local (common carrier) transportation services meeting their needs, and not meeting medical need for special mode transport at VA expense. Veterans without BT eligibility have noted similar issues. VTS allows access for many of these Veterans and anecdotal evidence indicates BT mileage costs are reduced when veterans are transported on a VTS vehicle or use a common carrier. Additional anecdotal evidence indicates BT special mode costs are also reduced when VTS provides transportation rather than VA purchased community special mode transport services. A decrease in available VTS services will likely require a return of many BT eligible Veterans to some form of that program.

Community Transportation Resources

The VTS Program has funded Mobility Manager positions at facilities to identify available community transportation resources and to create partnerships among transportation providers in their region, so as to expand the range of viable options that Veterans have for transportation. To date, VA has trained 47 Mobility Managers. Additional training sessions have been scheduled for July and August 2012; however, 18 facilities have not yet filled their Mobility Manager positions.

Coordination of transportation services is challenging due to differences in local, state, and Federal program requirements. Often, program rules are unclear about coordination of transportation services between different entities.

Programs may also have statutory or regulatory barriers related to sharing costs or have differences in service requirements and eligibility. For example, VA only has authority to provide transportation at VA expense to certain qualifying Veterans and non-Veterans in relation to VA health care: not all beneficiaries are eligible and there is no authority for transport of non-beneficiaries. HHS's Medicaid program is the largest source of Federal funds for non-emergency medical transportation for qualified low-income beneficiaries; however, barriers to transportation coordination for Medicaid grantees exists due to concerns about commingling Federal program funds and the potential for fraud. In addition, local community providers often have policies that impose income criteria or limit transportation to certain geographic areas, such as within county lines.

VTS analysis comprised environmental surveys which yielded the following results:

Canceled appointments and missed opportunities are a high cost to the system:

• Resource utilization
• Lack of timely care causes health complication and spiraling costs

Targeted VTS toward clinics with high Missed Opportunities:

• Temple TX demonstrated over 4% reduction in tracked clinics

VTS Veteran Survey results:

• Veterans using VTS indicate they have previously missed health care appointments due to transportation problems
• 25% of respondents (397/1591) indicated VTS was responsible for meeting appointment time

Readjustment Counseling Service

Question 155. Public Law 111–163, the Caregivers and Veterans Omnibus Health Services Act of 2010, provided VA with the authority to provide services through the Readjustment Counseling Service (Vet Center) Program to members of the Armed Forces and members of the Guard and Reserve who served in Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn.

A. What is the status of implementing this provision? What are the barriers VA is facing to providing services to members of the Armed Forces under this law?

Response. VA and DOD are currently in the final stages of the joint regulatory process that was required in Section 401 of Public Law 111–163. Implementation is expected immediately after OMB's approval of the proposed rule, public comment, and the publishing of the final rule.

B. Once this provision is fully implemented, does VA anticipate an increase in funding will be needed due to the program expansion?

Response. In anticipation of the implementation of section 401 of Public Law 111–163, VA has requested an increase in FY 2014 funding to Readjustment Counseling Service for expansion of Vet Center services to certain active duty Servicemembers.

Question 156. The fiscal year 2013 National Defense Authorization Act (NDAA) included the Mental Health ACCESS provision, which expands the eligibility criteria for those who are eligible to receive services at Vet Centers. Does the fiscal year 2014 budget request take into consideration the costs associated with the implementation of the Mental Health ACCESS provision within the 2013 NDAA regarding the expansion of the Vet Center program?

Response. Yes, VA's budget request includes resources to support this provision, estimated at $4.8 million in FY 2014.

Medical and Prosthetic Research

Question 157. According to VA, in 2011, 89 percent of VA facilities offered Complementary and Alternative Medicine to address physical and mental health conditions.

A. Please provide the Committee with a list of facilities that currently provide Complementary and Alternative Medicine and what facilities offer these treatments for mental health conditions.

Response. The attachment below contains a list of VHA facilities that currently provide CAM services.

COMPLEMENTARY AND ALTERNATIVE MEDICINE (CAM) MODALITIES PROVIDED AT VA BY VA STAFF OR NON-VA STAFF *
as Noted in the Healthcare Analysis & Information Group (HAIG) 2011
Complementary and Alternative Medicine Report
http://shfwire.com/files/pdfs/2011CAM_FinalReport.pdf

Bedford, MA 518
Manchester, NH 608
Northampton, MA 631
Providence, RI 650
Togus, ME 402
White River Junction, VT 405
VA Boston HCS 523
VA Connecticut HCS 689
Albany, NY 528A8
Bath, NY** 528A6
Canandaigua, NY 528A5
Syracuse, NY 528A7
Batavia, NY (VA Western New York HCS)*** 528A4
Buffalo, NY (VA Western New York HCS) 528
Bronx, NY 526
Northport, NY 632
VA Hudson Valley HCS 620
VA New Jersey HCS 561
Brooklyn, NY (VA New York Harbor HCS)** 630A4
New York, NY (VA New York Harbor HCS) 630

St. Albans-Queens, NY (VA New York Harbor HCS)** 630A5
Altoona, PA** 503
Butler, PA*** 529
Clarksburg, WV*** 540
Coatesville, PA 542
Erie, PA 562
Lebanon, PA** 595
Philadelphia, PA 642
Wilkes-Barre, PA* 693
Wilmington, DE 460
VA Pittsburgh HCS 646
Martinsburg, WV* 613
Washington, DC 688
Baltimore, MD (VA Maryland HCS)* 512
Fort Howard, MD (VA Maryland HCS)** 512A4
Perry Point, MD (VA Maryland HCS)*** 512A5
Asheville, NC 637
Beckley, WV** 517
Durham, NC 558
Fayetteville, NC 565
Hampton, VA 590
Richmond, VA 652

Salem, VA 658
Salisbury, NC 659
Atlanta, GA 508
Augusta, GA 509
Birmingham, AL 521
Charleston, SC 534
Columbia, SC 544
Dublin, GA 557
Tuscaloosa, AL 679
VA Central Alabama HCS* 619
Bay Pines, FL 516
Miami, FL 546
Orlando, FL* 675
San Juan, PR 672
Tampa, FL 673
West Palm Beach, FL 548
VA N. FL/S. GA Veterans HCS 573
Huntington, WV 581
Louisville, KY* 603
Lexington (Leestown), KY*** 596
Lexington (Cooper Dr.), KY* 596A4
Memphis, TN 614
Mountain Home, TN 621
VA Tennessee Valley HCS 626
Chillicothe, OH 538
Cincinnati, OH 539
Cleveland (Wade Park), OH* 541
Cleveland (Brecksville), OH** 541A0
Columbus, OH /OC/ 757
Dayton, OH 552
Battle Creek, MI 515
Detroit, MI 553
Indianapolis, IN 583
Saginaw, MI* 655
VA Ann Arbor HCS 506
VA Illiana HCS 550
VA Northern Indiana HCS 610
Hines, IL 578
Iron Mountain, MI** 585
Madison, WI* 607
Milwaukee, WI 695
North Chicago, IL 556
Tomah, WI 676
VA Chicago HCS 537
Columbia, MO* 589A4
Kansas City, MO 589
Marion, IL** 657A5
Poplar Bluff, MO* 657A4
St. Louis, MO* 657
Wichita, KS 589A7
VA Eastern Kansas HCS 589A5
Alexandria, LA 502
Fayetteville, AR 564 X X X X X X X X X X X X
Houston, TX 580 X X X X X X X X X X X X
Jackson, MS 586 X X X X X X X X X
Muskogee, OK 623 X X X X X X X X X
New Orleans, LA* 629 X X X X X X X X X X

Oklahoma City, OK* 635 X X X X X X X X
Shreveport, LA 667 X X X X X X X X X X X X
VA Central Arkansas HCS 598 X X X X X X X X X X X X X X X X X X X X X
VA Gulf Coast HCS* 520
VA Central Texas HCS* 674
Bonham, TX (VA North Texas HCS)** 549A4
Dallas, TX (VA North Texas HCS) 549
VA South Texas HCS 671
Phoenix, AZ 644
El Paso VA HCS** 756
VA Amarillo HCS 504
VA New Mexico HCS 501
VA Northern Arizona HCS 649
VA Southern Arizona HCS 678
VA TX Valley Coastal Bend* 740
VA West Texas HCS* 519
Cheyenne, WY 442
Grand Junction, CO* 575
Sheridan, WY 666
VA Salt Lake City HCS 660
VA Sourhern Colorado HCS*** 554GD
Denver, CO (VA Eastern Colorado HCS) 554
VA Montana HCS*** 436
Boise, ID 531
Portland, OR 648
Spokane, WA*** 668
Walla Walla, WA 687
White City, OR /Ind Dom/* 692
VA Alaska HCS* 463
VA Roseburg HCS 653
VA Puget Sound HCS 663
Honolulu, HI 459
Manila, PI*** 358
San Francisco, CA 662
VA Central California HCS 570
VA Northern California HCS 612
VA Sierra Nevada HCS 654
Livermore, CA (VA Palo Alto HCS)** 640A4
Palo Alto, CA (VA Palo Alto HCS)
Loma Linda, CA 605
VA San Diego HCS 664
VA Southern Nevada HCS 593
VA Greater Los Angeles HCS 691
VA Long Beach HCS* 600
Fargo, ND** 437
Iowa City, IA 636A8
Minneapolis, MN 618
Sioux Falls, SD** 438
St. Cloud, MN 656
VA Black Hills HCS 568
VA Central Iowa HCS 636A6
VA Nebraska-W Iowa HCS*** 636

[References to *, **, and *** were not provided with this worksheet.]

B. Please provide the Committee with a list of current and completed research studies on the efficacy of Complementary and Alternative Medicine for treatment of mental health conditions.

Response. See attached CAM Studies spreadsheet.

Completed Studies

VA Facility	Principal Investigator	Start Date	End Date	FY10 Funds	FY11 Funds	FY12 Funds	FY13 Funds	Project Title
Natural Products, Dietary Supplements, Diets								
Indianapolis, IN	Antony, Asok C.	9/30/2006	9/30/2010	$124,800	$0	$0	$0	Folate Receptor-Targeted Therapy for Cervical Cancer
Portland, OR	Fausti, Stephen A.	10/1/2007	12/31/2010	$181,700	$95,000	$0	$0	Prevention of Cisplatin Ototoxicity with the Antioxidant a-Lipoic Acid
Iowa City, IA	Dillon, Joseph S.	4/1/2008	3/31/2011	$150,000	$75,000	$0	$0	The Mechanisms of Dehydroepiandrosterone Actions on Vascular Endothelium
Minneapolis, MN	Gannon, Mary C.	4/1/2008	3/31/2011	$293,593	$229,528	$83,393		Metabolic Response to a LoBAG30 Diet in Diabetic Patients on Metformin
Salt Lake City, UT	McClain, Donald A.	4/1/2007	3/31/2011	$149,400	$74,700		$0	Iron and Type 2 Diabetes Risk: Role and Mechanisms
Palo Alto, CA	Zeitzer, Jamie M	4/1/2008	3/31/2011	$92,000	$32,700	$0	$0	Melatonin Replacement for Treatment of Sleep Disruption in Tetraplegia
Portland, OR	Bourdette, Dennis N.	10/1/2007	6/30/2011	$241,600	$138,500	$0	$0	Ginko Biloba for Cognitive Impairment in Multiple Sclerosis
Omaha, NE	Kharbanda, Kusum K.	9/30/2007	9/30/2011	$274,413	$280,885	$136,140	$0	Alcoholic Liver Injury: Treatment by Betaine
Long Beach, CA	Said, Hamid M.	9/30/2006	9/30/2011	$327,336	$326,934	$0	$0	Intestinal Folate Transport: Regulatory and Integrative Aspects
West Los Angeles, CA	Li, Zhaoping	4/1/2009	3/31/2012	$149,900	$149,900	$149,900	$0	Development of A Novel Anti-Hyperglycemic Agent
Portland, OR	Messamore, Erik	4/1/2008	3/31/2012	$253,478	$268,347	$133,046	$0	Niacin subsensitivity as a schizophrenia endophenotype
Portland, OR	Quinn, Joseph F.	4/1/2009	3/31/2012	$149,500	$149,500	$74,750	$0	Removing copper for pennies: an affordable strategy for Alzheimer's
Palo Alto, CA	Sheikh, Javaid I.	6/1/2005	6/1/2012	$2,477,007	$2,042,059	$1,607,188	$0	CSP 553 - Adjuvant Therapy for High Risk Prostate Carcinoma: Docetaxel & High Dose Calcitriol (DECAL)
Palo Alto, CA	McIntire, Kevin L.	7/1/2010	6/30/2012	$19,575	$88,938	$70,893	$0	Nutritional Supplementation and Work Overload in Uremic Muscle
Charleston, SC	Gattoni-Celli, Sebastiano	1/1/2010	12/31/2012	$174,000	$225,899	$225,899	$113,849	Vitamin D Supplementation in Veterans with Early-Stage Prostate Cancer
West Los Angeles, CA	Aronson, William J.	4/1/2008	3/31/2013	$149,900	$149,900	$149,900	$74,950	Effect of Weight Loss on Prostate Cancer Pathology
Detroit, MI	Majumdar, Achip N.	4/1/2009	3/31/2013	$340,523	$342,890	$342,277	$305,390	Targeting Multiple Signaling in Colon Cancer with Curcumin and Dasatinib

VA Facility	Principal Investigator	Start Date	End Date	FY10 Funds	FY11 Funds	FY12 Funds	FY13 Funds	Project Title
Mind-Body Medicine (Mindfulness, Yoga, Acupuncture)								
Washington, DC	Prisco, Michelle K.	9/1/2009	8/30/2011	$44,700	$63,100	$0	$0	The Effect of Acupuncture on PTSD-related Insomnia
Milwaukee, WI	Dillingham, Timothy R.	9/1/2010	8/31/2011	$8,100	$89,100	$0	$0	Guitars for Vets: Evaluating psychological outcomes of a novel music therapy
East Orange, NJ	Findley, Thomas W.	7/1/2010	9/30/2011	$49,424	$48,972	$0	$0	Pilot of Acupuncture to Improve Quality of Life in Veterans with TBI and PTSD
Indianapolis, IN	Schmid, Arlene A.	5/1/2010	9/30/2011	$55,400	$76,277	$0	$0	Yoga as a Complex Intervention for Veterans with Stroke
Decatur, GA	Vaughan, Elizabeth C.	3/1/2010	2/29/2012	$85,417	$186,919	$77,738	$0	Management of Lower Urinary Tract Symptoms in Parkinson's Disease
Pittsburgh, PA	Weiner, Debra K.	7/1/2009	6/30/2012	$225,600	$238,600	$215,750	$0	Efficacy of Periosteal Stimulation & Boosters for Advanced Knee OA Pain
Seattle, WA	Kearney, David J.	10/1/2010	9/30/2012	$0	$95,105	$99,995	$0	A randomized controlled trial of a mindfulness based intervention for Gulf War Syndrome
Brockton, MA	Moye, Jennifer A.	4/1/2011	3/31/2013	$0	$49,100	$101,400	$43,100	Yoga Cancer Rehabilitation Study
Manipulative and Body-Based Practices (spinal manipulation, massage therapy)								
Syracuse, NY	Dougherty, Paul .	9/30/2007	9/30/2011	$150,000	$112,500	$0	$0	Chiropractic Management of Lower Back Pain in Older Adults
Practices using Energy Fields (light therapy, magnet therapy)								
West Haven, CT	Rochester, Carolyn L.	9/1/2008	8/31/2011	$164,436	$206,220	$0	$0	Rehabilitation of Patients with COPD Using Electrical Muscle Stimulation
Cleveland, OH	Lin, Vernon W.H.	10/1/2007	9/30/2011	$136,257	$183,513	$0	$0	Respiratory Muscle Conditioning Using Magnetic Stimulation for SCI Patients
Columbia, SC	Youngstedt, Shawn D.	1/1/2009	12/31/2011	$181,740	$182,970	$94,184	$16,083	Bright Light: An Adjunct Treatment for Combat PTSD
Decatur, GA	Butler, Andrew J.	10/1/2010	9/30/2012	$0	$99,799	$99,578	$0	Effects of Sympathetic Nerve Activity
Cleveland, OH	Cooper, Kevin D.	10/1/2007	9/30/2012	$125,000	$30,000	$0	$0	Mechanistically-based Optimization of UV Radiation Therapy in Psoriasis
Cleveland, OH	Bogie, Kath M.	1/1/2010	12/31/2012	$141,116	$346,300	$272,100	$69,525	Determination of Physiological Mechanisms for Electrical Wound Therapy

Current Studies

Natural Products, Dietary Supplements, Diets								
Cleveland, OH	Jaskiw, George E.	7/1/2009	6/30/2013	$200,000	$150,000	$150,000	$112,750	Tyrosine Availability Influences Mesocortico-Limbic Catecholamines
Hines, IL	McGuire, Susan O.	7/1/2010	6/30/2013	$29,700	$257,500	$286,400	$243,200	Freeze-Dried Blueberries: Prevention and Rehabilitation Strategies in MS
Bronx, NY	Post, James B.	7/1/2011	6/30/2013	$0	$20,353	$80,065	$61,062	Vitamin D Supplementation on Physical and Cognitive Function-Pilot Study

VA Facility	Principal Investigator	Start Date	End Date	FY10 Funds	FY11 Funds	FY12 Funds	FY13 Funds	Project Title
Ann Arbor, MI	Ramnath, Nithya	7/1/2010	6/30/2013	$37,493	$149,972	$147,525	$105,132	The role of Vitamin D metabolism in Non-Small Cell Lung Cancer
Portland, OR	Bourdette, Dennis N.	10/1/2009	9/30/2013	$150,000	$150,000	$150,000	$150,000	Lipoic Acid Therapy for Experimental Autoimmune Encephalomyelitis
San Antonio, TX	Chatterjee, Bandana	10/1/2009	9/30/2013	$322,723	$282,598	$282,598	$282,598	Vitamin D3, Interference with Androgen Signal and Inhibition of Prostate Cancer
Minneapolis, MN	Dysken, Maurice	4/1/2005	9/30/2013	$2,252,827	$2,010,238	$2,029,702	$0	CSP 546 - Trial of Vitamin E and Memantine in Alzheimer's Disease (TEAM-AD)
Little Rock, AR	Kortebein, Patrick	10/1/2010	9/30/2013		$2,601	$75,000	$73,899	An exercise and nutritional intervention for deconditioned older adults.
Hines, IL	McGuire, Susan O.	10/1/2012	9/30/2013	$0	$0	$0	$175,000	Freeze-Dried Fruit: Prevention and Rehabilitation Strategies in TBI
Durham, NC	Yancy, William S.	10/1/2010	9/30/2013	$0	$321,700	$342,000	$343,300	Considering Patient Diet Preference to Optimize Weight Loss
Boston, MA	Gaziano, Michael J.	7/1/2000	10/1/2013	$234,116	$1,196,398	$1,590,956	$2,197,515	Selenium and Vitamin E Cancer Prevention Trial
Baltimore, MD	Miller, Michael .	1/1/2010	12/31/2013	$92,434	$123,245	$123,245	$123,245	Comparative Effects of Two Popular Diets in Veterans with the Metabolic Syndrome
Portland, OR	Chung, Kathryn A.	9/30/2012	9/30/2014	$0	$0	$0	$78,849	Reducing Dyskinesia in Parkinson Disease with Omega-3 Fatty Acids
Decatur, GA	Guidot, David M.	10/1/2010	9/30/2014		$162,000	$150,000	$150,000	The mechanisms by which alcohol and HIV render the lung susceptible to injury
Miami, FL	Levis, Silvina	10/1/2010	9/30/2014		$276,360	$266,996	$272,775	Vitamin D in Vulnerable Adults
Milwaukee, WI	Patel, Shailendra B.	10/1/2010	9/30/2014		$240,000	$150,000	$150,000	Regulation of Metabolism by Dietary Sterols
Charleston, SC	Young, M. Rita I.	10/1/2009	9/30/2014	$150,000	$246,200	$248,989	$248,989	Vitamin D Plus Celecoxib Therapy to Stimulate Intratumoral Immune Reactivity
San Antonio, TX	Fanti, Paolo	1/1/2011	12/31/2014		$112,500	$150,000	$150,000	Correction of glutathione deficiency for treatment of diabetic nephropathy
San Francisco, CA	Bikle, Daniel D.	4/1/2011	3/31/2015		$5,905	$265,000	$150,000	Role of vitamin D and calcium signaling in wound healing
Long Beach, CA	Kashyap, Moti L.	4/1/2011	3/31/2015		$85,300	$149,600	$149,600	Novel mechanisms of niacin to improve HDL function: Role of myeloperoxidase
Salt Lake City, UT	McClain, Donald A.	4/1/2011	3/31/2015		$115,900	$149,600	$149,800	Iron, Metabolic Regulation and Type 2 Diabetes Risk
Miami, FL	Troen, Bruce R.	4/1/2011	3/31/2015		$118,095	$148,662	$149,613	Differential Impact of Resveratrol and Resveratrol Memetics Upon Aging Bone
Chicago, IL	Barengolts, Elena I.	7/1/2011	6/30/2015		$37,493	$149,953	$149,900	Vitamin D deficiency and treatment in male veterans at risk for diabetes
San Francisco, CA	Dahiya, Rajvir	10/1/2011	9/30/2015		$0	$375,693	$328,672	Genistein, microRNAs and kidney cancer
Long Beach, CA	Said, Hamid M.	10/1/2011	9/30/2015		$0	$289,192	$351,844	Intestinal Vitamin B2 Absorption: Molecular/Cellular Aspects and Effects of Alcohol

VA Facility	Principal Investigator	Start Date	End Date	FY10 Funds	FY11 Funds	FY12 Funds	FY13 Funds	Project Title
Portland, OR	Peterson, Amie	11/1/2010	10/31/2015	$0	$204,508	$221,691	$221,691	The Effects of Vitamin D on Balance in Persons with Parkinson's Disease
Portland, OR	Spain, Rebecca	11/1/2010	10/31/2015	$0	$254,741	$276,790	$276,790	Lipoic Acid for Neuroprotection in Secondary Progressive MS
Temple, TX	Shetty, Ashok K.	1/1/2012	12/31/2015	$0	$0	$324,672	$336,422	Memory and Mood Enhancing Therapies for Gulf War Illness
Birmingham, AL	Katiyar, Santosh K.	4/1/2008	3/31/2016	$202,450	$208,613	$246,938	$234,430	Prevention of photocarcinogenesis by dietary immunomodulation
Durham, NC	Acheson, Shawn	10/1/2011	9/30/2016	$0	$0	$227,983	$199,046	Novel Prophylactic Pharmacotherapy in an Animal Model of Closed Head Injury
Indianapolis, IN	Antony, Asok C.	10/1/2012	9/30/2016	$0	$0	$0	$150,000	Mechanism of Folate Deficiency as a Co-Factor for HPV16-induced Carcinogenesis
Miami, FL	Howard, Guy A.	9/30/2007	9/30/2016	$355,171	$355,171	$208,461	$395,351	Human Osteoprogenitor Control by Hepatocyte Growth Factor and Vitamin D
Loma Linda, CA	Mohan, Subburaman	9/30/2007	9/30/2016	$235,941	$226,973	$123,256	$149,000	MERIT REVIEW: Nrf1 Molecular Pathway, Vitamin C Deficiency, and Spontaneous Fractures
Madison, WI	Safdar, Nasia	10/1/2011	9/30/2016	$0	$0	$196,200	$146,200	IMpact of PRObiotics for reducing infections in VEterans: The IMPROVE Study
Portland, OR	Salinthone, Sonemany	10/1/2012	9/30/2016	$0	$0		$319,613	Elucidating the mechanisms that mediate the effects of lipoic acid in MS
Columbia, MO	Sowers, James R.	10/1/2012	9/30/2016	$0	$0	$0	$200,000	Interactions of the RAAS and a Western Diet on Insulin Metabolic Actions
Charleston, SC	Gattoni-Celli, Sebastiano	1/1/2013	12/31/2016	$0	$0	$0	$226,800	Vitamin D3 Supplementation for Low-Risk Prostate Cancer: A Randomized Trial
Ann Arbor, MI	Kakarala, Madhuri	10/1/2012	9/30/2017	$0	$0	$0	$247,500	Curcumin and Piperine in Breast Cancer Prevention Targeting Stem Cells
Decatur, GA	Mehta, Ashish J.	10/1/2012	9/30/2017	$0	$0	$0	$238,000	Alcohol abuse, oxidative stress, and zinc deficiency in lung disease

Mind-Body Medicine (Meditation)

VA Facility	Principal Investigator	Start Date	End Date	FY10 Funds	FY11 Funds	FY12 Funds	FY13 Funds	Project Title
San Diego, CA	Bormann, Jill E.	1/1/2012	12/31/2013	$0	$0	$340,889	$488,482	Portable Mantram Meditation for Veterans with Military Related PTSD
Tuscaloosa, AL	Davis, Lori L.	1/1/2012	3/31/2014	$0	$0	$239,263	$479,809	A Multisite Randomized Controlled Trial of Mindfulness Meditation Therapy for PTSD
Minneapolis, MN	Lim, Kelvin O.	1/1/2012	12/31/2013	$0	$0	$222,057	$467,024	Meditation Interventions for Treatment of PTSD in Veterans

Mind-Body Medicine (Mindfulness, Yoga, Acupuncture)

VA Facility	Principal Investigator	Start Date	End Date	FY10 Funds	FY11 Funds	FY12 Funds	FY13 Funds	Project Title
Indianapolis, IN	Davis, Louanne W.	10/1/2010	9/30/2013	$0	$125,164	$125,164	$125,164	Effects of Mindfulness-Based Conjoint CBT and PTSD
San Antonio, TX	Kumar, Addanki P.	10/1/2010	9/30/2013	$0	$199,000	$149,000	$149,000	Akt/CREB signaling: Target for prostate Cancer

VA Facility	Principal Investigator	Start Date	End Date	FY10 Funds	FY11 Funds	FY12 Funds	FY13 Funds	Project Title
Portland, OR	Taylor-Young, Patricia	2/1/2012	5/31/2014	$0	$0	$14,389	$49,846	Acupuncture for Symptom Management in Veterans with Hepatitis C
Indianapolis, IN	Davis, Louanne W.	7/1/2010	6/30/2014	$38,514	$205,483	$239,683	$231,098	Effects of Mindfulness-Based Cognitive-Behavioral Conjoint Therapy on PTSD and Relationship Functioning
Decatur, GA	Huang, Wei	10/1/2010	9/30/2015	$0	$302,744	$316,220	$287,824	Novel Approaches to Sleep Difficulties: Application in Mild TBI
San Diego, CA	Groessl, Erik J.	10/1/2012	9/30/2016	$0	$0	$0	$218,729	Yoga Therapy to Improve Function Among Veterans with Chronic Low Back Pain
Memphis, TN	Stuart, John M.	10/1/2012	9/30/2016	$0	$0	$0	$730,000	Program Project for Mechanisms and Treatment of Arthritis
Decatur, GA	Vaughan, Elizabeth C.	3/1/2012	2/28/2017	$0	$0	$114,458	$193,743	Behavioral therapy to treat urinary symptoms in Parkinson's disease
Manipulative and Body-Based Practices (spinal manipulation, massage therapy)								
Miami, FL	Bramlett, Helen	10/1/2010	9/30/2014	$0	$181,442	$182,386	$183,357	Novel Treatment Strategies for Targeting Posttraumatic Epilepsy
Practices using Energy Fields (light therapy, magnet therapy)								
Sepulveda, CA	Martin, Jennifer L.	1/1/2010	6/30/2013	$95,325	$200,300	$178,200	$119,075	Treating Sleep Problems in VA Adult Day Health Care
Pittsburgh, PA	Forman, Steven D.	10/1/2008	9/30/2013	$0	$25,814	$49,000	$51,000	Targeted Transcranial Magnetic Stimulation to Decrease Food Craving
Palo Alto, CA	Yesavage, Jerome A.	6/1/2008	9/30/2013	$1,753,831	$1,032,540	$1,751,605	$2,949,726	CSP 556- The Effectiveness of rTMS in Depressed VA Patients
Portland, OR	Folmer, Robert L.	1/1/2011	12/31/2014	$0	$672,166	$238,704	$245,039	Clinical Trial of Transcranial Magnetic Stimulation for Relief of Tinnitus
Boston, MA	Spector, Myron	3/1/2011	2/28/2015	$0	$302,565	$426,766	$397,423	Extracorporeal Shock Wave-Stimulated Periosteum for Bone Reconstruction
Palo Alto, CA	Ashford, John W.	10/1/2012	9/30/2016	$0	$0	$0	$275,000	rTMS for the Treatment of Chronic Pain in GW1 Veterans
Palo Alto, CA	Rosen, Allyson C.	10/1/2012	9/30/2016	$0	$0	$0	$192,000	MRI Analysis of Coil Position to Improve rTMS Treatment of Depression
Total of all				$13,066,440	$17,240,737	$18,099,082	$18,144,822	

Question 158. For the last few years, VA has been transforming the way health care is provided to veterans. A part of this transformation is the Patient-Center Care (PCC) model that VA is currently implementing. This "approach to healthcare * * * prioritizes the Veteran and his/her values, and partners with him/her to create a personalized strategy to optimize their health, healing, and well-being."

A. Please provide the Committee with a list of research studies that were used to define the PCC model.

Response. Patient Centered Care (PCC) is a fundamental shift in the U.S. medical model and a cultural transformation in the way health care is delivered. There is not one single, specific model, but rather this approach is based on significant research from both within and outside VA. VHA charged the Universal Services Taskforce to review the evidence supporting the PCC Model. These findings were described in the 2009 Universal Services Taskforce Report, "Veterans Health Care: Leading the Way to Excellence." Consultation was obtained from the Institute of Medicine (IOM), Booz Allen Hamilton, Kaiser Permanente, the Samueli Institute, the American Nurses Credentialing Center (ANCC), and most recently the Planetree Organization has worked VHA. Notably, the Task Force reported that "Numerous organizations have constructed supporting evidence and/or PCC delivery models." Among those Planetree, Picker, and the Institute for Family-Centered Care have surfaced as leaders in PCC through research and publication. Although each of these organization's models have distinctions, meta-analysis notes important areas of equivalence among leading organizations in their definitions, guiding principles and common themes (Shaller, 2007), which are consistent with the approaches utilized by VHA.

In addition, the Institute of Medicine (IOM) was established by the National Academy of Sciences to secure services of eminent members of appropriate professions to examine policy matters pertaining to the health of the public. IOM also serves as an advisor to Federal agencies and released two seminal reports informing the VHA PCC approach. The elements of the PCC approach, however, are rooted in the research and recommendations of the 2001 IOM Report, "Crossing the Quality Chasm: A New Health System for the 21st Century," at http://iom.edu/~/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf.

In this report, IOM called for health care to transform from care based on visits, where professional autonomy drives variability and the professionals control care to one that is based on "continuous healing relationships," "care that is customized according to patient needs and values," and care where "the patient is the source of control." These recommendations, as well as those of the IOM "Summit on Integrative Medicine & the Health of the Public: Issue Background & Overview," have informed the key elements of the VHA PCC approach. (The IOM Summit report can be found at http://www.iom.edu/~/media/Files/Activity%20Files/Quality/Integrative Med/IM20Summit20Background20Paper20Weisfeld2022309.pdf.) The specific ways in which these key elements can and should be delivered are varied and are being developed and piloted in many different settings. Evidence continues to emerge supporting the PCC model as described by the Nuka System of Care (Gottlieb, 2013) and the Group Health Cooperative (Greene, 2012).

B. What performance measurements are being used to determine the effectiveness of the PCC model and whether any improvements are needed to the model?

Response. Given that this is a shift in the overall approach to health and health care, which truly constitutes a cultural transformation and not a specific model, the true outcomes will ultimately be improvement in the health and well-being of our Veterans. VA is committed to ongoing evaluation and adaption of these approaches and, as such, has several research initiatives underway.

Since 2006, VA has used the Survey of Healthcare Experiences of Patients (SHEP) to track patient satisfaction. Currently, VA has 6 composites within SHEP as it relates to this model (see attachment below). Since this tool does not sufficiently capture the impact of this new medical model, VA is in the process of developing and validating measurement tools to accurately reflect outcomes of patient centered care. The frameworks were reviewed by an expert panel of researchers and administrators involved in the development and adoption of patient-centered care across the organization. Measurement experts will determine which elements within each framework will be measured at the level of patients, providers, and/or facilities.

It is expected that the measurement tool will be developed by September 2013 and that patient, provider, and facility level data will be obtained in 2014. Data from these tools will be analyzed to further refine the tools and serve as initial assessments of the implementation and outcomes associated with PCC.

Survey of Healthcare Experiences of Patients (SHEP)

Composite	Inpatient Survey Items	Method of Calculation
Communication about Medication	Question 16. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for? Question 17. Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?	Questions 16 and 17 have the following response scale: Never, Sometimes, Usually, Always. The score on each item is calculated as the percentage of responses that fall in the top two categories (Usually, Always). Communication about Medication is then calculated as the average of the site's scores on the two items.
Responsiveness of Hospital Staff	Question 4. During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it? Question 11. How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?	Question 4 has the following response scale: Never, Sometimes, Usually, Always, I never pressed the call button. The score on Question 4 is calculated as the percentage of responses that fall in the top two categories (Usually, Always); responses of 'I never pressed the call button' are excluded from the denominator in the calculation of this percentage. Question 11 has the following response scale: Never, Sometimes, Usually, Always. The score on Question 11 is calculated as the percentage of responses that fall in the top two categories (Usually, Always). "Responsiveness" is then calculated as the average of the site's scores on the two items.
Pain Management	Question 13. During this hospital stay, how often was your pain well controlled? Question 14. During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?	Questions 13 and 14 have the following response scale: Never, Sometimes, Usually, Always. The score on each item is calculated as the percentage of responses that fall in the top two categories (Usually, Always). Pain Control is then calculated as the average of the site's scores on the two items.

Survey of Healthcare Experiences of Patients (SHEP)

SHEP Inpatient Composites Quarterly Trend
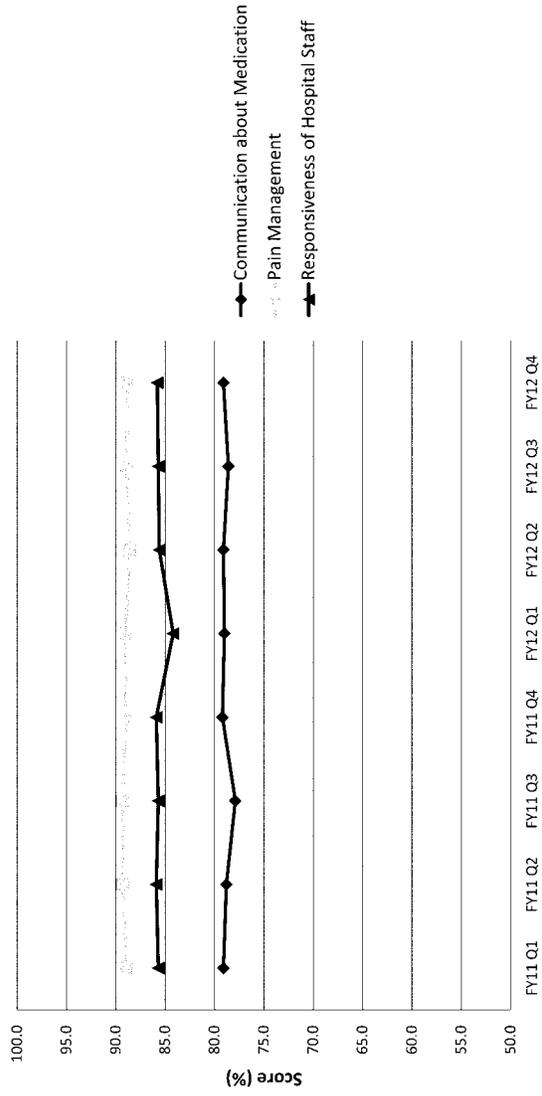
Score (%)

100.0
95.0
90.0
85.0
80.0
75.0
70.0
65.0
60.0
55.0
50.0

FY11 Q1   FY11 Q2   FY11 Q3   FY11 Q4   FY12 Q1   FY12 Q2   FY12 Q3   FY12 Q4

Communication about Medication
Pain Management
Responsiveness of Hospital Staff

VETERANS HEALTH ADMINISTRATION

2

Survey of Healthcare Experiences of Patients (SHEP)

| Composite	Outpatient Survey Items	Method of Calculation
Getting Needed Care	Question 12. In the past 12 months, how often was it easy to get the care, tests or treatment you thought you needed through VA?	Questions 12 and 22 have the following response scale: Never, Sometimes, Usually, Always.
	Question 22. In the last 12 months, how often was it easy to get appointments with VA specialists?	The score on each item is calculated as the percentage of responses that fall in the top two categories (Usually, Always). Getting Needed Care is then calculated as the average of the site's scores on the two items.
Getting Care Quickly	Question 2. In the last 12 months, when you needed care right away, how often did you get care as soon as you thought you needed?	Questions 2 and 4 have the following response scale: Never, Sometimes, Usually, Always.
	Question 4. In the past 12 months, not counting the times you needed care right away, how often did you get an appointment as soon as you thought you needed?	The score on each item is calculated as the percentage of responses that fall in the top two categories (Usually, Always). Getting Care Quickly is then calculated as the average of the site's scores on the two items.
How Well Doctors/Nurses Communicate	Question 15. In the last 12 months, how often did your personal VA doctor or nurse explain things in a way that was easy to understand?	Questions 15, 16, 18, and 19 have the following response scale: Never, Sometimes, Usually, Always.
	Question 16. In the last 12 months, how often did your personal VA doctor or nurse listen carefully to you?	The score on each item is calculated as the percentage of responses that fall in the top two categories (Usually, Always). How Well Doctors/Nurses Communicate is then calculated as the average of the site's scores on the four items.
	Question 18. In the last 12 months, how often did your personal VA doctor or nurse show respect for what you had to say?	
	Question 19. In the last 12 months, how often did your personal VA doctor or nurse spend enough time with you?	

Survey of Healthcare Experiences of Patients (SHEP)

SHEP Outpatient Composites Quarterly Trend

Getting Care Quickly

Getting Needed Care

How Well Doctors/Nurses Communicate

Score (%): 100.0, 95.0, 90.0, 85.0, 80.0, 75.0, 70.0, 65.0, 60.0, 55.0, 50.0

FY11 Q1, FY11 Q2, FY11 Q3, FY11 Q4, FY12 Q1, FY12 Q2, FY12 Q3, FY12 Q4
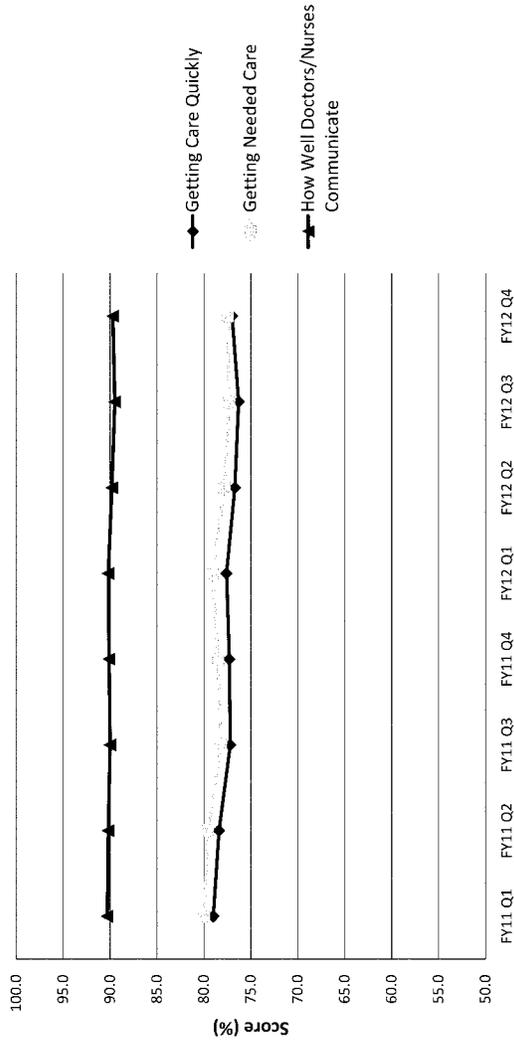
Question 159. One of VA's major goals for VA Research and Development is the Million Veteran Program; this program collects genetic samples and general health information of veterans. How much does VA expect to spend on this research project in fiscal year 2014?

Response. As of April 23, 2013, 153,803 Veterans have enrolled. They accomplished this by signing consent and Health Insurance Portability and Accountability Act (HIPAA) forms and providing a blood sample. Another 213,180 Veterans have completed the Baseline Survey and are awaiting appointments to fill out consent paperwork and conduct a blood draw. The FY 2014 Million Veteran Program (MVP) spending is projected to be $23.214 million.

Our initial projections were that it would take 5 to 7 years to enroll 1,000,000 Veterans, reaching a maximum enrollment of 225,000 per year by the end of the

study. Overall, we have found that enrolling younger Veterans at VA medical centers is more difficult than expected, and there are other administrative considerations as well. For this reason, we are currently exploring alternative methods such as Web-enrollment. Further, in order to make enrollment possible for all Veterans nationwide, including those in rural areas, we are exploring mechanisms that do not require a visit to a VA hospital to donate a blood specimen.

All MVP enrollees sign an informed consent form and a HIPAA authorization form. They agree to allow access to their medical records on an ongoing basis and add that information to the VA Central Research Data base so that approved MVP researchers can follow their health and care for as long as they are alive. If the MVP enrollee participates or has participated in any other VA studies, he or she gives permission to access data from these studies and add that data to the VA Central Research Data base. MVP enrollees also agree to donate a blood sample that will be used for future studies related to characteristics of health or any disease, illness, or condition. MVP enrollees also agree to future contact by MVP staff.

The samples and/or medical information will be available to approved researchers in a coded manner at VA, other Federal health agencies, and academic institutions within the United States for research projects approved by appropriate VA oversight committees. VA takes precautions to protect this data, consistent both within VA and during any approved sharing with other Federal entities or approved academic institutions.

Rural Health

Question 160. In fiscal year 2012, the Office of Rural Health was appropriated approximately $248 million; please provide the Committee with a detailed description of how this funding was utilized.

Response. In FY 2012, the Office of Rural Health funds were distributed to VISNs and VA Central Office program offices to support new projects, sustain existing projects, and expand existing projects. Over 400 projects were funded and were allocated to the following activities:

Project ARCH Fee Care Pilot* $26.8M
Access and Quality: transportation, outreach clinics, mobile clinics $34.3M
Community Based Outpatient Clinics $77.8M
Collaboration and Outreach: rural Veteran outreach program, mobile ....
Veteran centers, education of rural clergy $11.6M
Geriatrics: stroke, caregivers support for demented Veterans $43.5M
Homelessness $0.6M
Mental Health: Post Traumatic Stress Disorder, Traumatic Brain Injury $13.2M
Specialty Care: Cardiology, Audiology, Prosthetics, Optometry, Radiology,
    Dermatology $7.6M
Telehealth and New Models of Care $28.8M
Training and Education $3.1M
Women Veterans $1.2M
                                                                                                                      ———
    Total $248.5M
                                                                                                                      ═══

*Project Access Received Closer to Home (ARCH) is a 3-year pilot program in five of the VISNs designed to provide Veterans with health care services closer to where they live. It implements Section 403 of P.L. 110–387: The Veterans' Mental Health and Other Care Improvements Act of 2008 and was amended by Section 308 of P.L. 111–163, the Caregivers and Veterans Omnibus Health Services Act of 2010. Each of the five pilot sites identified services that are most needed by the VHA-enrolled Veterans in that region. Through Project ARCH, two sites provide primary care services (VISN 6—Farmville, Virginia, and VISN 15—Pratt, Kansas) and three sites offer specialty care services (VISN 1—Northern Maine; VISN 18—Flagstaff, Arizona; and VISN 19—Billings, Montana).

Women Veterans

Question 161. In a question for the record regarding the fiscal year 2013 budget request, VA provided a list of women's projects from the fiscal year 2013 Strategic Capital Investment Process. Please provide the Committee with an updated list of construction projects relating to correcting patient privacy deficiencies.

Response. Please see attached.

VISN Number	Facility Number	Facility Name	Project Number	Project Title	PTR Status
1	402	Togus	402-12-545	Women's Clinic Renovation	Construction
1	689	Connecticut HCS - West Haven	689-11-110	Women Veterans Privacy Improvements	Construction Documents
2	528A7	Syracuse	528A7-12-703	Renovate for Comp & Pen / Women's Clinic	Construction
2	528A7	Syracuse	528A7-13-701	Renovate for Women's Clinic	Construction
3	526	Bronx	526-11-103	Renovate Women's Health & Admin Med	Design Drawings
4	693	Wilkes-Barre	693-13-101	Renovate First Floor West Women Veterans Clinic	Design Drawings
6	652	Richmond	652-13-103	Improve Patient Privacy 4C/4B	Design Drawings
6	659	Salisbury	659-13-104	Correct Privacy, Access, and Utility System Deficiencies in Building 2	Design Drawings
6	659	Salisbury	659-13-101	Renovate Medical/Surgical Nursing Units on Floors 2-3 for Patient Privacy Bldg 2	Design Drawings
8	573A4	NF/SG HCS - Lake City	573A4-13-101	Renovate Womens' Restrooms	Construction
10	757	Columbus ACC	757-13-101	Improve UCC Privacy and Security	Construction
11	583	Indianapolis	583-12-145	Renovate Exam Rooms for Privacy	Construction
11	515	Battle Creek	515-12-112	Renovate Various Buildings for Women's Privacy	Construction
12	556	North Chicago	556-13-125	Renovate Men's and Women's bathrooms/showers Building 132/Pool filtrations system Replacement	Construction
12	676	Tomah	676-13-122	Comstruct Women's Toilet 1st Floor Building 403	Out for Bid/Negotiation
12	556	North Chicago	556-13-164	Provide New Kitchens for Four FHCC Owned Private Homes	Pending
12	556	North Chicago	556-13-163	Replace Roofs & Gutters on FHCC Private Homes	Pending
15	589A6	EKHCS - Leavenworth	589A6-CSI-300	FCA - Consolidate Women's Health and Wellness	Construction
15	657	St. Louis	657-CSI-500	Create Women Centric Veteran Imaging and Procedure Area, Building 1	Design Drawings
16	586	Jackson	586-10-107	Renovate Ward 4C- North & South for Patient Privacy	Construction
18	678	Tucson	678-CSI-104	Expand for Women's Health and OEF/OIF	Construction
18	644	Phoenix	644-13-016	Provide HVAC/Nurse-Call OEF/OIF and Women's Clinic	Completed Project
19	660	Salt Lake City	660-13-037S	Women's Clinic	Construction
20	531	Boise	531-CSI-103	Construct Women's Clinic	Design Drawings
21	612A4	NCHCS - Sacramento	612A4-13-100	Remodel Womens Health Building 98	Construction
21	662	San Francisco	662-13-221	Renovate Women's Clinic Lactation area	Construction
22	600	Long Beach	600-12-177	Create private showers with restrooms for Women Veterans	Punch List/As-Builts
23	438	Sioux Falls	438-13-200	Improve Women's Health/Patient Privacy	Design Drawings

[Table continued.]

VISN Number	Actual Design Obligation Date	Obligated Design Dollars	Actual Construction Obligation Date	Obligated Construction Dollars	Total FY13 Obligated Dollars	Planned/ Revised Construction Completion Date	Actual Construction Completion Date
1			04/10/2013	$2,203,000	$2,203,000	04/10/2014	
1			07/01/2013	$1,127,940	$1,127,940	07/01/2014	
2			02/25/2013	$1,871,700	$1,871,700	02/24/2014	
2			03/01/2013	$1,013,700	$1,013,700	02/24/2014	
3			07/29/2013	$340,000	$340,000	08/29/2014	
4	06/05/2013	$619,908			$619,908	09/25/2015	
6	02/13/2013	$394,773			$394,773	09/25/2015	
6	05/16/2013	$358,860			$358,860	12/16/2015	
6	05/16/2013	$359,201			$359,201	03/01/2015	
8			06/20/2013	$207,459	$207,459	11/30/2013	
10			05/01/2013	$249,764	$249,764	12/31/2013	
11			02/25/2013	$445,092	$445,092	09/30/2013	
11			08/01/2013	$992,819	$992,819	02/28/2014	
12	01/04/2013	$103,519	07/25/2013	$1,938,200	$2,041,719	05/20/2014	
12	05/23/2013	$10,076			$10,076	12/01/2013	
12			09/06/2013	$53,680	$53,680	09/30/2014	
12			08/22/2013	$82,300	$82,300	09/30/2014	
15			12/28/2012	$2,521,558	$2,521,558	05/07/2014	
15	05/31/2013	$168,581			$168,581	05/29/2015	
16			12/28/2012	$5,726,000	$5,726,000	12/30/2014	
18			06/20/2013	$4,535,345	$4,535,345	12/31/2014	
18	12/01/2012	$1	02/15/2013	$149,350	$149,351	06/03/2013	06/03/2013
19			08/15/2013	$37,613	$37,613	09/30/2013	
20	04/03/2013	$239,676			$239,676	12/31/2015	
21			07/03/2013	$485,186	$485,186	05/30/2014	
21			06/28/2013	$39,944	$39,944	11/30/2013	
22			10/24/2012	$119,874	$119,874	04/09/2013	06/21/2013
23	02/12/2013	$73,448			$73,448	03/01/2015	
					$26,468,567		

OFFICE OF INFORMATION AND TECHNOLOGY

Question 162. In response to the fiscal year 2013 budget questions for the record regarding VA's scheduling package, VA stated that it would not be able to determine the timeline of deliverables and costs associated with the scheduling package until after the completion of the Concept Exploration and Life Cycle Cost Anaylsis in January 2013.

A. Has the Concept Exploration and Life Cycle Cost Analysis been completed? If so, please provide the Committee with the expected total cost of a new scheduling package and the timeline associated with the project.

Response. VA will procure a scheduling solution in two phases. In the first phase, which is now ongoing, VA is running a risk-reduction contest under the America Competes Act, with a call for scheduling application submissions. The purpose of this contest is to reduce procurement and deployment risk. VA will award up to three prizes for scheduling packages that demonstrate their compatibility with the Open Source version of VA's electronic health record, VistA. The contest had 41 contestants registered and closed the week of June 17, 2013. The submissions are currently under review with a target of announcing a winner at the end of the current fiscal year.

The second phase will involve the actual procurement of a scheduling solution. As this risk-reduction activity proceeds, VA will continue working with DOD and the VA/DOD Interagency Program Office (IPO) to determine joint requirements and a master development and acquisition plan. This plan will be based upon an evaluation of contestant responses for proposed functionality and compliance with integrated Electronic Health Record (iEHR) architecture.

B. The fiscal year 2014 budget request expects VA to spend $30 million for the development of a new scheduling package. Please provide the Committee with an outline of how VA expects to utilize that funding.

Response. The purpose of conducting the contest described in question 162 A is to inform the process for procuring an actual scheduling replacement solution. For FY 2014, VA plans to use what it has learned through the contest and to spend approximately $4 million on pre-planning and acquisition activities. These activities center on two basic areas: (1) defining business needs, and (2) mapping technical and architectural requirements to meet those needs.

The remaining $26 million of the $30 million mentioned in the question will be spent on initial schedule package development efforts, which are anticipated to begin in mid-FY 2014. Specifically, these funds will be used to acquire commercial off-the-shelf (COTS) software and configure it to the VA environment.

Question 163. The fiscal year 2014 request includes $15.8 million for the Virtual Lifetime Electronic Record (VLER), Health. Currently, VLER is deployed at only 13 VA medical facilities across the country. GAO testimony provided to the House Committee on Veterans' Affairs on February 27, 2013, stated that both Departments had the "goal of deploying VLER nationwide at or before the end of 2012."

A. It is clear that both Departments have missed this goal of achieving a national rollout of VLER by the end of 2012. Does VA plan to expand VLER out to additional sites in 2013?

Response. The Virtual Lifetime Electronic Record (VLER) is the broad umbrella of information sharing. VLER will allow VA, DOD, and others to easily share information on Servicemembers and Veterans and will enable VA to provide proactive care and benefits to Veterans that they have earned and deserve. VA believes the question refers more specifically to the VLER Health Exchange capability, which provides health information exchange between VA, DOD, and private-sector facilities.

VLER Health is currently deployed to 16 sites, with several more in the queue. As of April 30, 2013, VLER Health Exchange partner sites were added at:

• Boise, Idaho, with the Idaho Health Information Exchange (HIE)

• Biloxi, Mississippi Department of Veteran Affairs Medical Center (VAMC) (which includes the Joint Ambulatory Care Clinic in Pensacola, Florida), with the Pensacola HIE.

Full deployment of the VLER Health Exchange capability is dependent on upgrading the technology to accommodate enterprise-wide deployment, and on gaining HIE private partners who are approved to exchange health information through the eHealth Exchange (formerly referred to as the Nationwide Health Information Network or NwHIN).

The Department of Veterans Affairs (VA) can begin to add new HIE partners and develop a schedule for full deployment once HIE and Partner Integration contracts are in place.

B. If so, what costs are associated with implementing VLER at these additional sites? Please provide the Committee with a detailed timeline of the rollout, including the additional sites and costs associated with implementation.

Response. As of July 9, 2013, the actual costs for these two deployments are not available because contracts to support enterprise-wide deployment activity are still pending award. The two existing deployments involved minimal costs, as they were accomplished by VLER Health Federal staff.

C. Have the Departments developed a plan for VLER that includes the scope, cost and schedule estimation, and project planning documents? If so, please provide those documents to the Committee.

Response. Again, VA assumes the question refers to the VLER Health activities within the larger VLER initiative. The VA/DOD Interagency Program Office (IPO) is responsible for VLER Health Program Management, including VLER Health systems, capabilities, and initiatives. IPO's VLER Health program focuses on a portfolio of programs that manage the electronic exchange of clinically relevant health information between DOD, VA, and other Federal and non-Federal health exchange partners.

VLER Health is now working on an FY 2014 plan to present to the DOD/VA Joint Executive Council (JEC) in September 2013, which will include details on further scope, to include cost planning estimates of the national rollout. VA will provide this plan to the Committee when it becomes available.

For VLER initiatives outside of VLER Health, the VLER Enterprise Program Management Office publishes all of their documents on their public Web site at http://www.va.gov/vler/.

Question 164. According to GAO's testimony from the February 27, 2013, House hearing, in 2001 the VHA began to "modernize VistA by standardizing patient data and modernizing the health information software applications." To modernize VistA, VA decided to use an incremental approach based on six phases which was to be completed in 2018. Between 2001 and 2007, VA spent $600 million on eight projects related to modernizing VistA. In April 2008, VA estimated that it would cost roughly $11 billion to complete the modernization of VistA by 2018. However, in August 2010, this project was terminated.

A. Since August 2010, how much has VA spent on upgrades to VistA?

Response. The chart below shows the VistA DME obligations from FY 2010 to YTD FY 13.

FY	VistA Total Obligations*
FY 10	$350.948
FY 11	$320.654
FY 12	$227.567
FY 13 YTD	$65.739
Totals	$964.908

*Total amounts VA obligated for upgrades to VistA, by fiscal year.

B. Were these upgrades similar to the ones identified in VA's attempt to modernize VistA by 2018?

Response. The chart below shows the subset of DME obligations (seen above) for projects that VA determined to be "similar to the ones identified in VA's attempt to modernize VistA by 2018."

FY	Subtotal Similar to VistA Modernization**
FY 10	$211.217
FY 11	$122.665
FY 12	$87.282
FY 13 YTD	$28.080
Totals	$449.244

**The projects that are similar to the ones previously identified in VA's "attempt to modernize VistA by 2018" are those that fall under HealtheVet VistA.

C. How much in the fiscal year 2014 budget will be allocated to upgrade VistA?

Response. $25 million will be allocated to upgrade VistA in fiscal year 2014.

Question 165. According to the DOD and VA press conference on February 5, 2013, Secretary Shinseki stated that the Departments planned to expand the use of the graphical user interface (GUI) to seven additional VA sites and two additional DOD sites no later than July 2013.

A. What is the anticipated cost of implementing the GUI at these additional nine sites?

Response. The Janus Joint Legacy Viewer is a web-based application hosted at VA's Austin Information Technology Center and at the Military Health System Enterprise Service Operations Center. The cost to implement Janus includes hosting facility expenses as well as funds to support program contracts, including: WebSphere application licenses; MedWeb appliance server and licenses; and TRICARE Management Activity Cyber Security risk assessments. The total cost to implement this enterprise version of Janus is approximately $5.3 million.

Since Janus is a web-based application, and no additional hardware is required at the nine pilot sites, these costs should be considered as enterprise-wide expenses, not attributable to the nine sites specifically.

For the pilot deployment, a small team will be visiting each site to provide training and to ensure a smooth transition to Janus. Additionally, VA is developing a training video and has put together detailed guides to facilitate virtual delivery of future deployments and training.

B. Do DOD and VA plan to implement the GUI at additional sites after July 2013? If so, what are the additional costs associated with the implementation of the GUI at the additional sites?

Response. VA is developing a plan to expand Janus beyond the pilot sites. Since Janus is a web-based application, and hardware is not required at the local sites, we project decreasing marginal costs as Janus expands to more sites. Moreover, as virtual training will be available, it would be unnecessary to have a team visit each site.

However, before expanding Janus to a larger enterprise base, performance and load testing—as well as analysis of feedback from the pilot sites—must occur. This will help determine requirements and costs in order to scale the system for enterprise-wide use.

C. In addition, at the press conference, VA also stated that DOD and VA would select "a core set of integrated Electronic Health Record (iEHR) capabilities no later than March 2013." Have DOD and VA selected the core set of iEHR capabilities? If so, please provide the Committee with the core set of iEHR capabilities.

Response. The Interagency Clinical Informatics Board (ICIB)—a joint VA and DOD board established to oversee the functional aspects of interagency clinical information systems throughout the development and acquisition lifecycle—has identified 7 capabilities that are the core functions of an EHR.

The iEHR Core is a foundational set of clinical and supporting functionality necessary to deliver health care that leverages IT capabilities and supports an electronic health record.

Offering the Core functionality as a single set provides a stable foundation, supports integration integrity and reduces interface complexity when identifying the remaining medical capability selections.

The Core provides the clinical capabilities of creating and managing orders; entering, analyzing and reviewing the patient's health record and other clinically relevant information; supporting the provider in decisionmaking and situational awareness.

The 7 functions that have been identified as the iEHR Core are:

1. Orders Service
2. Documentation
3. Document Management
4. Clinical Decision Support/Alerts
5. Access Control
6. Information Management/Terminology Services
7. Federal Data Repository/Data Warehouse

VA has decided to deploy an iEHR Core based on VistA. DOD has decided to obtain their core functions through a competitive acquisition.

Question 166. According to the fiscal year 2014 Budget Fast Facts information sheet, VA has allocated $344 million for the iEHR, including $252 million for the development, modernization, and enhancement of iEHR and VLER.

A. Please provide the Committee with a detailed breakdown of the sustainment cost associated with iEHR and VLER for fiscal year 2014 and any licensing agreements that are associated with these projects.

Response. The following table highlights iEHR and VLER Health sustainment funds for FY 2014.

	FY 2014 (PB)
iEHR Sustainment	$87.5
VLER Health Sustainment	$4.2
Total	$91.7

B. Please provide the Committee with an estimated sustainment cost associated with iEHR and VLER over the next five years.

Response. The following table highlights iEHR enacted funds and estimated costs for sustainment for FY's 2013 through 2018. Funding beyond FY 2014 has not been formally developed.

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018
iEHR Sustainment	$65.0	$87.5	$153.1	$275.6	$231.6	$268.1
VLER Health Sustainment	$0.8	$4.2	$7.7	$13.9	$11.7	$13.5
Total	$65.8	$91.7	$160.8	$289.5	$243.3	$281.6

C. Please provide the Committee with a detailed breakdown of the $252 million for the development, modernization, and enhancement of iEHR and VLER and any deliverables associated with the development, modernization, and enhancement of iEHR and VLER.

Response. The following amounts have been allocated to VLER Benefits, VLER Core, and VLER Memorials:

VLER Benefits	$8,500,000
VLER Core	$27,056,666
VLER Memorials	$10,000,000

The following spreadsheet provides the details for each project at the acquisition/increment level.

Congressional Project	SPI Strip Type	Funding Status	SPI #	Strip #	DME	Planned Amount	Committed Amount	Obligated Amount	Project	Description	Budget Priority Category	Congressional Report Program	Requestor	2237 #	PO #	SPI Title
VLER Benefits	Development	Approved	13-INTER-13	2	Yes	$1,028,000.00		$0.00	VLER Benefits Phase I	2013-A-PD-10805-VLER- VLER Benefits Support Services - Increment 1	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	Warrior Support	Dick Rickard			VLER Benefits Phase I
VLER Benefits	Development	Approved	13-INTER-13	7	Yes	$115,950.00	$115,950.00	$0.00	VLER Benefits Phase I	PMO Support - 2013-A-PD-10101-VLER - VLER PMO Fiscal Support Services - Base Period	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	Warrior Support	Dick Rickard	116-13-3-1376-0029		VLER Benefits Phase I
VLER Benefits	Development	Approved	13-INTER-13	9	Yes	$1,028,000.00	$0.00	$0.00	VLER Benefits Phase I	2013-A-PD-10805-VLER- VLER Benefits Support Services - Option 1/Veterans Lifetime Electronic Records (VLER) Initiative Warrior Support (WS) Federal Case Management Tool (FCMT) Support Services	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	Warrior Support	Dick Rickard			VLER Benefits Phase I
VLER Benefits	Development	Approved	13-INTER-13	11	Yes	$810,000.00	$0.00	$0.00	VLER Benefits Phase I	2013-A-PD-10805-VLER - VLER Benefits DSG Increment 2	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	Warrior Support	Dick Rickard			VLER Benefits Phase I
VLER Benefits	Development	Approved	13-INTER-13	12	Yes	$149,780.00	$0.00	$0.00	VLER Benefits Phase I	2013-A-PD-10103-VLER - VLER PMO Acquisition and Fiscal Support Services	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	Warrior Support	Dick Rickard			VLER Benefits Phase I
VLER Benefits	Development	Approved	13-INTER-13	14	Yes	$91,846.00	$0.00	$0.00	VLER Benefits Phase I	2013-A-PD-10105-VLER- VLER PMO MITRE Support Services - Option	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	Warrior Support	Dick Rickard			VLER Benefits Phase I
VLER Benefits	Development	Approved	13-INTER-13	15	Yes	$278,654.00	$0.00	$0.00	VLER Benefits Phase I	2013-A-PD-10102-VLER - VLER PMO Admin Support Services	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	Warrior Support	Dick Rickard			VLER Benefits Phase I
VLER Benefits	Development	Approved	13-INTER-13	16	Yes	$293,780.00	$0.00	$0.00	VLER Benefits Phase I	2013-A-PD-10102-VLER- VLER PMO Admin Support Services	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	Warrior Support	Dick Rickard			VLER Benefits Phase I
VLER Benefits	Development	Approved	13-INTER-13	17	Yes	$860,000.00	$0.00	$0.00	VLER Benefits Phase I	2013-A-PD-10807-VLER - VLER Benefits-Electronic Case File Transfer (eCFT) - IAA Transfer for DoD Option on Contract W9133L-12-F-0092	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	Warrior Support	Dick Rickard			VLER Benefits Phase I
VLER Benefits	Development	Approved	13-INTER-142	1	Yes	$89,378.96	$0.00	$0.00	Warrior Support Federal Case Management Tool (FCMT)	BALANCE	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	Warrior Support	Dick Rickard			Warrior Support Federal Case Management Tool (FCMT)
VLER Benefits	Development	Approved	13-INTER-142	2	Yes	$70,000.00	$70,000.00	$70,000.00	Warrior Support Federal Case Management Tool (FCMT)	PMO Support - 2013-A-PD-10106-VLER - PMO Support Services - Extension	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	Warrior Support	Dick Rickard	116-13-2-1376-0013	116-E35407	Warrior Support Federal Case Management Tool (FCMT)
VLER Benefits	Development	Approved	13-INTER-142	3	Yes	$1,498,817.04	$1,498,817.04	$1,498,817.04	Warrior Support Federal Case Management Tool (FCMT)	2013-A-PD-10304 Warrior Support FCMT Development - Increment 4	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	Warrior Support	Dick Rickard	116-13-3-1376-0028	116-E35592	Warrior Support Federal Case Management Tool (FCMT)
VLER Benefits	Development	Approved	13-INTER-142	4	Yes	$1,589,922.00	$0.00	$0.00	Warrior Support Federal Case Management Tool (FCMT)	2013-A-PD-10305 Warrior Support FCMT Development - Increment 5	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	Warrior Support	Dick Rickard			Warrior Support Federal Case Management Tool (FCMT)
VLER Benefits	Development	Approved	13-INTER-142	5	Yes	$523,472.00	$0.00	$0.00	Warrior Support Federal Case Management Tool (FCMT)	2013-A-PD-0306 Warrior Support FCMT Development - SDS Remediation for VTA	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	Warrior Support	Dick Rickard			Warrior Support Federal Case Management Tool (FCMT)
VLER Benefits	Development	Approved	13-INTER-142	6	Yes	$132,410.00	$0.00	$0.00	Warrior Support Federal Case Management Tool (FCMT)	2013-A-PD-0307 Warrior Support FCMT Development - VTA Enhancements	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	Warrior Support	Dick Rickard			Warrior Support Federal Case Management Tool (FCMT)

Congressional Project	SPI Strip Type	Funding Status	SPI #	Strip #	DME	Planned Amount	Committed Amount	Obligated Amount	Project	Description	Budget Priority Category	Congressional Report Program	Requestor	2237 #	PO #	SPI Title
VLER Core	Development	Approved	13-INTER-11	2	Yes	$371,074.00	$371,074.00	$0.00	VLER Core Phase I	PMO Support - 2013-A-PD-10101-VLER - VLER PMO Fiscal Support Services - Base Period	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	VLER Services	Steven Green	116-13-3-1372-0034		VLER Core Phase I
VLER Core	Development	Approved	13-INTER-11	3	Yes	$3,300,000.00	$0.00	$0.00	VLER Core Phase I	2013-A-PD-10701-VLER-FY13 VLER CORE A&A Support	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	VLER Services	Steven Green			VLER Core Phase I
VLER Core	Development	Approved	13-INTER-11	4	Yes	$5,051,722.00	$0.00	$0.00	VLER Core Phase I	2013-A-PD-10702-VLER - VLER Core Development - Base & Optional CLINS	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	VLER Services	Steven Green			VLER Core Phase I
VLER Core	Development	Approved	13-INTER-11	5	Yes	$1,027,499.00	$503,474.51	$1,027,499.00	VLER Core Phase I	2013-A-PD-10703-VLER - VLER Core HDR Support	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	VLER Services	Steven Green	116-13-1-1372-0001	116-E35097	VLER Core Phase I
VLER Core	Development	Approved	13-INTER-11	6	Yes	$5,051,721.00	$0.00	$0.00	VLER Core Phase I	2013-A-PD-10704-VLER - VLER Core Development - Option CLIN	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	VLER Services	Steven Green			VLER Core Phase I
VLER Core	Development	Approved	13-INTER-11	7	Yes	$479,231.00	$0.00	$0.00	VLER Core Phase I	2013-A-PD-10103-VLER - VLER PMO Acquisition and Fiscal Support Services	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	VLER Services	Steven Green			VLER Core Phase I
VLER Core	Development	Approved	13-INTER-11	8	Yes	$5,500,000.00	$0.00	$0.00	VLER Core Phase I	2013-A-PD-10701-VLER FY13 VLER CORE A&A Support	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	VLER Services	Steven Green			VLER Core Phase I
VLER Core	Development	Approved	13-INTER-11	10	Yes	$447,910.00	$0.00	$0.00	VLER Core Phase I	2013-A-PD-10105-VLER - VLER PMO MITRE Support Services - Option	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	VLER Services	Steven Green			VLER Core Phase I
VLER Core	Development	Approved	13-INTER-11	11	Yes	$891,691.00	$0.00	$0.00	VLER Core Phase I	2013-A-PD-10102-VLER - VLER PMO Admin Support Services - Option	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	VLER Services	Steven Green			VLER Core Phase I
VLER Core	Development	Approved	13-INTER-11	12	Yes	$940,094.00	$0.00	$0.00	VLER Core Phase I	2015-A-PD-10102-VLER - VLER PMO Admin Support Services	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	VLER Services	Steven Green			VLER Core Phase I
VLER Core	Development	Approved	13-INTER-11	13	Yes	$675,000.00	$0.00	$0.00	VLER Core Phase I	2013-A-PD-10708-VLER - VLER Core - Development - AIDE Environment	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	VLER Services	Steven Green			VLER Core Phase I
VLER Core	Development	Approved	13-INTER-11	14	Yes	$15,750.00	$0.00	$0.00	VLER Core Phase I	2013-A-PD-10709-VLER - VLER Core - Software Licenses - UI PRO	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	VLER Services	Steven Green			VLER Core Phase I
VLER Core	Development	Approved	13-INTER-11	15	Yes	$18,750.00	$0.00	$0.00	VLER Core Phase I	2013-A-PD-10710-VLER - VLER Core - Software Licenses - XLM SPY	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	VLER Services	Steven Green			VLER Core Phase I
VLER Core	Development	Approved	13-INTER-11	16	Yes	$105,500.00	$0.00	$0.00	VLER Core Phase I	2013-A-PD-10711-VLER - VLER Core - Software Licenses - NoSQL DB (MONGO or Couch)	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	VLER Services	Steven Green			VLER Core Phase I
VLER Core	Development	Approved	13-INTER-126	1	Yes	$1,989.84		$0.00	VLER Data Access Service (DAS)	BALANCE	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	VLER Services	Steve Green			VLER Data Access Service (DAS)
VLER Core	Development	Approved	13-INTER-126	2	Yes	$455,361.66	$455,361.66	$455,351.66	VLER Data Access Service (DAS)	2013-A-PD-10401-VLER-VLER DAS / FIST - A&A Services - 2 Month Option	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	VLER Services	Steve Green	116-13-1-1372-0002	116-E35149	VLER Data Access Service (DAS)
VLER Core	Development	Approved	13-INTER-126	3	Yes	$455,361.68	$455,361.68	$455,361.68	VLER Data Access Service (DAS)	2014-A-PD-10403-VLER- VLER DAS - FIST - A&A Services - 2 Months Extension	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	VLER Services	Steve Green	116-13-2-1372-0012	116-E35264	VLER Data Access Service (DAS)
VLER Core	Development	Approved	13-INTER-126	4	Yes	$68,410.80	$68,410.80	$68,410.80	VLER Data Access Service (DAS)	PMO Support - 2013-A-PD-10106-VLER - PMO Support Services - Extension	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	VLER Services	Steve Green	116-13-2-1372-0018	116-E35406	VLER Data Access Service (DAS)
VLER Core	Development	Approved	13-INTER-126	5	Yes	$2,200,000.00	$0.00	$0.00	VLER Data Access Service (DAS)	2013-A-PD-10701-VLER FY13 VLER CORE A&A Support	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	VLER Services	Steve Green			VLER Data Access Service (DAS)

Congressional Project	SPI Strip Type	Funding Status	SPI #	Strip #	DME	Planned Amount	Committed Amount	Obligated Amount	Project	Description	Budget Priority Category	Congressional Report Program	Requestor	2237 #	PO #	SPI Title
VLER Memorials	Development	Approved	13-BENE-32	3	Yes	$4,000,000.00	$1,600,364.23	$1,600,364.23	VLER Memorials Phase I	2013-A-PD-10901-VLER - VLER Memorials Software Engineering Services - Increment 1 - Base Period	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	Memorials Legacy Development Support	Toby Rudik	116-13-2-1315-0015	116-E35595	VLER Memorials Phase I
VLER Memorials	Development	Approved	13-BENE-32	5	Yes	$150,749.00	$150,749.00	$0.00	VLER Memorials Phase	2013-A-PD-10103-VLER PMO Support - 2013-A-PD-10101-VLER - VLER PMO Fiscal Support Services - Base Period	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	Memorials Legacy Development Support	Toby Rudik	116-13-3-1315-0031		VLER Memorials Phase I
VLER Memorials	Development	Approved	13-BENE-32	6	Yes	$2,147,000.00	$858,995.50	$858,995.50	VLER Memorials Phase I	2013-A-PD-10902-VLER - VLER Memorials Software Engineering Services - Increment 1 - Option CLINS 1	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	Memorials Legacy Development Support	Toby Rudik	116-13-2-1315-0015	116-E35595	VLER Memorials Phase I
VLER Memorials	Development	Approved	13-BENE-32	7	Yes	$1,636,849.00	$0.00	$0.00	VLER Memorials Phase I	2013-A-PD-10904-VLER - VLER Memorials Software Engineering Services - Increment 1 / Option CLINS 2	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	Memorials Legacy Development Support	Toby Rudik			VLER Memorials Phase I
VLER Memorials	Development	Approved	13-BENE-32	8	Yes	$194,888.00	$0.00	$0.00	VLER Memorials Phase	2013-A-PD-10103-VLER - VLER PMO Acquisition and Fiscal Support Services	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	Memorials Legacy Development Support	Toby Rudik			VLER Memorials Phase I
VLER Memorials	Development	Approved	13-BENE-32	9	Yes	$140,400.00	$0.00	$0.00	VLER Memorials Phase	2013-A-PD-10105-VLER - VLER PMO MITRE Support Services - Option	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	Memorials Legacy Development Support	Toby Rudik			VLER Memorials Phase I
VLER Memorials	Development	Approved	13-BENE-32	10	Yes	$362,259.00	$0.00	$0.00	VLER Memorials Phase	2013-A-PD-10102-VLER - VLER PMO Admin Support Services	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	Memorials Legacy Development Support	Toby Rudik			VLER Memorials Phase I
VLER Memorials	Development	Approved	13-BENE-32	11	Yes	$381,913.00	$0.00	$0.00	VLER Memorials Phase	2013-A-PD-10102-VLER - VLER PMO Admin Support Services	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	Memorials Legacy Development Support	Toby Rudik			VLER Memorials Phase I
VLER Memorials	Development	Approved	13-BENE-49	2	Yes	$6,151.00	$6,151.00	$6,151.00	Memorial Affairs Letters Enhancements	2013-A-PD-10801-VLER - Memorial Affairs Letters Enhancements - SLAM Install	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	Memorials Legacy Development Support	Toby Rudik	116-13-2-1315-0009	116-C33050	Memorial Affairs Letters Enhancements
VLER Memorials	Development	Approved	13-BENE-58	2	Yes	$1,200,000.00	$480,109.27	$480,109.27	Memorial Affairs Redesign	2013-A-PD-10901-VLER - MAR Software Engineering Services - Increment 1 - Base Period	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	Memorials Legacy Development Support	Toby Rudik	116-13-2-1315-0015	116-E35595	Memorial Affairs Redesign
VLER Memorials	Development	Approved	13-BENE-58	3	Yes	$70,000.00	$70,000.00	$70,000.00	Memorial Affairs Redesign	2013-A-PD-10103-VLER PMO Support - 2013-A-PD-10106-VLER -PMO Support Services - Extension	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	Memorials Legacy Development Support	Toby Rudik	116-13-2-1315-0016	116-E35405	Memorial Affairs Redesign
VLER Memorials	Development	Approved	13-BENE-59	2	Yes	$10,000.00	$0.00	$0.00	Memorial Affairs Performance and Usability Enhancements (MAPUE)	2013-A-PD-10903-VLER - MAPUE - Production Release eBenefits Precurial Planning	MI 04 Implement Virtual Lifetime Electronic Records (VLER)	Memorials Legacy Development Support	Toby Rudik			Memorial Affairs Performance and Usability Enhancements (MAP

The $252 million in development, modernization, and enhancement (DME) funds will support the following major iEHR programs:

- Identify Management
- Access Control Services
- Immunization
- Laboratory
- Pharmacy
- Presentation Services
- VistA Modernization
- Service-Oriented Architecture (SOA) Suite Enterprise Service Bus (ESB)

Question 167. According to the fiscal year 2014 Budget Fast Facts information sheet, VA has allocated $155 million for the total development and implementation of VBMS, which included $32.8 million for the development costs.

A. Please provide the Committee with a detailed breakdown of the sustainment cost associated with VBMS for fiscal year 2014 and any licensing agreements that are associated with VBMS.

Response. Sustainment funds support maintenance and operations for OIT systems and applications at the existing capability and performance level. Sustainment does not support new functionality or enhancements. In addition to maintenance or replacement of infrastructure on an as-needed basis, sustainment involves correcting critical software defects that have an immediate, adverse impact on OIT's as well as our business partners' capability to support VA's daily mission critical objectives.

There are two types of sustainment: mandatory and marginal. Mandatory sustainment funds existing systems and applications. Marginal sustainment funds newly deployed applications or systems from the point of deployment until the end of the fiscal year.

For FY 2013, VBMS funding supported:

> Marginal Sustainment: $50.582 million
> Mandatory Sustainment: $28.476 million

The cost of VBMS licenses are explained in the table below, which is broken out by fiscal year. Some licenses support development work, and some support sustainment.

> FY 2011: $18,000
> FY 2012: $2.334 million
> FY 2013: $1.532 million
> FY 2014: $1.692 million

B. Please provide the Committee with an estimated sustainment cost associated with VBMS over the next five years.

Response. Please see the spreadsheet below.

Cost for VBMS

Millions	FY14	FY15	FY16	FY17	FY18	Total
VBMS DME	37.983	58.576	9.065			105.624
VBMS Marginal Sustainment	-	2.965	7.486			10.451
VBMS Mandatory Sustainment	-	69.193	54.103	48.782	11.225	183.303
VBMS Sub Total	37.983	130.734	70.654	48.782	11.225	299.378

Millions	FY14	FY15	FY16	FY17	FY18	Total
Software Licenses	1.524	1.734	1.822	1.913	2.008	9.001

VBMS Software License Cost	FY11	FY12	FY13	Total
Kofax Maintenance		2.000	1.221	3.221
Thunderhead License		0.071		0.071
wlett Packard (HP) Unified Functional Testing Software		0.140		0.140
Adobe ROBOhelp 9 Software Maintenance	0.008	0.010	0.003	0.021
JAWS Software Maintenance	0.010	0.008	0.010	0.028
IBM FileNet Capture Software		0.104		0.104
Symantec Licenses (250)			0.008	0.008
Loadrunner			0.210	0.210
VBMS Performance Monitoring (Foglight)			0.080	0.080
Total SW License Cost	0.018	2.334	1.532	3.884

Question 168. The fiscal year 2014 budget request indicates the $32.8 million associated with the development of VBMS will allow VA to "retire legacy software applications." Please provide the Committee with a list of which legacy software applications will be retired, the anticipated timeline, and any costs associated with the retirement of the legacy software.

Response. The FY 2014 budget request of $32.8 million includes Development, Maintenance and Enhancement (DME) funding for both VBMS ($20.7 million) and VETSNET ($12.1 million).

FY 2014 VBMS DME will support the development of VBMS "Generation 3," which will focus on achieving the following goals:

• Improving electronic claims processing by providing increased system functionality and more complex automation capabilities for all VBMS end-users;
• Making enhancements to VBMS that will reduce dependency on legacy systems for claims establishment, development, and rating;
• Developing capability to accept electronic Servicemember Treatment Records (STRs) and Personnel Records from DOD, in general and to support the Veterans Opportunity to Work (VOW) legislation; and
• Enabling end-users to leverage enhanced system functionality to perform their work more efficiently and accurately.

The VBMS Project Management Office (PMO), together with VBA Compensation Services, has initiated the process to retire the legacy application "RBA2000" in FY 2014. RBA2000 is the VETSNET application that assists VBA decisionmakers with the preparation of disability and ancillary ratings. Upon the retirement of RBA2000, all RBA2000 functionality will be replaced by the rating tool within the VBMS application.

Because the effort to retire RBA2000 is still in a planning state, the exact cost and timeframe have yet to be determined. A timeline will be developed for complete retirement of RBA2000 as soon as business requirements have been identified.

The retirement of legacy systems is an active objective of all IT projects. RBA2000 is the only legacy application that VA will be able to retire in the near term. VA anticipates that future enhancements to VBMS and other projects will enable it to further reduce legacy systems.

Question 169. In fiscal year 2012, VA undertook a pilot project to determine the feasibility of using a cloud email system, which placed a number VA email users into the cloud system. Depending on successful outcomes, the project would be expanded to additional users.

A. How many VA email users were originally placed in the cloud email system?

Response. At this point, no production users have been placed in the cloud email system. Test mailboxes have been migrated successfully.

B. Please provide the Committee with the metrics VA will use to determine the success of cloud email systems.

Response. The goal of this project is to procure and implement a cloud-based, software-as-a-service (SAAS) e-mail system that will deliver cloud e-mail capabilities for up to 15,000 VA mailboxes while meeting VA functional and security requirements. The system will also be capable of scaling up to support a user base of 600,000 mailboxes.

Upon completion of the project, recommendations and findings will be compiled and presented to VA's CIO to help him make an informed decision on the migration of the remaining VA mailboxes to the cloud e-mail system.

Overall success of this project will be determined according to three metrics:

1. Success Factor: SaaS costs less than current e-mail systems
    Metric: Cost of Microsoft Exchange Server and associated maintenance compared to cost per-seat offered by the new SaaS vendor
2. Success Factor: SaaS is secure
    Metric: Federal Information Security Management Act (FISMA) and Federal Risk and Authorization Management Program (FedRAMP) certifications are obtained for the SaaS solution
3. Success Factor: Transition is seamless
    Metric: Results of project

C. What is the timeline to determine whether this pilot project will be expanded?

Response. Per the contract's period of performance, the project expansion will occur on or before September 27, 2013.

Question 170. The Interagency Program Office (IPO), established in the fiscal year 2008 National Defense Authorization Act, serves as the "single point of accountability for DOD and VA in the rapid development and implementation of Electronic Health Record (EHR) systems and VLER Health capabilities."

a. Since the change in strategy regarding the iEHR, has the role and accountability of the IPO changed? If so, please provide the Committee with any changes that have taken place due to changes in the development of the iEHR.

Response. VA and DOD remain committed to the IPO as the single point of accountability for achieving interoperability between the Departments' EHR systems. The Departments recently signed a charter outlining the IPO's responsibility for managing the interagency processes, having authority over dedicated resources and to ensuring those resources adequately support all IPO requirements. These responsibilities include overseeing, identifying, and approving health, domain, and messaging standards for the Departments to implement in their EHRs. VA delivered the new charter to the House and Senate Veterans' Affairs Committees on December 20, 2013.

b. Please provide the Committee with a detailed staff organization chart and a breakdown of staff that are assigned to the IPO including VA, DOD, and any contract employees.

Response. See the chart that follows.

INTERAGENCY PROGRAM OFFICE (IPO)

Question 171. As part of the iEHR strategy, VA agreed to consolidate and move VistA systems into DOD-Defense Information System Agency (DISA) data centers. VA anticipates the complete migration for Regions 2 and 3 during fiscal year 2013 and complete migration for Regions 1 and 4 during fiscal year 2014. The migration of Regions 1, 2, 3, and 4 will "enabl[e] full iEHR connectivity with DOD systems."

A. What are the costs associated with the migration of Regions 2 and 3 and with the migration Regions 1 and 4?

Response. Approximately $15 million was spent on Region 2 and 3 migrations in FY 2012, with $31.3 million planned for execution in FY 2013. Migration costs for Regions 1 and 4 are being estimated for the out-year budgets (migrations will take place in 2016/2017).

B. What are the cost savings associated with the complete migration of VistA into DOD-DISA data centers?

Response. VA leveraged the VistA migration projects to accomplish multiple objectives:

1. Data Center Consolidation

2. Pre-standardization of networks, hardware, platforms, and applications in anticipation of VA/DOD Health Record System Merging

3. Security hardening for mission critical health record systems (implementation of high availability, disaster recovery, and continuation-of-operations capabilities for mission critical systems)

The individual costs of these objectives cannot be differentiated, and do not lend themselves to standard Total Cost of Operations modeling used for estimating savings and cost avoidance for pure consolidations. Because VA leveraged the three mandates in one effort, short-term cost savings are not expected. However, over the longer term, VA will avoid the cost of constructing space for security hardening at multiple existing facilities that do not have capacity for the required redundant equipment. VA also expects significant long-term operational cost savings stemming from use of more efficient "commodity hardware" for both existing production systems and security hardening efforts.

Question 172. Currently, VA is nationally implementing VA Point of Service (VPS) kiosks allowing veterans, who are seeking services at VA medical facilities, to use these kiosks to check into their appointments, update or confirm contact and demographic information, and review insurance information.

A. Please provide the Committee with a list of: which VA facilities currently have these kiosks; how many kiosks are at each facility; a timeline of what additional facilities will receive a kiosk; and how many kiosks these additional facilities will receive.

Response. Please see table below for kiosk data.

Current State: Kiosk Deployed by Facility

VISN	Facility	Kiosks Deployed	VISN	Facility	Kiosks Deployed
1	Maine	32	6	Richmond	78
2	Syracuse	39	7	Atlanta	55
3	North Port	32	7	Atlanta—Carrollton	6
4	Altoona	44	8	Gainesville	62
4	Butler	27	10	Dayton	41
4	Clarksburg	21	16	Oklahoma City	28
4	Coatesville	33	17	Central Texas	47
4	Erie	20	19	Salt Lake City Health Care System	60
4	Lebanon	29	20	Anchorage	33
4	Philadelphia	89	20	Portland	63
4	Pittsburgh	72	21	Hawaii	39
4	Wilkes-Barre	35	22	Las Vegas	40
4	Wilmington	39		Test Devices*	58
5	Martinsburg	43			
				Total deployed	1165

*[There is no footnote for the asterisk above.]

Response: Future State: National Deployment will be accomplished in WAVEs
The schedule is provided below:

Wave	VISN	Site	Projected Kiosks	Projected Deployment Start Date
1	1	Bedford	22	8/5/2013
1	1	Boston HCS	69	8/5/2013
1	1	Central MA HCS	38	8/5/2013
1	1	Connecticut HCS	56	8/5/2013
1	1	Manchester	26	8/5/2013
1	1	Providence	29	8/5/2013
1	1	White River Junction	43	8/5/2013
1	6	Asheville	30	8/5/2013
1	6	Beckley	27	8/5/2013

Wave	VISN	Site	Projected Kiosks	Projected Deployment Start Date
1	6	Durham	61	8/5/2013
1	6	Fayetteville	56	8/5/2013
1	6	Hampton	32	8/5/2013
1	6	Salem	48	8/5/2013
1	6	Salisbury	47	8/5/2013
1	16	Little Rock	57	8/5/2013
1	16	Muskogee	35	8/5/2013
1	16	New Orleans	31	8/5/2013
1	16	Shreveport	41	8/5/2013
1	16	Alexandria	21	8/5/2013
1	16	Biloxi	30	8/5/2013
1	16	Fayetteville	35	8/5/2013
1	16	Houston	50	8/5/2013
1	16	Jackson	28	8/5/2013
1	20	Boise	48	8/5/2013
1	20	Puget Sound	52	8/5/2013
1	20	Roseburg	33	8/5/2013
1	20	Spokane	26	8/5/2013
1	20	Walla Walla	41	8/5/2013
1	20	White city	17	8/5/2013
2	2	Albany	34	8/5/2013
2	2	Bath	15	8/5/2013
2	2	Canandaigua	27	8/5/2013
2	2	WNY HCS	24	8/5/2013
2	3	Bronx	52	8/5/2013
2	3	Brooklyn	24	8/5/2013
2	3	Castle Point	7	8/5/2013
2	3	East Orange	37	8/5/2013
2	3	Lyons	11	8/5/2013
2	3	Manhattan	30	8/5/2013
2	3	Montrose	10	8/5/2013
2	3	St. Albans	8	8/5/2013
2	21	Fresno	37	8/5/2013
2	21	Palo Alto	66	8/5/2013
2	21	Reno	22	8/5/2013
2	21	Sacramento	74	8/5/2013
2	21	San Francisco	70	8/5/2013
2	22	Greater Los Angeles	97	8/5/2013
2	22	Loma Linda	78	8/5/2013
2	22	Long Beach	67	8/5/2013
2	22	San Diego	54	8/5/2013
3	7	Augusta	99	1/20/2014
3	7	Birmingham	72	1/20/2014
3	7	CAVHCS	68	1/20/2014
3	7	Charleston	57	1/20/2014
3	7	Columbia	87	1/20/2014
3	7	Dublin	22	1/20/2014
3	7	Tuscaloosa	16	1/20/2014
3	10	Chillicothe	28	1/20/2014
3	10	Cincinnati	34	1/20/2014
3	10	Cleveland	65	1/20/2014
3	10	Columbus	38	1/20/2014
3	11	Indianapolis	33	1/20/2014
3	11	Danville	33	1/20/2014
3	11	Marion IN	9	1/20/2014
3	11	Fort Wayne	7	1/20/2014
3	11	Detroit	20	1/20/2014
3	11	Ann Arbor	21	1/20/2014
3	11	Battle Creek	20	1/20/2014
3	11	Saginaw	31	1/20/2014
3	12	Lovell FHCC	29	1/20/2014
3	12	Jesse Brown	50	1/20/2014
3	12	Hines Jr VAH	38	1/20/2014
3	12	Middleton	28	1/20/2014

Wave	VISN	Site	Projected Kiosks	Projected Deployment Start Date
3	12	Tomah	28	1/20/2014
3	12	Milwaukee	39	1/20/2014
3	12	Iron Mountain	15	1/20/2014
4	8	Bay Pines VA HCS	44	1/20/2014
4	8	Miami	21	1/20/2014
4	8	Orlando	31	1/20/2014
4	8	San Juan	48	1/20/2014
4	8	Tampa	20	1/20/2014
4	8	West Palm Beach	25	1/20/2014
4	15	Eastern Kansas City	48	1/20/2014
4	15	Harry S. Truman	10	1/20/2014
4	15	St. Louis	51	1/20/2014
4	15	John J. Pershing	13	1/20/2014
4	15	Kansas City	19	1/20/2014
4	15	Marion	36	1/20/2014
4	15	Robert J. Dole	22	1/20/2014
4	17	North Texas	93	1/20/2014
4	17	South Texas	61	1/20/2014
4	17	Texas Valley Coastal	50	1/20/2014
4	17	Austin CBOC	19	1/20/2014
4	19	Cheyenne	22	1/20/2014
4	19	Denver (ECHCS)	36	1/20/2014
4	19	VA Montana HS	44	1/20/2014
4	19	Grand Junction	18	1/20/2014
4	19	Sheridan	25	1/20/2014
5	5	Maryland HCS	29	1/20/2014
5	5	Washington DC	20	1/20/2014
5	9	Huntington	32	1/20/2014
5	9	Lexington	30	1/20/2014
5	9	Mountain Home	47	1/20/2014
5	9	Tennessee	50	1/20/2014
5	9	Louisville	34	1/20/2014
5	9	Memphis	32	1/20/2014
5	18	Tucson	49	1/20/2014
5	18	Phoenix	46	1/20/2014
5	18	Prescott	19	1/20/2014
5	18	Amarillo	22	1/20/2014
5	18	West Texas	21	1/20/2014
5	18	El Paso	17	1/20/2014
5	18	Albuquerque	52	1/20/2014
5	23	Black Hills	16	1/20/2014
5	23	Fargo	42	1/20/2014
5	23	Minneapolis	77	1/20/2014
5	23	Sioux Falls	25	1/20/2014
5	23	Central Iowa	22	1/20/2014
5	23	Iowa City	23	1/20/2014
5	23	Nebraska	52	1/20/2014
5	23	St. Cloud	17	1/20/2014
		Total	4524	

B. Please provide the Committee with a detailed breakdown of costs associated with either leasing or purchasing these kiosks.

Response. Please see table below.

Kiosk devices and Accessories

Equipment	Price
Free Standing Kiosk	$4,308.80
Free Standing Headphone Jack	$30.00
Free Standing Surge Protector	$20.00
Free Standing Card Scanner	$856.00

Kiosk devices and Accessories—Continued

Equipment	Price
Free Standing Kiosk Total	$5,214.80
Desk Top Kiosk	$2,998.40
Desk Top Headphone Jack	$30.00
Desk Top Surge Protector	$20.00
Desk Top Card Scanner	$856.00
Desk Top Kiosk Total	$3,904.40
Wall Mount Kiosk	$2,998.40
Wall Mount Headphone Jack	$30.00
Wall Mount Surge Protector	$20.00
Wall Mount Card Scanner	$856.00
Wall Mount Kiosk Total	$3,904.40

C. What is the cost associated with the maintenance and sustainment of these ki-osks?

Response. Kiosk 2 year warranty (renewal): $235 (per kiosk). Three tier service desk support: $3,223,936 for 12 months ($415/kiosk annually).

D. Please provide the Committee with a timeline of when additional functionality is expected to be delivered to these kiosks.

Response. Kiosks Future Releases and Functionality

Software Release 5.3 New Functionality (scheduled release August 2013):
   Release of Information submission
   Patient Queuing (appointment-based pilot)
   Notification verbiage and categorization overhaul
Software Release 5.4 New Functionality (scheduled release September 2013):
   Beneficiary-Travel Application with optional queuing
   MVP Phase B
   Staff Patient Queue Improvements
   Alternative Patient Lookup (Last 5 or name lookup)
   Patient Queue Filter overhaul
   Notification filtering
Additional Optional Workflow offerings
   Allergy Review (dependent upon VPS*1*3 VistA patch approval)
   VetLink 5.4 aligns with VPS*1*2 VistA patch
   Pilot testing expected to begin FY14Q1
Software Release 5.5 New Functionality: (scheduled release February 2014):
   Staff-facing application improvements and redesign
   Approve Patient Update
   Patient Queue
   Bill pay
   Patient Question Queue
   Predictive update recommendations based on patient actions
   Improved Queuing functionality and integration

Question 173. The fiscal year 2014 budget request proposes to realign funding be-tween the medical care and Information Technology Systems appropriations, which would fund 80 FTE at a cost of $4.495 million out of the medical care appropria-tions.

A. What metrics were used to determine that these 80 FTE should be funded through medical care instead of IT appropriations?

Response. OIT and VHA propose to realign personnel in FY 2014 as follows:

VHA/OIT Realignment (FTE Change Analysis)	FTE			Obligations ($M)		
	Medical Services	Medical Support & Compliance	Information Technology	Medical Services	Medical Support & Compliance	Information Technology
Austin Human Resources Support Services		+53	−53		+$6.346	−$6.346
Clinical Applications Coordinator	+53		−53	+$6.138		−$6.138
Information Technology Support Staff		−26	+26		−$7.989	+$7.989

VHA/OIT Realignment (FTE Change Analysis)	FTE			Obligations ($M)		
	Medical Services	Medical Support & Compliance	Information Technology	Medical Services	Medical Support & Compliance	Information Technology
Total	+53	+27	−80	+$6.138	−$1.643	−$4.495

• The FY 2014 budget request realigns 53 FTE and $6.346 million to Austin Human Resources Support Services. These FTEs and funds are being moved from the IT appropriation to the Medical Support and Compliance (MS&C) appropriation. Note that certain human resource specialists that perform functions more appropriately aligned with the Veterans Health Administration (VHA) are still located within OIT. In FY's 2012 and 2013, following a reassignment effective as of December 2011, these staff were supported by OIT on a reimbursable basis.

• Clinical Application Coordinators (CACs) were assigned to OIT when the separate IT Appropriation was created in FY 2006. CACs provide direct support to clinical services, and coordinate facility efforts in support of VHA's Medical Center Management. Due to the nature of their functions, VA's intent now is to realign them back to VHA.

• In addition to the above realignments, 26 FTE and $7.989 million were moved to OIT from VHA's Office of Informatics and Analytics. The functions corresponding to these FTEs are better aligned under OIT.

B. Please provide a list of positions and pay-grades for the 80 FTE staff that would be affected by the realignment?

Response. The following is a list of positions and pay-grades for the 79 FTEs that are proposed for realignment.

Austin HR Transfer (from OIT to VHA)

Human Resource Management
(HR Specialists/HR Assistants)

	FTE
GS-13	3
GS-12	7
GS-11	26
GS-9	7
GS-7	9
GS-6	1
Total	53

subject to change based on requirements

CAC Transfer (from OIT to VHA)

Information Technology Management
(IT Specialists/Program Managers)

	FTE
GS-13	3
GS-12	31
GS-11	15
GS-9	4
Total	53

subject to change based on requirements

IT Support Staff Transfer (from VHA to OIT)

General Administrative, Clerical and Office Services
(Management & Program Analysts/Program Managers)

	FTE
GS-15	1
GS-14	12
GS-13	13
Total	26

subject to change based on requirements

NATIONAL CEMETERY ADMINISTRATION

Question 174. The fiscal year 2014 budget request for the National Cemetery Administration (NCA) is $5.1 million below the amount provided by the fiscal year 2013 Continuing Resolution. The chart entitled "Analysis of Increases and Decreases—Obligations" shows a reduction of $15.4 million for change in contracts, other services and travel.

a. Please provide the Committee with details on what is included in the "[c]hange in contracts, others service and travel" and what led to the expected reduction?

Response. The reduction of $15.4 million shown in the fiscal year 2014 budget request column for this line item is due to a decrease in funding for national shrine and other repair projects. The reduction of funds in these lines had to be used for workload increases, operating cost increases, and the initial activations of three new cemeteries, two urban cemeteries, and two National Veterans Burial Grounds in rural areas.

b. What other factors or assumptions contributed to the $5.1 million reduction in the fiscal year 2014 request?

Response. American Recovery and Reinvestment Act (ARRA) funds ($26.3 million) for national shrine projects were used to address the most immediate shrine needs that would have otherwise been accomplished through annual appropriations. In addition, increased use of beam system foundations that maintain the height and alignment of headstones and markers for longer periods of time will decrease the need for follow-up national shrine projects.

Question 175. According to the fiscal year 2014 budget request, in 2012, 82 percent of headstones, markers, and niche covers were clean and free of debris or objectionable accumulations; 69 percent of headstones and/or markers in national cemeteries were at the proper height and alignment; and 93 percent of gravesites had grades that were level and blend with adjacent grade levels. For fiscal year 2014, the annual target for these three metrics are 80 percent, 70 percent, and 84 percent, respectively.

a. All three annual targets in 2014, for the metrics mentioned, are lower than the 2012 and well below the strategic target. Why are the three annual targets below 2013 actual percent?

Response. Projected increases in the number of gravesites in national cemeteries, along with expected flat or decreased national funding beginning in 2012, will lead to a short term projected decrease in performance in 2014 for these measures.

b. Given the low percentages versus those stated in the strategic targets, what steps is NCA taking to meet the strategic targets?

Response. NCA is implementing new operational techniques designed to produce more lasting results in the repair and appearance of gravesites. One example is the increased use of beam system foundations that maintain the height and alignment of headstones and markers for longer periods of time, thereby decreasing the need for follow-up national shrine projects.

Question 176. Public Law 113–2, the Disaster Relief Appropriations Act of 2013, included $2.1 million for NCA to make necessary repairs as a result of Hurricane Sandy in October 2012.

a. Please provide the Committee with a list of projects undertaken with funds from Public Law 113–2.

Response. The funding was used to repair tree damage caused by Hurricane Sandy at three VA national cemeteries: Beverly National Cemetery in New Jersey, and Long Island National Cemetery and Cypress Hills National Cemetery in New York. The funding was used to remove or prune damaged trees and clean up debris.

b. Has all of the additional $2.1 million been spent or obligated?

Response. NCA has obligated $876,119 for damages caused by Hurricane Sandy. All damage has been repaired and no additional repair projects have been identified where these specific purpose funds could be used. Per Public Law 113–2, the funding was designated "for necessary expenses related to the consequences of Hurricane Sandy." Accordingly, NCA cannot realign the funds for another purpose.

Question 177. On February 7, 2013, the IG issued a report entitled "Audit of Internal Gravesite Review of Headstone and Marker Placement." The audit found that NCA's internal review of the placement of headstones and markers did not identify and report all misplaced headstones and unmarked gravesites. Specifically, at four of the 12 audited cemeteries, the IG found seven errors not previously reported. After revising its procedures, NCA identified an additional 146 errors at four of the 12 cemeteries the IG audited.

a. Given the findings of the IG audit, does NCA believe the information provided to Congress on its internal audit is valid?

Response. Yes, the information provided to Congress is valid. NCA accepted the Department of Veterans Affairs (VA) Office of Inspector General's (OIG) recommendations made in a July 2012 Management Advisory Memorandum, which preceded OIG's final audit report. NCA immediately adjusted its methodologies to increase the accuracy of the headstone and marker review. As a result of OIG's recommendations, Memorial Service Network (MSN) executive leaders conducted independent gravesite reviews at every national cemetery and soldiers' lot administered by VA after the cemetery directors had completed reviews of their entire cemeteries. MSN senior leaders conducted these reviews either through statistically valid random sampling of gravesites or complete cemetery re-audits. With these reviews by independent MSN teams, NCA gained reasonable assurance that the audit results reported to Congress were valid in terms of the discrepancies reported at 147 of 164 national cemeteries and soldiers' lots administered by VA. Additionally, the NCA Headstone and Marker audit provided actionable data on which NCA is prioritizing efforts to ensure the accountability of remains at all national cemeteries now and in the future. These efforts will include full audit reviews at 17 cemeteries to achieve reasonable assurance that all gravesites are accurately marked at those facilities.

b. How many additional errors were found using the revised procedures at other NCA cemeteries?

Response. At four of the 12 cemeteries that OIG reviewed as part of its Phase I audit, NCA independent review teams reported 111 additional discrepancies. (The main differences between this number and the 146 errors noted in the question are explained in Under Secretary Muro's January 15, 2013, response to OIG's draft audit report. This letter is Appendix F of OIG's final report; specific references about differences reported for Winchester and Philadelphia National Cemeteries are on page 23 of the final report.) NCA included these and other findings of the independent review teams in the Phase II report to Congress. NCA did not separately tabulate for all cemeteries the discrepancies identified by the independent review teams from those reported by cemetery directors in the Phase II report.

c. Please provide a list of all errors identified by both phase one and phase two of the audit by cemetery and the difference in errors from what was originally reported and those discovered after the IG audit.

Response. Phase I results reported to Congress on April 3, 2012, included a total of 251 corrective actions (243 headstone/marker errors and 8 reburials—see Attachment). The Phase I review was limited to sections of cemeteries that had undergone "raise and realign" projects. In July 2012, during OIG's audit which focused on NCA's administration of Phase I, OIG issued a Management Advisory Memorandum which preceded OIG's final audit report. NCA immediately adjusted its methodologies to increase the accuracy of the NCA headstone and marker review. As a result of OIG recommendations, Memorial Service Network executive leaders conducted independent gravesite reviews at every national cemetery and soldiers' lot administered by VA, that is, all cemeteries and all sections that cemetery directors reviewed under both Phase I and Phase II. NCA reported these findings with the Phase II report to Congress on February 6, 2013. The Phase II results included 527 corrective actions: 520 headstone/marker errors, and seven potential reburials. (Phase II summary findings are attached. NCA later determined that two of the potential burials identified in the Phase II review were not necessary.) NCA did not categorize the findings of the independent review teams according to different sections reviewed under Phase I or Phase II.

d. What personnel actions were taken by NCA in response to cemetery directors who did not accurately audit their cemeteries?

Response. NCA is in the process of taking appropriate actions in response to the results of our gravesite review. In addition to looking at which cemetery directors

did not accurately audit their cemeteries, NCA is also investigating whether, and which, employees can be held accountable for gravesites which were mismarked or unmarked. NCA is reviewing the circumstances of each case to ensure consistency in responses across the organization. Although the process is not complete, one of the cemetery directors whose audit results were called into question by OIG has voluntarily left NCA. Another cemetery director has been removed from the position of director and demoted—actions related to the audit formed part of the basis for that personnel action.

Question 178. The fiscal year 2014 budget request for Grants for Construction of Veterans Cemeteries includes $1.6 million less for fiscal year 2014 compared to the fiscal year 2013 Continuing Resolution.

a. How many states have pending requests for state veterans cemeteries grants? Please list the grant applications by state and location.

Response. As of July 29, 2013, there are 31 states, 11 tribal organizations, and the territories of Guam, the U.S. Virgin Islands, and the Commonwealth of the Northern Mariana Islands with pending requests.

Grant Applications by State and Location

State	Location	Date Received	Estimated Amount	Description	Priority
AK	Fairbanks	3/23/2009	$6,468,231.11	establishment	2
AR	North Little Rock	4/19/2010	$753,495.00	operations and maintenance	4
AR	North Little Rock	6/29/2010	$600,000.00	expansion	3
AZ	Flagstaff	4/20/2009	$7,450,000.00	establishment	2
AZ	Yuma	4/20/2009	$6,800,000.00	establishment	2
AZ	Kingman	4/20/2009	$6,800,000.00	establishment	2
AZ	Chinle (tribal)	4/20/2009	$9,600,000.00	establishment	2
AZ	Northern Tucson	6/24/2009	$5,300,000.00	establishment	2
AZ	San Carlos (tribal)	6/28/2013	$3,483,102.00	establishment	2
CA	Rancheria (tribal)	6/30/2008	$57,000.00	expansion Toulmne Band	3
CA	Monterey	2/25/2009	$15,944,487.00	establishment	2
CA	Yountville	6/26/2009	$4,695,760.00	improvement	4
CA	Auberry (tribal)	6/7/2012	$1,143,000.00	establishment	2
CA	Igo	6/28/2013	$95,377.00	improvement	4
CT	Middletown	6/17/2013	$3,626,500.00	expansion	1
DE	Millsboro	4/12/2010	$74,250.00	operations and maintenance	4
DE	Millsboro	6/28/2013	$1,008,000.00	expansion	1
GU	Agatna Heights	5/25/2011	$3,952,500.00	expansion	1
GU	Agatna Heights	5/25/2011	$175,000.00	operations and maintenance	4
HI	Hilo	6/29/2010	$312,291.00	improvement	4
HI	Lanai	6/29/2010	$88,287.00	improvement	4
HI	Kauai	6/29/2010	$1,477,381.00	improvement	4
HI	Hoolehua	6/29/2010	$438,408.00	improvement	4
HI	Kauai	6/29/2010	$26,478.00	operations and maintenance	4
HI	Kaneohe	6/29/2010	$3,092,939.00	operations and maintenance	4
HI	Makawao	6/29/2010	$1,119,667.00	operations and maintenance	4
HI	Hilo	6/29/2010	$563,434.00	operations and maintenance	4
HI	Hilo	6/29/2010	$2,829,703.00	operations and maintenance	4
HI	Kailua-Kona	6/29/2012	$795,459.00	improvement	4
HI	Makawao	6/29/2012	$6,556,200.00	expansion	1
HI	Kaneohe	6/27/2013	$12,168,00000	expansion	1
ID	Southeastern	8/13/2012	$11,150,10000	establishment	2
IN	West Lafayette	7/1/2010	$0.00	operations and maintenance	4
KY	South Eastern	4/7/1999	$7,255,000.00	establishment	2
KY	Hopkinsville	7/1/2010	$149,048.00	operations and maintenance	4
LA	Rayville	12/21/2006	$6,800,000.00	establishment	2
LA	Jennings	12/21/2006	$6,800,000.00	establishment	2
MA	Agawam	7/1/2013	$2,173,025.00	expansion	1
MD	Owings Mills	6/30/2010	$2,500,000.00	operations and maintenance	4
MD	Hurlock	6/30/2010	$1,250,000.00	operations and maintenance	4
MD	Flintstone	6/30/2010	$1,250,000.00	operations and maintenance	4
MD	Crownsville	6/30/2010	$1,630,000.00	operations and maintenance	4
MD	Crownsville	6/24/2011	$4,000,000.00	expansion	3
MD	Cheltenham	6/25/2011	$3,773,450.00	expansion	3
MD	Flintstone	6/24/2013	$2,600,000.00	expansion	1
MD	Hurlock	6/24/2013	$2,240,000.00	expansion	1
ME	Augusta-Civic Center	4/6/2012	$430,000.00	improvement	4

Grant Applications by State and Location—Continued

State	Location	Date Received	Estimated Amount	Description	Priority
ME	Augusta-Civic Center	2/20/2013	$1,763,250.00	expansion	1
ME	Augusta-Mt. Vernon Rd	2/21/2013	$1,852,500.00	expansion	1
MI	Grand Rapids	6/30/2010	$100,100.00	operations and maintenance	4
MN	Duluth	6/30/2008	$8,350,000.00	establishment	2
MN	Southwest Minnesota	6/4/2009	$7,900,000.00	establishment	2
MN	SE Minnesota	6/29/2010	$7,900,000.00	establishment	2
MN	Little Falls	6/28/2013	$475,000.00	expansion	1
MO	St. James	4/13/2010	$368,065.00	improvement	4
MP	Rota	6/30/2013	$500,000.00	establishment	2
MP	Tinian	6/30/2013	$500,000.00	establishment	2
MT	Columbia Falls	8/4/2009	$100,000.00	improvement	4
MT	Crow Agency (tribal)	7/1/2013	$3,000,000.00	establishment	2
MT	Poplar (tribal)	7/1/2013	$5,150,000.00	establishment	2
NC	Goldsboro	7/1/2011	$6,000,000.00	establishment	2
NE	Grand Island	10/23/2000	$5,102,000.00	establishment	2
NE	Grand Island	6/28/2012	$267,840.00	operations and maintenance	4
NJ	Wrightstown	2/14/2002	$3,400,000.00	public information center	4
NJ	Wrightstown	4/15/2010	$701,750.00	operations and maintenance	4
NJ	Vineland	6/28/2011	$300,300.00	improvement	4
NM	Fort Stanton	4/9/2001	$3,500,000.00	establishment	2
NV	Fallon	7/1/2009	$1,250,000.00	establishment	2
NV	Boulder City	4/20/2010	$1,402,076.00	operations and maintenance	4
NV	Fernley (tribal)	6/7/2013	$1,379,874.00	expansion	1
NY	Putnam County	7/1/2011	$5,000,000.00	establishment	2
OK	Pawnee (tribal)	7/1/2008	$1,950,000.00	establishment	2
OK	Wewoka (tribal)	7/1/2012	$100,000.00	establishment	2
OK	Ponca City (tribal)	7/1/2013	$205,000.00	establishment	2
RI	Exeter	6/28/2011	$885,947.00	expansion	1
SC	York County (tribal)	6/26/2013	$984,200.00	establishment	2
TN	Knoxville	7/1/2010	$438,705.00	operations and maintenance	4
TN	Nashville	7/1/2010	$307,265.00	operations and maintenance	4
TN	Jackson	7/1/2011	$6,000,000.00	establishment	2
TN	Nashville	4/13/2012	$1,447,975.00	expansion	1
TN	Memphis	4/13/2012	$1,370,000.00	expansion	1
TN	Knoxville	4/13/2012	$120,000.00	improvement	4
TN	Eastern Region	5/8/2013	$6,000,000.00	establishment	2
TX	Mission	2/26/2013	$598,860.00	expansion	1
TX	Killeen	4/30/2013	$4,437,076.00	expansion	1
VI	St. Thomas	6/30/2001	$1,200,000.00	establishment	2
VI	St. Croix	6/30/2001	$1,200,000.00	establishment	2
VT	Montpelier	6/29/2005	$2,750,000.00	expansion and improvement	3
WA	Medical Lake	6/29/2013	$1,000,500.00	expansion	1
WI	Union Grove	6/22/2010	$373,905.45	operations and maintenance	4
WI	Union Grove	4/13/2012	$4,638,700.00	expansion	1
WI	Spooner	4/13/2012	$1,671,800.00	expansion	1
WY	Evansville	2/13/2006	$1,100,000.00	improvement	4

b. What metrics does NCA use to determine the funding requirements for the Grants for Construction of Veterans Cemeteries?

Response. Each year, NCA's Veterans Cemetery Grants Service (VCGS) conducts a review of all pending pre-applications from the current year and previous years and creates a priority list that ranks all pre-applications across four priority groups. The priority list is reviewed and signed by the Secretary of Veterans Affairs and published by October 1st of each year. The four priority groups are explained below:

• Priority Group 1: This group includes expansion projects required to prevent an interruption in burial service at existing state and tribal Veterans cemeteries within 4 years of the date of the pre-application. These projects are assigned the highest priority.

• Priority Group 2: This group is comprised of new establishment projects. To determine the funding requirements for new establishment projects, VCGS reviews the estimated Veteran population that would be served by the proposed cemetery along with the estimated interment rate and partners with states and tribes to adjust their project scope accordingly.

• Priority Group 3: This group includes expansion projects required to prevent an interruption in burial service at existing state and tribal Veterans cemeteries outside of the 4 years since the date of the pre-application.

• Priority Group 4: This group is comprised of projects to improve existing state or tribal Veterans cemeteries and operation and maintenance projects that address NCA national shrine standards of appearance.

VCGS reviews the submitted project scope, budget, and detailed cost estimates for all submitted pre-applications. When analyzing project budgets and their associated cost estimates, VCGS compares the projected costs against established NCA estimating methodologies. VCGS works closely with all states and tribal organization applicants to refine their cost estimates and budgets to reflect the most efficient and effective use of VCGS grants funds to serve Veterans and their families.

VOCATIONAL REHABILITATION AND EMPLOYMENT

Question 179. A significant increase in subsistence allowance payments was projected for fiscal year 2012 due to changes under Post-9/11 Veterans Educational Assistance Improvements Act of 2010, Public Law 111–377, which allowed individuals eligible for the Post-9/11 GI Bill to receive subsistence allowance at the basic allowance for housing rate in lieu of the historical monthly allowance rate. The current estimated obligations for fiscal year 2013 are $136 million less than projected.

a. Please describe the reasons why the significant increase of subsistence allowance did not materialize.

Response. The current estimate for subsistence allowance was updated from $491.7 million to $386.3 million for FY 2013, a decrease of $105.4 million. While the current estimate of $386.3 million is a decrease from the initial FY 2013 estimate, it still represents a 28 percent increase over FY 2012 subsistence allowance payments, and a 35 percent increase over FY 2011 payments.

The number of projected trainees receiving subsistence in FY 2013 decreased from 68,093 to 64,864, based on actual FY 2012 experience. This resulted in a decrease of $23.3 million to the subsistence allowance payments. In addition, the initial projection estimated that 40 percent of trainees receiving subsistence would be eligible for the basic allowance for housing (BAH) rate by FY 2013. However, based on FY 2012 actual experience, this assumption was reduced to reflect that 15 percent of trainees would receive subsistence at the BAH rate in FY 2013. This decreased the FY 2013 current estimate an additional $82.1 million.

b. Was the decrease due to eligible participants not taking advantage of the basic allowance for housing rate? Please explain and detail any other factors leading to the decrease.

Response. Actual experience indicates that fewer trainees are receiving subsistence at the BAH rate than was initially projected. This could be due to an overestimate of the number of Veterans receiving subsistence that are eligible for the BAH rate, eligible participants not taking advantage of the BAH rate, or a combination of both. At this time, data are not available to determine the primary reason that fewer Veterans are receiving subsistence at the BAH rate than expected.

When applying for benefits, Veterans are informed of which level of subsistence allowance they are eligible for and Veterans then determine which benefit they are electing to receive. It is unlikely that new participants are applying for the lower rate of subsistence when they are eligible for the BAH rate. However, Veterans that were already receiving subsistence prior to the enactment of Public Law 111–377 must ask their Vocational Rehabilitation Counselor to switch to the higher BAH rate. On August 9, 2011, VR&E Service directed field staff to provide a standardized letter to Veterans that were already receiving subsistence prior to the enactment of Public Law 111–377 notifying them about their potential eligibility for the higher BAH rate.

Question 180. The fiscal year 2014 budget request includes "$104 million [for] a new Transition Assistance Program to help separating servicemembers better transition to civilian life." The $104 million will be used, in part, to implement the new Transition GPS (Goals, Plans, Success) program, which is part of the redesigned Transition Assistance Program.

a. How many VA FTE or contractors will directly interact with servicemembers through the Transition GPS program?

Response. At the end of FY 2013, VA will have 392 briefers that will directly interact with Servicemembers through benefits briefings, career technical training, and individual assistance to requesting Servicemembers. The 392 briefers will provide support to 208 locations.

At the end of FY 2014, VA is projected to have an additional 321 briefers directly interacting with Servicemembers through benefits briefings, career technical train-

ing, capstone events, individual assistance to requesting Servicemembers, and virtual briefings. The additional 321 will provide support at 247 stateside locations and 74 overseas locations.

b. Of the $104 million, how much has been requested for FTE or contractors participating in the Transition GPS program?

Response. All of the $104 million has been requested for Transition Goals, Plans, Success (GPS) contracting.

c. Please provide a detailed timeline for implementation of VA's portion of the Transition GPS program, including locations inside and outside the United States.

Response. See attached implementation timeline, "VBA-SVAC-QFR180cattach."

d. Please detail the assumptions made for an increased workload due to the implementation of the Transition GPS program. Please include additional Vocational Rehabilitation and Employment (VR&E) and VBA workloads affected by implementation.

Response. The following assumptions were made in determining briefer support for full implementation of mandatory Transition GPS, which incorporates requirements of Public Law 112–56, sections 201–265, 125 Stat. 711.

• Transitioning Servicemember throughput of approximately 307,000 as provided by the Services.

• 100 percent mandatory participation by Servicemembers.

• Classroom size of no more than 50 participants.

• Contract briefers will conduct the VA Benefits I Briefing (4 hours), VA Benefits II Briefing (2 hours), and the Career Technical Training Track (16 hours curriculum with the assumption that 30% of transitioning Servicemembers will attend and seek individual assistance).

• Briefers will provide individual assistance to requesting Servicemembers with a planning factor of 1 hour per Servicemember.

• Contract Briefers will also support Capstone Events (1–2 hours dedicated to each transitioning Servicemember). Service models for Capstone may differ.

• Travel time and cost to support itinerant installations where there is no permanent briefer support due to lower transition throughput.

• Initial briefer training for VA Benefits I and II Briefings as well as follow-on training for Career Technical Training Track.

• The end state by September 30, 2014, which includes 713 briefers who will support both U.S. and overseas locations.

Additional assumptions made for increased workload for second and third-order effects, to include VR&E and other VBA workloads:

• Assumed a 70 percent claims intake rate based on approximately 307,000 separating Servicemembers. The intake rate was adjusted by 67,000 to account for incoming claims with existing pre-discharge programs.

• Under legacy TAP, only about 50 percent of Servicemembers attended Transition Assistance Program (TAP). With mandatory attendance required for Transition GPS and VOW/VEI, the assumption is to expect increases in VA benefit applications (across all 6 types of benefits) due to pre-separation counseling and information provided in the VA Benefits I and II Briefings, the Capstone event, individual assistance, military lifecycle planning, and the two-day Career Technical Training Track.

Question 181. The Vocational Rehabilitation Counselor (VRC) Skill Certification Test "is an internal, professional-level examination that tests technical and procedural knowledge, along with the situational judgment associated with the journey-level VRC position."

a. If a VRC fails the certification test, what additional training would a VRC be required to take?

Response. According to the 5 U.S.C. 7106 (b)(1) Pilot Memorandum of Understanding, "the supervisor and employee will identify training available to gain knowledge in deficit areas, to remediate knowledge gaps and allow sufficient time for employees to complete the training." VR&E leadership in the ROs identify the training that a VRC must complete if he or she fails the certification test. VR&E Service recommends VRCs complete the VRC Foundational Training and Performance Support Systems (TPSS) module in order to remediate their knowledge gaps and to pass the certification test.

b. If a VRC does not meet the requirements of the certification test, would the VRC be required to pass prior to resuming his or her duties?

VBA Response: If a VRC does not pass the certification test, the individual is not prohibited from resuming his or her duties.

Question 182. Please provide the Committee with data on VR&E activities by regional office, including but not limited to: 1) number of counselors at each office,

2) number required at each office, 3) rehabilitation rate, 4) timeliness, 5) cases, and 6) number of veterans served.

Response. The number of VRCs required is based upon the Office of Field Operations (OFO) RAM, which is a staffing model based on workload demands and performance. In addition to VRC FTE allocations, OFO also allocates VR&E contract counseling funds to augment counseling services provided by VA employees. The total GOE contracting allocation for VR&E contract counseling services for FY 2013 is $4,000,000. Station allocations are made based on workload demands and may be adjusted throughout the fiscal year to ensure coverage during workload surges and unexpected workload influx, or to assist in transitioning while vacant positions are being backfilled. The table below shows data as of April 30, 2013:

	Vocational Rehabilitation Counselor (VRC)	VRCs Required	Rehab Rate	Days to Notification of Entitlement Determination (Timeliness)	Chapter 31 Participants	Number of Veterans Served (All Chapters)
USA FYTD 2013	981	981	78.1%	44.2	116,121	124,682
Eastern Area (16 ROs)	193	195			26,495	26,965
Baltimore	14	14	71.3%	29.9	1,938	2,039
Boston	10	10	63.8%	80.7	1,406	1,453
Buffalo	14	14	67.8%	41.0	1,823	1,961
Cleveland	24	25	87.1%	52.5	4,336	4,340
Detroit	30	30	79.5%	54.5	4,087	4,189
Hartford	9	10	95.9%	34.8	1,510	1,508
Indianapolis	20	20	72.8%	54.0	2,952	2,962
Manchester	5	5	30.2%	44.1	515	528
New York	16	16	91.3%	49.9	1,618	1,627
Newark	9	10	39.2%	43.8	1,657	1,678
Philadelphia	14	14	77.5%	42.1	1,796	1,807
Pittsburgh	9	9	67.2%	43.4	782	801
Providence	7	6	52.0%	34.2	523	515
Togus	8	7	82.4%	34.7	714	716
White River Junction	2	3	100.0%	44.1	593	595
Wilmington	2	2	89.6%	48.6	245	246
Southern Area (12 ROs)	302	301			34,534	36,388
Atlanta	45	45	81.8%	47.2	4,665	4,821
Columbia	28	27	78.4%	31.2	2,487	2,693
Huntington	9	8	35.6%	45.9	643	637
Jackson	6	7	81.4%	45.7	1,025	1,050
Louisville	19	19	78.1%	41.0	2,345	2,376
Montgomery	27	27	90.6%	36.6	3,415	3,475
Nashville	21	21	84.3%	51.6	2,615	3,061
Roanoke	24	24	63.3%	38.8	2,934	3,007
San Juan	6	6	87.8%	42.0	701	732
St. Petersburg	62	62	84.8%	43.8	8,271	8,318
Washington	24	24	92.5%	39.5	2,389	2,505
Winston-Salem	31	31	79.8%	36.6	3,044	3,713
Central Area (14 ROs)	251	248			27,662	30,641
Chicago	15	15	86.5%	38.0	1,875	1,962
Des Moines	8	8	84.5%	39.6	1,210	1,226
Fargo	6	5	72.1%	29.3	385	384
Houston	55	55	90.6%	41.4	6,243	6,493
Lincoln	8	7	84.8%	36.4	680	686
Little Rock	11	11	38.3%	24.0	1,320	1,313
Milwaukee	11	11	88.1%	29.5	1,239	1,236
Muskogee	19	19	87.6%	48.3	2,126	2,229
New Orleans	13	13	77.0%	34.4	1,305	1,375
Sioux Falls	7	7	66.7%	33.5	673	683
St. Louis	18	18	79.8%	37.4	1,661	1,716
St. Paul	11	11	83.0%	41.0	1,322	1,344
Waco	58	58	80.7%	52.1	6,872	9,049

	Vocational Rehabilitation Counselor (VRC)	VRCs Required	Rehab Rate	Days to Notification of Entitlement Determination (Timeliness)	Chapter 31 Participants	Number of Veterans Served (All Chapters)
Wichita	11	10	80.0%	22.1	751	945
Western Area (16 ROs)	235	237			27,430	30,688
Albuquerque	8	8	89.8%	53.5	1,068	1,090
Anchorage	6	6	95.7%	47.4	866	863
Boise*						
Cheyenne**						
Denver	25	25	85.1%	33.8	3,178	3,377
Fort Harrison	6	6	88.0%	35.3	770	772
Honolulu	10	11	79.2%	65.9	1,347	1,647
Los Angeles	25	26	76.4%	46.3	4,043	4,129
Manila	2	2	85.7%	33.2	158	163
Oakland	22	22	82.9%	47.8	3,242	3,331
Phoenix	21	21	85.0%	46.6	2,176	2,465
Portland	20	20	75.3%	63.3	2,093	2,133
Reno	7	7	90.7%	42.9	788	807
Salt Lake City	18	18	86.2%	39.8	2,159	1,763
San Diego	31	31	76.4%	38.5	2,220	4,038
Seattle	34	34	83.2%	66.0	3,322	3,645

HOUSING

Question 183. The Committee recently received the following from VA in response to a question concerning the National Mortgage Settlement.

In 2012, the Department of Justice (DOJ) worked to achieve a settlement with five banks who participated in the VA home loan program. The two-part settlement contained (1) approximately $10M for violations related to mortgage loan origination and servicing (the National Mortgage Settlement), and (2) approximately $45M pursuant to the False Claims Act. The first part of the settlement is intended to settle any potential claims related to VA guaranty claim payments, which are paid from the loan subsidy account of the Veterans Housing Benefit Program Fund (VHBPF). The second part of the settlement addresses impermissible loan transaction fees charged to Veterans.

None of the settlement money due VA, approximately $42M, will be paid to VA home loan borrowers. Because the VA Home Loan Program is subject to the Federal Credit Reform Act, the following actions will be taken once funds are received from DOJ. Funds associated with the National Mortgage Settlement will be deposited in the VHBPF loan subsidy account and spread over all loan cohorts to cover the potential guaranty claims that VA may pay. Funds associated with the False Claims Act portion of the settlement are not deemed "funds incident to housing loan operations," and will therefore be deposited back to Treasury.

a. How many guaranty claims does VA believe it will pay that would be covered by the $10 million portion of the settlement?

Response. VA does not understand what is meant by "sufficient" with regard to the settlement funds. The funds were not tied to specific loans or specific mortgage origination/servicing violations. However, VA has not released its right to adjust claims if it finds specific instances of origination or servicing violations. As noted above, any excess funds within individual cohorts identified through re-estimates will be transferred to Treasury.

b. Of those covered by funds put in the VHBPF loan subsidy account, does VA believe the $10 million will be sufficient? Please provide justification.

Response. VA does not understand what is meant by "sufficient" with regard to the settlement funds. The funds were not tied to specific loans or specific mortgage origination/servicing violations. However, VA has not released its right to adjust claims if it finds specific instances of origination or servicing violations. As noted above, any excess funds within individual cohorts identified through re-estimates will be transferred to Treasury.

Question 184. The fiscal year 2014 budget request housing workload section for 2014 states: "The number of refinance loans will decrease as interest rates steadily rise." In questions for the record regarding the fiscal year 2013 budget request, the Committee asked about VA's interest rate assumptions, as VA had asserted that interest rates would steadily rise during 2012 and 2013. Since the February 29, 2012, budget hearing, the 30-year fixed mortgage interest rate, according to Freddie Mac, has fallen from 3.9 percent on March 1, 2012, to 3.4 percent on April 25, 2013. In light of the continued decline in interest rates, has VA looked at other economic assumptions aside from those prepared by the Office of Management and Budget? If so, please explain what assumptions VA now utilizes.

Response. VA's guidance for economic assumptions in the budget request is prepared by OMB; VA continues to use OMB assumptions under the requirements of the Federal budget process. VA does review outside mortgage industry projections, and these have been consistent with OMB's assumptions, including interest rate expectations. VA will update forecasts for refinance and purchase loan guaranties during the 2014 Mid-Session Review budget cycle in June 2013.

Question 185. The fiscal year 2014 budget request housing workload section indicates, "[t]hese economic conditions have led to declining housing prices and tightening credit." The Standard & Poor's/Case-Shiller 20-city home price index, released April 30, 2013, show housing prices increased from an 8.1 percent year-over-year gain in January to 9.3 percent in February.

a. Given the recent news on rising home prices, how would continued growth in the housing market effect VA's workload assumptions for 2013 and 2014?

Response. In general, housing price changes alone do not have as strong an impact on VA loan volume as do interest rate fluctuations and changes in credit underwriting in the conventional market. This was seen in the increase in VA loan volume following the mortgage market collapse (and decreased availability of conventional credit), and the surge of refinance volume in the recent low interest rate environment. But if housing price increases continue at a consistent rate, leading to a full recovery, VA loan volume is likely to increase moderately as a result.

VA-guaranteed loan workload, and assumptions thereof, must be analyzed by the component loan types—purchase loans and refinance loans. Continued moderate housing price increases is not expected to have a substantial impact on the volume of VA purchase loans as this volume is not particularly sensitive to such increases and has historically been stable. However, slight increases in purchase loan volume could still result due to current homeowners who are now willing to move and obtain a new loan with the new ability to sell an existing home at a higher price.

The ability to refinance may improve for certain borrowers if housing prices consistently increase as a lender's loan-to-value ratio refinance requirements may be newly achieved. There may be a slight increase in projected refinance volume as a result; however, this must be tempered with the forecasted increasing interest rates, which may hold some of these borrowers back from refinancing.

Should housing prices continue to increase, VA would see more of an impact on the number of default resolution options available to borrowers than on loan volume. Underwater borrowers typically do not have the same default resolution opportunities available to them. Increasing home prices will reduce the number of underwater borrowers and increase those opportunities.

VA will take into account recent changes in housing market conditions and forecasts in its mid-session review and update workload projections as necessary.

b. How are VA's workload assumptions effected by regional differences in the housing market?

Response. VA's workload assumptions are based on projected changes in the overall U.S. housing market. All regions constitute overall volume expectations, in aggregate. However, VA is currently exploring the procurement of a credit market's analytical tool that would provide regional housing data. It remains to be seen whether overall program workload assumptions would be adjusted based on the data available. The information would likely be more beneficial for targeting default resolution outreach to regions with higher projected defaults.

FILIPINO VETERANS EQUITY COMPENSATION FUND

Question 186. The fiscal year 2014 budget request for the Filipino Veterans Equity Compensation Fund indicated that 3,500 Notices of Disagreement (NODs) have not been resolved. The estimate for fiscal year 2014 is that $45.1 million in unobligated funds will remain at the end of the fiscal year.

a. When does VA expect that the remaining 3,500 NODs will be resolved?

Response. Through May 8, 2013, the Manila RO received a total of 4,515 notices of disagreement (NODs). Currently, only 495 of the NODs remain pending. Of those,

238 were certified to the Board of Veterans' Appeals (BVA) and 257 are pending at the RO.

The majority of the 257 appeals pending at the RO are awaiting additional service records, service verification, or hearings. The Manila RO regularly provides the National Personnel Records Center (NPRC) a list of all pending requests for service verification. Weekly follow-ups are completed via email. Additionally, Filipino Veterans Equity Compensation (FVEC) appeals are given priority in the scheduling of hearings. At this time, all hearings have been scheduled.

Typically, the appeals at the RO are resolved or certified to BVA in 30 to 60 days. This is dependent upon receiving documents from NPRC and can be extended if the claimant submits additional documents for review.

b. Please detail what, if any, commonalities exist in the NODs and what steps VA is taking to address these.

Response. There are two commonalities that exist among the NODs. Most of the NODs received (89 percent) are denials based on no qualifying military service and Question 11 percent were due to untimely filed claims, untimely filed NODs, or untimely substantive appeals.

As stated earlier, the majority of the 257 pending at the RO are awaiting additional service records, service verification, or hearings. The Manila RO regularly provides NPRC a list of all pending requests for service verification and weekly follow-ups are completed via email. Additionally, FVEC appeals are given priority in the scheduling of hearings. At this time, all hearings have been scheduled.

Question 187. The fiscal year 2014 budget request discusses two ongoing lawsuits that could affect the Filipino Veterans Equity Compensation Fund's unobligated balance.

a. Please describe each lawsuit and how they could potentially affect the unobligated balance.

Response. Both lawsuits challenge VA's administration of the Filipino Veterans Equity Compensation (FVEC) fund, and in particular the ways in which VA verifies whether a claimant had the service required by law.

Recinto v. *U.S. Dep't of Veterans Affairs* was brought by individual Filipino Veterans alleging their claims were wrongfully denied because of reliance on faulty records, and by individual widows of Filipino Veterans challenging the statute on constitutional grounds. The number of individual claims directly involved in this case is small. However any ruling that the Government's process or the statute itself is legally deficient could conceivably expand the scope of the program in ways that are difficult to predict.

De Fernandez v. *U.S. Dep't of Veterans Affairs* is a putative class action brought by three individuals and an organization seeking declaratory and injunctive relief. The suit principally alleges VA relies on faulty records and unjustified "loyalty challenges" to wrongfully deny legitimate claims. If a class were certified and plaintiffs were successful, plaintiffs would likely ask the court to force VA to re-adjudicate all denied FVEC claims under new procedures crafted by the court.

VBA projects that the end of fiscal year 2014 unobligated balance for the Filipino Veterans Equity Compensation Fund will be $45.1 million

b. Does VA have a timeline for when the lawsuits will be resolved? If so, please provide that timeline to the Committee.

Response. *Recinto* has been dismissed by the district court, and the dismissal was affirmed by the United States Court of Appeals for the Ninth Circuit (9th Circuit). *Recinto* v. *U.S. Dep't of Veterans Affairs*, 706 F.3d 1171 (9th Cir. 2012). Plaintiffs have petitioned the United States Supreme Court for Certiorari. The case should be resolved in mid-October, if the Court does not grant the petition.

Relying chiefly on *Recinto*, the district court dismissed *De Fernandez*. Plaintiffs have appealed to the Ninth Circuit. Because the case has not yet been briefed, the appeal is unlikely to be fully resolved in less than a year.

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RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JON TESTER TO HON. ERIC K. SHINSEKI, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 188. The President has requested $7 billion to expand inpatient, residential, and outpatient mental health care for Fiscal Year (FY) 2014, an increase of $469 million from FY 2013. I appreciate steps taken by the Department of Veteran Affairs (VA) to increase its number of mental health professionals. In Montana and other rural states, we have not made much progress.

a. What kinds of strategies is the VA currently using to retain our current mental health workforce, particularly those in rural areas?

b. Do you currently have the tools and flexibility you need to ensure we maintain a high quality VA medical workforce in rural America? Are there any statutory obstacles?

c. Can you speak to any ongoing collaboration with other Federal agencies, such as Health and Human Services or the Indian Health Service, to enhance our efforts? Are there opportunities to build upon these partnerships?

Response to a, b, and c combined: VA has been working closely with outside resources to address any gaps and create a more patient-centric network of care focused on wellness-based outcomes. In response to President Barack Obama's Executive Order 13625, "Improve Access to Mental Health Services for Veterans, Servicemembers, and Military Families," signed on August 31, 2012, VA is working closely with the Department of Health and Human Services (HHS) to establish 15 pilot projects with community-based providers. These providers include community mental health clinics, community health centers, substance abuse treatment facilities, and rural health clinics, to test the effectiveness of community partnerships in helping to meet the mental health needs of Veterans in a timely way. Both the Health Services and Resources Administration (HRSA) and the Substance Abuse Mental Health Administration (SAMHSA) of the HHS provided names of potential community partners. The fifteen pilots have been established across Georgia, Tennessee, Wisconsin, Mississippi, South Dakota, Nebraska, and Iowa.

Pilot projects are varied and may include provisions for inpatient, residential, and outpatient mental health and substance abuse services. Some sites shall include capabilities for tele-mental health, staff sharing, and space utilization arrangements to allow VA providers to provide services directly in communities that are distant from a VA facility. The pilot project sites were established based upon community provider available capacity and wait times, community treatment methodologies available, Veteran acceptance of external care, location of care with respect to the Veteran population, and mental health needs in specific areas.

VA currently collaborates with federally Qualified Health Centers (FQHCs) and community mental health clinics across the country. These community partnerships were developed locally as a means to provide mental health services to Veterans in areas where direct access to VA health care is limited by geography or workload. One of the most robust of the pilot sites is in Montana and serves as a prototype that other facilities may follow. Since 2001, the VA Montana Health Care System has followed a model utilizing community mental health contracted care to address the challenges of a geographically large area and the population dispersion of Montana's Veterans in need of mental health services. Montana has a population of 989,415 (46% reside in rural areas), a land area of 145,546 square miles and has the second-highest Veteran per capita population. Within Montana's 56 counties, part or all of 54 counties are designated mental health care shortage areas. For non-VA community mental health (MH) services, Montana is divided into four regions consisting of a regional mental health center and several satellite offices. Under these VA contracts, Veterans are seen by mental health providers at 45 sites. This allows VAMTHCS to provide mental health services at the local level to Veterans in all 56 counties. In 2011, the number of Veterans treated under the contract was 2,221, increasing to 2,388 in fiscal year (FY) 2012. The choice of contract provider depends on the type of clinical services required. A contract provider may be utilized for one service while a VA provider may be utilized for a different mental health service.

Question 189. Vet Centers are extremely beneficial to Montana Veterans, and it is vital that the number of Vet Centers increase throughout the state. Recent laws have expanded Vet Center eligibility to include a number of individuals still on active duty, as well as their families. While I am supportive of these efforts, I also believe it might be appropriate for the Department of Defense Health Program to fund their share of the caseload. Should the Department of Defense be authorized or directed to help supplement funding for Vet Centers if servicemembers begin making up a substantial portion of the caseload? Dr. Petzel, has this been part of the ongoing discussions with the Department of Defense during the regulatory process?

Response. VA would like to thank the Senator and his staff for their continued interest and support of the Vet Center Program. The Veterans Health Administration appreciates the interest in this issue, and VA has had a discussion regarding this issue with staff from Senator Tester's office in June 2013. The VA's Readjustment Counseling Service (RCS) does have some concerns with a proposal that would ask DOD to reimburse RCS for services to active duty Servicemembers and for that additional funding to be used to expand the Mobile Vet Center (MVC) program. The below bullets outline the concerns:

- Reimbursement of services by DOD to RCS
  − There would be no way to ensure that Servicemember confidentiality remains intact as some form of identifier would have to be used and communicated from RCS to DOD to verify that an individual received services at a Vet Center. Servicemembers and Veterans alike use Vet Centers because they are safe and confidential places where they can remain anonymous. Vet Center staff only break confidentiality when clients allow through a signed release of information or in situations to avert crisis.
  − VHA has already requested yearly increases to RCS's budget, specifically to provide Vet Center services to Active Duty Servicemembers (increase of staff and augmentation of space).
  − RCS is not set up to receive or process any form of third party billing.
- RCS has recently expanded the MVC Program
  − In 2012, RCS expanded the MVC Fleet from 50 to 70 vehicles to ensure increased access to Veterans and Servicemembers who recently returned from Combat Zones or Areas of Hostilities as well as those who are geographically distant from existing Vet Center services. With this new expansion, a MVC is stationed within a 120 minute drive time to all major Active Duty Military Installations whose base population is over 10,000 and Demobilization Sites. Further, MVCs are located within reasonable driving distances to many of the military installations and Reserve and National Guard Armories that are below this population limit.
  − MVCs and staff regularly participate in events where Active Duty Servicemembers are present such as demobilization events or other events on military installations and armories.

VA would welcome the opportunity to discuss the Vet Center Program in further detail with Senator Tester or his staff and appreciate his support of the program.

Question 190. Proportionally, American Indians serve in our Armed Forces in greater numbers than any other ethnic group. The United States has unique responsibilities to them both, as veterans who have proudly served our Nation, and as American Indians who have sacrificed immeasurably. In Montana, providing health care for veterans on reservations is a difficult task. Rural isolation only adds to the challenge. I have advocated for the VA to improve its communication and outreach efforts with the tribes in relation to its funding for Tribal Veterans Representatives or Tribal Veteran Service Centers. Has the VA taken any recent steps to address this issue?

Response. VA's Office of Rural Health provides fiscal assistance to support annual Tribal Veteran Representative training in Montana and other VA networks across the country. These training efforts ensure that every tribal community in Montana has a local point of contact for Veterans services. This serves as a critical point of access to VA services and benefits for Veterans living in some of Montana's most rural areas. The TVR training is also supported by VISN 19. VISN 19 employs tribal outreach workers who support tele-health infrastructure established between the VA at tribal sites located throughout Montana. Most TVRs are paid by tribal funds or serve as volunteers.

VA is also in the process of implementing reimbursement agreements to IHS and tribal health programs for direct care services provided to American Indian and Alaska Native Veterans. It is anticipated that through these agreements, additional partnerships will expand between the VA, IHS and tribal governments that will effectively serve the needs and priorities related to access for Veterans living on tribal lands in Montana.

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RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. DEAN HELLER TO HON. ERIC K. SHINSEKI, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 191. I respectfully request that you provide a breakdown of the funding allocated to each Department of Veterans Affairs Regional Office (VARO) under the Veterans Benefits Administration (VBA). I would like to know the number of full-time employees at each VA Regional Office as well as the number of pending and backlogged claims at each VARO?

Response. The respective funding allocations, the number of FTE, and the number of pending and backlogged claims per RO are broken down on the attached spreadsheet, entitled "Question 192 funding allocation FTE backlog." The FY 2013 funding allocation is pending finalization; however, staffing levels and, consequently, funding levels are expected to remain relatively even with FY 2012. Many ROs administer several benefit programs and activities in addition to compensation (loan guar-

anty, education, fiduciary hubs, national call centers, pre-discharge programs, brokering centers, pension centers, etc.). Therefore any comparisons cannot consider only compensation workload.

Question 192. An integral tool of reducing the VA claims backlog is transitioning to a paperless system—the Veterans Benefits Management System (VBMS). Part of this transition includes the Veterans Claims Intake Program (VCIP), which scans and converts evidence in support of claims into digital information. In the VA's fiscal year 2014 budget request, VCIP is allocated $136.44 million—which the VA budget states is an increase of $119 million over 2013, an addition of 34 full time employees, and includes support contract costs to execute VCIP.

I understand that VBA contracts with the private sector to perform large scale scanning operations of paper claims to feed them electronically to VMBS for electronic claims processing. I also understand that there is an internal scanning operation of medical and personnel records at the Records Management Center (RMC) in St. Louis.

How does your internal scanning production at the RMC in St. Louis compare to the scanning production at the contractors facilities? If there is a difference in productivity, please explain any discrepancy. If there is no difference, why does VBA not keep the scanning work in-house by expanding or replicating the operation performed in-house at the RMC?

I want to ensure that if Congress provides a significant increase in funding to the VCIP that quality and timely production is maximized.

Response. The limited scale scanning operation at the Records Management Center (RMC) provides document conversion services for Service Treatment Records and Military Personnel Files, and is configured differently than operations at the scan vendor sites. The current configuration of desktop scanners was specifically selected for the handling of these materials, and as a result the RMC scans fewer types of evidence, and at a lower page per minute rate than scan vendors. Currently, the RMC's maximum capacity is under 500,000 images per month.

In contrast, the contracted scanning vendors employ dedicated facilities with high-speed and high-volume scanners to process more evidence types, at a much higher page-per-minute rate than the RMC. While this approach requires a significant initial investment, the current estimate for scan operations at these vendors is projected to routinely be in excess of 40 million images per month.

Expansion of RMC to handle such large volume would require significant investment in developing the expertise, skills, and training of the VBA staff for this function, diverting attention from the priority goals of accurate and timely claims processing.

The model used at the RMC is based on a specific type of evidence, with a narrow focus. To apply the approach used by contract scan vendors would require extensive rework of this configuration, and meeting the demand using internal VBA resources would require expansion of this staff and the facilities and systems infrastructure on significant scale. This would require an investment of time and money greater than the use of contractors, with a greater long-term cost to the taxpayer.

In the first 11 months of operations, the contracted scanning vendors have enabled VBA to convert paper claims materials into over 240 million images cumulatively, with an average 5-day turnaround time from date of receipt of paper claims materials to date of upload into VBMS, while maintaining 99 percent accuracy.

Question 193. In Fiscal year 2014, what has the VA budgeted for its teleaudiology program?

Response. In FY 2014, VHA will fund a total of $655,000 in staffing costs for technicians, equipment maintenance service, and warranty costs for the initial 10 Tele-Audiology sites that are providing remote hearing aid fittings and adjustments. VHA will also continue its expansion of TeleAudiology sites to 19 of its 21 Veterans Integrated Service Networks (VISNs) in FY 2014. All costs for audiologists, additional technicians, and telecommunications are covered by the existing VHA budget that is not specific to TeleAudiology.

Question 194. Between FY 2014–2018, what is the VA projected to spend on the teleaudiology initiative?

Response. VA projects to spend $3,629,000 for currently projected budgets between FY 2014–2018 (excluding audiologists, additional technicians at expansion sites, and telecommunications as explained above):

• FY 2014 = $655,000 ($112,000 for VHA National TeleAudiology Lead + $528,000 for existing site technicians +$15,000 for annual maintenance service and warranty for existing sites).

• FY 2015 = $743,500 ($640,000 for staff (see FY 2014 above) + $103,500 for annual maintenance service and warranty for 69 original and expansion sites.

- FY 2016 = $743,500 ($640,000 for staff (see FY 2014 above) + $103,500 for annual maintenance service and warranty for 69 original and expansion sites.
- FY 2017 = $743,500 ($640,000 for staff (see FY 2014 above) + $103,500 for annual maintenance service and warranty for 69 original and expansion sites.
- FY 2018 = $743,500 ($640,000 for staff (see FY 2014 above) + $103,500 for annual maintenance service and warranty for 69 original and expansion sites.

Question 195. In fiscal year 2012, what did the VA spend on veterans' transportation to and from VA clinics for hearing evaluations and hearing aid services?

Response. In FY 2012, the average waiting time for hearing aids was 40.5 days.

Question 196. In fiscal year 2012, what percentage of qualified veterans received two sets of hearing aids?

Response. In FY 2012, 1.3 percent of the 281,893 purchase orders involved two sets of hearing aids. A total of 278,250 Veterans had one purchase order for hearing aids, and 3,643 Veterans had two purchase orders (65 of these Veterans had 3 purchase orders). The majority of orders (89.6 percent) were for binaural hearing aids (one for each ear).

Question 197. In fiscal year 2012, what was the average wait time for a veteran to receive the following items: a hearing evaluation, follow up-service, and a hearing aid?

VHA Response: VHA provides hearing evaluations for new patients and follow-on care for established patients in Audiology clinics identified by clinic stop code 203. VHA tracks waiting times for both new and established patients. In FY 2012 both new and established patient waiting times were measured from the desired date for the appointment to the completed appointment. VHA defines a new patient as one who has not seen a qualified provider in a specific clinic stop code in the past 24 months. An established patient is one who has already been seen at least once by a qualified provider in a particular clinic stop code within the last 24 months. A new patient seeking audiology care will need a hearing evaluation before any treatment can be provided, therefore we assume that a new patient appointment will have involved a hearing evaluation and the associated new patient waiting time will apply. An established patient has already had the initial hearing evaluation in the past 24 months or longer and any appointments now would be considered follow-on care and the associated wait times for established patients would apply.

Chairman SANDERS. General Shinseki, thank you very much.

Let me begin by addressing an issue that is a serious one, that I think every member here has spoken of and you have acknowledged, and one that is of great concern to this country.

Now my understanding is that the VA is now processing more claims today than they ever have before——

Secretary SHINSEKI. That is true.

Chairman SANDERS [continuing]. In significant numbers.

But my understanding is also that according to the most recent Monday morning workload report there were nearly 890,000 claims for entitlement to benefits pending, almost 70 percent of which have been pending longer than the Department's goal of 125 days. And this number does not even take into account other pending work, including award adjustments and appeals.

I believe you established that goal not long after you took your position. You brought forth a very, very ambitious goal, and you said that you wanted to process all claims in 125 days and with a 98 percent accuracy by 2015. Is that correct?

Secretary SHINSEKI. That is correct.

Chairman SANDERS. All right, let me ask you this: what benchmarks have you set and must VA meet to make sure that VA achieves those goals?

In other words, I think all of us would agree that the task that you have undertaken, going from an unbelievable amount of paper, a system that was virtually all paper when you took office, to a paperless system is just a huge transformation.

The concern here—and others have raised it—is, what reason do we have to believe that you are, in fact, going to be able to successfully undertake that transformation and meet the goals, ambitious goals that you have established?

Secretary SHINSEKI. Well, thank you for that question, Mr. Chairman. I am going to call on Secretary Hickey to add some detail, but let me just describe what situation existed when we arrived.

We were in paper and have been in paper for decades. We continue to get paper today.

If you are going to manage a situation, it takes a certain kind of approach and resourcing. We thought that for the long term the benefit to veterans was to end the backlog, and so we set the goal of ending the backlog in 2015.

We did some rough calculations, and the backlog when we arrived was not defined as 125 days, 98 percent accuracy. If we want to make a bold move here and help veterans, then we have to move quickly. And so we set ambitious goals, we did our best estimates, and we have laid out a plan in this budget that is resourced, that drives those numbers toward ending the backlog in 2015.

I think all of you will remember after we established that goal of ending the backlog we also took on some unfinished business.

We had Vietnam veterans—my first year here as I moved around—who were not very happy with the fact that they had not had their issues addressed. In many cases, I was told that we were just waiting for them to pass so we would not have to take care of that. I cannot think of a more demeaning circumstance—for a veteran to feel that that is what their VA, who exists for them, looked upon the situation.

I heard the same kinds of things from Gulf War veterans—20 years after the Gulf War, no decisions regarding their health care issues.

Then, as I think all of us can acknowledge, PTSD has been around as long as combat and had never been acknowledged as associated with combat—verifiable PTSD.

So, even as we established ourselves at ending the backlog, we took on three pretty significant decisions—for the Vietnam generation, three new diseases for exposure to Agent Orange' nine new diseases never recognized before for Gulf War veterans; and then for all combat veterans with verifiable PTSD, access, a service connection so that they could submit their claims.

I would say that those numbers, added to the paper process that we had, in fact, were going to grow the inventory and complicate the backlog, and we testified to that when those decisions were made. There were a number of hearings on this.

And my prediction was we are going to go up, but at the same time we are going to put in place an automation system that would correct all of that, and in time we would bring the backlog back down.

Well, we are in mid-stride here. We are now fielding that automation tool. It took us 2 years to develop it. It is called VBMS— Veterans Benefits Management System. It is in 30 of the 56 regional offices. We are seeing some indications that it is having good

success, and we intend to field the remaining offices as quickly as possible.

We have some good learning that came out of automating the new 9/11 GI Bill process, and out of that, the learning indicated to us was that there is a tremendous lift that comes once you have the system fielded. We followed that model of fielding, incrementally, an IT program that is robust enough to handle our claims processing.

As I say, we are scheduled to complete this year, 31 December. We are pulling that as far to the left as we can and fielding as quickly as we can and doing it prudently, where we do not run the risk of overreach.

Chairman SANDERS. General Hickey, did you want to add anything to that?

Ms. HICKEY. I would just like to add to the discussion that the Secretary has said. I know that we are asked routinely about our milestone. So I wanted to give you just a few bits and pieces of the milestones that we have experienced in the education claims process that is literally being built by the same people building VBMS.

We have tripled—tripled—our productivity through the spring season as a result of the automated rules engines that went into the long-term solution, our paperless IT system, last fall the 24th of September. We went from doing 79,000 claims a month to doing more than 285,000 claims a month. Reducing the days it took to do those claims down to 4.5 days on average is where we are right now today in the body and the bulk of our 9/11 GI Bill claims.

We are applying the exact same strategy to the rules-based capability going into VBMS where, quite literally, the veteran will go online, which exists today on e-benefits, file their claim like they do their taxes—apropos to say that today. It goes directly into VBMS.

Without even advertising it—we completed that whole piece here this year in January. Without even advertising it, we have 500 claims a week going into that system. And it goes directly into VBMS, never turns into paper, and allows us to immediately start working them.

Today, we do not have 3 percent in paper anymore. We have 3 percent electronic. We have 14 percent of our paper that has already been converted to electrons just since January the 28th. I have more than 116,000 electronic claims now, electronic folders, that we did not have before January of this year.

So we are well moving along in this process, and in fact, this week I will have another six regional offices on the new IT system.

Chairman SANDERS. OK. Thank you very much.

Senator Burr.

Senator BURR. Mr. Secretary, the VA backlog reduction plan shows that in order to eliminate the backlog by 2015 VA will need to decide 1.2 million claims this year, 1.6 million claims next year, and 1.9 million claims in 2015. But, VA is projecting in the budget submission that it will decide 335,000 fewer claims in 2013 and 2014.

So, can the VA reach 2 million claims in 2015? That would be a 92 percent increase in productivity over the 2012 level.

Ms. HICKEY. So, Senator Burr, I am sorry. I do not exactly know your numbers, but I am happy to take your numbers and go look at them and come back to you and sit down and visit with you.

I can tell you——

Senator BURR. Well, I would be happy to. I am pulling them right out of the backlog reduction plan which was submitted in January. I got it January 25 in my office.

The math would work out. To eliminate the backlog by 2015, VA would need to decide 1.2 million claims this year, 1.6 million claims next year, and 1.9 million claims in 2015.

Now, in the projections under the budget submission from the President, that says that over the next 2 years you will decide 335,000 less claims than what the backlog reduction plan said.

I am trying to figure out if 2015 is—if you are certain on that. Then that means that you have to process over 2 million claims in 2015. Is that how your math looks at it?

Ms. HICKEY. Senator Burr, I would love to come, sit down and talk to you about that. Those numbers are a little different to me than the numbers we sent across and then have followed up on in questions to your staff. So I am happy to do that with you.

Senator BURR. Well, in the budget submission, you do say that you will decide 335,000 fewer claims in 2013 and 2014, right?

Ms. HICKEY. Senator, the budget submission is slightly different than the plan that you received in January that was based on some assumptions made last fall, and there have been some differences in what we have seen in terms of the actuals that have been submitted to us. We have seen a significant drop in—not significant. That is not a good word. We have seen a drop in the number of claims that have been submitted to us of late.

So we have adjusted the budget based on those issues.

Senator BURR. OK. Currently, nearly 70 percent of the claims are backlogged, meaning that they have been waiting for a decision for more than 125 days.

The strategic plan you submitted less than 3 months ago projected that the backlog would be reduced to 68 percent in 2013 and 57 percent in 2014, but according to the budget submission you now expect no more than 40 percent of the claims to be backlogged during either of these 2 years.

So, in revising these projections, what metrics did you look at, and what did they show you?

Ms. HICKEY. Senator, I looked at the actual submissions of receipts of claims that we have received from our veterans over the last 5 months, and each month they have been lower than our expected volume.

Senator BURR. So the math works out to where you would have only a 40 percent backlog situation in 5 months?

Ms. HICKEY. No, Senator, it does not. And I do not think that— you all would throw me out of here if I said that that would happen. That is not where we are.

We are at about 69 percent of our claims right now that are older than 125 days, and we are working every single day to drive that number south. We are doing it by a focus on our people, process and technology solutions and, as far as we can, pushing up our productivity by our folks.

I can tell you today that my raters are 17 percent more effective and at a higher productivity than they were prior to us moving into this new transformation plan.

Senator BURR. But, General Hickey, last year you testified—or, excuse me, the Secretary testified that during 2013 the backlog would be reduced from 60 percent to 40 percent and that would "demonstrate that we are on the right path."

At the time, did you envision that the backlog would stay above 65 percent for the first half of the fiscal year or that it would be 70 percent in April?

Ms. HICKEY. Senator, we do have some APG guidance, our annual planning guidance, that we communicate with to our Federal Government partners, and they are usually aspirational in nature.

When we see a change or a difference, as the Secretary has pointed out, in terms of the workload that we saw increase due to Agent Orange, *Nehmer*, the increased claims associated with PTSD and the like, we did note that we would probably not be able to meet that 40 percent APG guidance. But the thought was you leave your stretch goal out there so that you keep trying to work hard to get to it, and that is what we have done.

Senator BURR. Here would be a simple question: is the strategic plan that you sent to Congress aspirational?

Ms. HICKEY. So, Senator Burr, I grew up as a strategic planner in the military for quite a while, and I know that every strategic plan I built over the years for the U.S. Air Force always was a plan. And plans are always in contact. You know, they change and they adjust for reality and actuals.

So we have and will continue to improve upon that plan and continue to adjust.

Senator BURR. But when you developed that plan was it developed to be aspirational, or was it developed to give us an accurate blueprint of how VA perceived the timeline would move on disability backlogs?

Secretary SHINSEKI. Senator, I think in all planning there is an aspect of aspiration at the beginning, and then it is—with assumptions and the availability of resources—it is adjusted for what we think is achievable.

In a long-term plan like this one, with as much dynamics involved, we make an assumption, for example, that the flow of veterans out of uniform to the VA is going to follow a pattern that we have been provided by the Department of Defense. If that changes, that adjustment, then we will have to look and see whether we can accommodate that change, and if not, then we will have to say we have a requirement for resourcing.

Senator BURR. Mr. Secretary, thank you very much.

And, Ms. Hickey, I look forward to sitting down with you to look at the matrix that brought about such a change in only 3 months.

And let me just say, Mr. Secretary, that I was not really addressing the increased number of claims that come in the door. I was addressing the number of claims that are actually processed and determined.

Secretary SHINSEKI. Yes.

Senator BURR. And that does not seem to be getting better.

I thank the Chair.

Chairman SANDERS. Thank you, Senator Burr.

Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

General, I am going to try to ask you two questions in too short a period of time.

It is homelessness on the one hand, suicides on the other. How do you pick the tragedy—the worst tragedy?

There are up to 22 suicides a day—so let me just concentrate on that for a second.

You are making an enormous move in mental health. You are bringing in not only the mental health experts but also the support staff that they need to have. It will take time to get them into the system and trained.

But how do you look at the general population—starting with PTSD and then, obviously, as it gets into mental health things clarify themselves—and raise red flags?

How do you take somebody who is on a suicide watch list or something of that sort? How do you go to work on that person? How do you try to break through?

Secretary SHINSEKI. Senator, the issue here is no one should have to wait for mental health care. And we have resourced our Veterans Health Administration by nearly 57 percent, an increase from 2009 to the 2014 budget. We believe this is where we have to put our emphasis.

Regarding the suicide number you cited—22—you know, 4 years ago we were not receiving suicide information, veterans' suicide information, from the States. So we wrote, and the States have been very responsive. Now we have that information flowing into the CDC of which we have this latest number—22.

Four years ago, we did an estimate by the best way we could, from our mental health experts, and they pegged the number at about 18. So, while this looks like a growth in the last 4 years, it is really a better number based on data we have received. Eighteen was a fair call, but we have better information with 22, and we can set about doing things that we could only speculate on 4 years ago.

So an increase in the mental health budget allows us now to do things like increase staffing where we find that we need additional resources.

Dr. Petzel will provide an update on where we are with regard to hiring additional mental health, and then I will come back and close out on suicides.

Senator ROCKEFELLER. Before he does that, can I ask my second question?

Secretary SHINSEKI. Certainly. Absolutely.

Senator ROCKEFELLER. I remember a number of years ago the excitement that was felt generally when DOD and the Veterans Administration were planning to work together. I went to a number of common facilities, joint facilities, and everyone was full of optimism.

Now all of a sudden, evidently, unless I am wrong, there has been a pullback from that. The electronic records and all kinds of benefits flow from this cooperation. There has been a pullback from DOD. I am curious about that.

Secretary SHINSEKI. We are both still committed to a seamless transition of servicemembers into VA. That has not changed.

We are both also committed to an electronic health record that we share in common. And in the language that we have come to use over the past 4 years of growing the concept, it is a single, joint, common, integrated, electronic health record, open in architecture, nonproprietary in design.

All of those terms are code to keep us focused on what we want in an electronic health record—one that we share together and one that will be as good 5 years from now as it is on the day we first invest and purchase it as opposed to being faced over and over with an aging electronic health record that we somehow have to refinance years down the road.

So this is the concept that we have committed ourselves to.

I would say that my sense is we have not backed away from that although Secretary Hagel, who has just arrived, is in the midst of getting into this issue. I have agreed that he ought to have time to do that.

Senator ROCKEFELLER. But you do not know of any backaway.

Secretary SHINSEKI. I am not aware of any backing away.

Senator ROCKEFELLER. I am happy to hear that.

Thank you, Mr. Chairman.

And I apologize for doing that to you—asking two questions.

Secretary SHINSEKI. Should we answer the first one?

Senator ROCKEFELLER. No, because my time has run out. You know, I have got to play by the rules.

Chairman SANDERS. Senator Johanns.

Senator JOHANNS. Thank you, Mr. Chairman.

Mr. Secretary, in the fiscal year 2014 budget request, I note that there is funding for one—just one, across the entire country—major medical facility. That is about $150 million for a mental health facility in Seattle.

I am not questioning at all whether that is needed or not, but in contrast, the minor construction request is for $715 million, substantially more. That is an increase of 17.8 percent from the 2013 level.

Does the VA have an estimate of the amount of minor construction funding that is needed to keep aging facilities patched together until they finally make their way up the priority list, which, if we are only doing one a year, that is going to be a long, long wait?

But how much of that money then is actually going into trying to keep aging facilities operating? Is it all that money?

Secretary SHINSEKI. Well, Senator, let me answer the broad question of our construction budget. It includes $2.39 billion for major, minor construction which you have asked about, non-recurring maintenance which has a lot to do with facility condition, and major medical leases.

Minor construction, as you indicated, has increased by 17 percent compared to 2013. This is important to us because this is money that gets into the hands of hospital erectors very quickly and impacts more facilities for the kinds of things you are concerned about and services directly to veterans.

The major medical leases. Our request there is an increase of 12 percent compared to 2013. And, here, those leases are intended to

provide health care delivery closer to where veterans live, and that is all this business of community-based outpatient clinics and so forth.

Major construction. The request is for $342 million, and as you indicated, there is one major project here on the list. But it is a stable program, and we have a plan for in-phase funding the execution of a number of large projects.

Non-recurring maintenance, $709.8 million, again remains stable in comparison to 2013. And, here, we are dealing with safety, facility condition deficiencies and other high priority needs to make sure that the facilities we do have are safe, secure and accessible to veterans.

This is a balance across our programs. And I would just offer that it is a stable overall program with emphasis on minor, major leases, or medical leases, and assuring that the non-recurring maintenance is maintained at a stable level as well.

Senator JOHANNS. You can kind of see where I am headed. My concern is that you have got a whole host of old buildings out there. It certainly would not be what you would want if you were going to build a facility today, obviously, because they are probably 50, 60, 70 years old. And I am worried that we are putting money into these old facilities, which to me seems almost like a waste.

Has the VA studied any possibility of trying to jumpstart this program, to try to get more new construction versus putting money into old buildings, or are we just stuck where we are at?

Secretary SHINSEKI. I do not describe us as being stuck. I mean, if there was another dollar to be had, there is a place I could put it in construction, but as I say, it is stable approach to a large footprint.

Part of our responsibility is to decide what part of that footprint we no longer need. In the last several years we have reduced the amount of vacant space, and consolidated and reduced the amount of underutilized space; in both categories, some 25 or 26 percent reduction. So we do that as well.

There are other pieces of our property that we can dispose of, and we do through either demolition or look for other means to find other uses for what we no longer need.

We used to have an enhanced use lease authorization that expired in December 2011, and our efforts to have that authorization renewed and extended have succeeded in providing for an enhanced use lease arrangement for homeless requirements only. So we do have that.

And, right now, we have a number of projects where we have created homeless housing for veterans. We have others that are in design, and other work is underway—about 5,500 units in all.

So we do manage those older pieces of property. We have need for some of it, not all of it, and we need a way to efficiently dispose of it.

Senator JOHANNS. Thank you, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Johanns.

Senator Tester.

Senator TESTER. Yes, thank you, Mr. Chairman.

I have got more questions than we have got time, but we will start with the Caregivers Bill of 2010. In that bill was a provision

to establish a rural veterans' coordination pilot so that OIF and OEF veterans could get care from community-based providers for mental health in cases where the VA did not have capacity. The provision gave the VA clear authority to contract out mental health services for OIF and OEF veterans in rural areas where mental health providers are at a premium.

Can you give me any progress on this?

Why I say that is because Montana has four community mental health centers serving the West, the South, Central, the East, and the North, too. None of those are contracted with.

Just wondering, where are we as far as progress goes on this?

Secretary SHINSEKI. Dr. Petzel.

Dr. PETZEL. Thank you, Senator Tester.

Thank you, Mr. Secretary.

The event of the bill has really been overtaken by the executive order from the President. We are in the process now of developing 15 contract pilots across the country with federally qualified, community-based clinics to pilot the concepts of the contract. If this is successful—and we are quite confident it is going to be—we are going to be doing this across the country.

I was not aware that—you enlightened me. I was not aware of the fact that the Montana clinics were not contract pilots.

Senator TESTER. Well, you can correct me if I am wrong, but I do not believe that they are.

Dr. PETZEL. I will check.

Senator TESTER. They are not contracted with the VA.

Now the question is, OK, so these 15 pilots which the executive order enhanced in 2010, where are they at? Are they up and running? Is the pilot running so you are going to assess them, and if they are not, when will they be?

Dr. PETZEL. Virtually all of them are delivering care.

Senator TESTER. OK.

Dr. PETZEL. A number of them are doing it by contract. Some others had difficulties getting the contracts executed immediately, so they are doing it on a fee basis. But the contracts are in process, and we expect that within a month or two everybody will be operating on a contract.

Senator TESTER. OK. And when would you anticipate an assessment of their effectiveness will be done?

Dr. PETZEL. I would hope that we could do that late summer.

Senator TESTER. Super.

I want to talk a little bit about health care providers in general, mental health care providers specifically, and this can still go to you, Dr. Petzel, if appropriate; if not, you, Mr. Secretary.

We have issues. It goes along with the partnerships, but we have issues with folks—mental health care professionals and health care professionals in general—being staffed up to snuff. We have had conversations off the grid with you on that.

What kind of strategies are the VA using to retain the current mental health workforce, particularly in rural areas, and if it applies to regular health care folks, could you address them both?

Dr. PETZEL. Thank you, Senator Tester.

The VA has got really very flexible possibilities when it comes to hiring and retaining people. First of all, for clinical psychologists,

psychiatric social workers, nurse practitioners in mental health, and psychiatrists, we have great flexibility in terms of the salary. Our salaries are very competitive almost anywhere around the country.

Senator TESTER. Who has that flexibility? Is that locally with the State VA or is that with the VISN or is that with you?

Dr. PETZEL. The flexibility lies with the individual facilities.

Senator TESTER. OK.

Dr. PETZEL. There are certain circumstances where they would have to come in, but it is unusual. They have great ranges of salaries that they can work with.

Senator TESTER. Do you need any other tools for recruitment?

Dr. PETZEL. I think that the thing that limits us a little bit is the fact that our debt forgiveness stops at $60,000. Particularly for medical students and residents, that may be a drop in the bucket, so to speak. I would like to see if we can raise the limit on which we can forgive debt.

Senator TESTER. I would love to have a recommendation since you are in the business. I do not have any idea what a nurse practitioner with a mental health background would come out of college with as far as debt, but I would love to get some recommendations from you on where that $60,000 cap ought to be.

Dr. PETZEL. We will talk.

Senator TESTER. OK. The other I wanted——

Secretary SHINSEKI. Senator, I would just——

Senator TESTER. Yes, go ahead.

Secretary SHINSEKI. Senator, I would just like to put a fine point on the last statement. Sixty thousand dollars is $60,000. It is not a drop in the bucket, but increasing it would give us flexibility we do not have today.

Senator TESTER. I understand, General. And you are right, $60,000 is a lot of dough, but some of these folks are coming out college with maybe $200,000 of debt. I do not know how much. I just do not.

So it would be good to—we will do some research on that end, too, so it is not all on your shoulders.

The last thing that I have—well, I have got more but real quickly, if you might, and I am not going to play by the rules.

What kind of impact does this have—I am talking about flexibility on salary. What kind of effect does that have on existing staff?

I do not want to be the devil's advocate here, but if you have got somebody on staff that is making—I will just pick a figure—$75,000 a year and you offer somebody new in $100,000, what kind of impact does that have on morale, and is it something you are cognizant of?

Is there some way you can address existing staff that are doing a hell of a good job and that are already there? We do not want to take those folks for granted.

Dr. PETZEL. The short answers to both questions is yes and yes. We are cognizant of the fact that, particularly with psychiatrists, that that could be a problem; and we have ways that we can address that with existing staff.

Senator TESTER. Super. Thank you very much.

Chairman SANDERS. Thank you, Senator Tester.

Senator Isakson.

Senator ISAKSON. Thank you, Mr. Chairman.

Secretary Shinseki, I want to follow up just a second on what Senator Johanns was talking about on leases. In the President's budget, in the construction account, there is $6.4 million for the relocation of a CBOC in Cobb County—it is an old facility of 7,900 square feet in Austell—to a newer facility in the northeastern part of that area. That is a huge area of metropolitan Atlanta that serves a lot of veterans that many times are forced to go to the veterans' hospital in Decatur, GA, which puts more pressure on that facility.

I just wanted to say thank you to the President and to you because I know your request had to have something to do with that.

I hope that is a two-for. One, it is a better facility for the veterans, but two, I think it is a lot more efficient on cost than anything else we could do, especially with the current facility. So, thank you very much.

Second, Under Secretary Hickey, I notice you had a Washington moment last week when the *Washington Examiner* got a hold of one of your emails, which I read. First of all, having had my emails gotten into before, I know how it feels when somebody does that. But they commented on an email you had sent to someone—doesn't matter who it was—talking about assembling a bunch of big brains quickly to deal with the problem of timing in terms of claims approval.

It was dated, I think, March 30, which was a couple weeks after the hearing we had here on claims, where you had indicated we were kind of on track on claims. Then this email goes out, looking for the best brains you can get to come in and help since you have got a real crisis.

Can you kind of clarify that for me?

Ms. HICKEY. Thank you, Senator Isakson.

Secretary SHINSEKI. Senator, can I just start and let Secretary Hickey finish up?

Senator ISAKSON. You are the boss.

Secretary SHINSEKI. I would just say from the perspective of innovation, this has been something we have been doing for 3 years—going out and getting the best minds to come in and help us, inside VA, outside VA, casting a broad net. In that first year we got 40 initiatives which we have taken aboard. Not all of them work, but we investigated all of them. The next year we did the same thing.

So, I would just say this sort of fits our always looking for a better way to do what we are doing to address the needs of veterans, get it to them as fast as we can. I think Secretary Hickey was a part of that.

And I would say in 2015, when we hit the target we have set for ourselves, we will still be looking for good ideas.

So, with that, Secretary Hickey.

Ms. HICKEY. Senator Isakson, the Secretary said it very well. We keep doing process improvement. In fact, it is now part of the culture and the governance in VBA. We actually have people whose job it is to create process improvement.

So this was nothing more than let's keep thinking about this. Let's keep getting more and more ideas on the table, and let's keep charging hard with the plan we believe is going to get us there.

But we were not even just looking at compensation claims. We were looking at our whole—I have six other business lines. We were looking at everything we do and how we can do more and better to increasingly serve our veterans, their family members, and their survivors. It was a course of action to keep going.

Probably if you saw every other email in my box, you will see we have got an urgency in VBA, no matter what we are doing right now, to just do a much better job by our veterans, their family members, and their survivors.

Senator ISAKSON. What you said was what I hoped the answer was to the question. Now I pose this to you—and I am speaking for myself now, though the Chairman and Ranking Member may disagree. We do not necessarily fall in the big brain category, I do not think, but I will speak for myself on that point.

But, you know, it might be helpful to us, to call out to us to come down to see what your problems are, to look at them firsthand, just to get our eyes on them because sometimes we will ask questions about why something is taking so long to do or something is not happening, and you will give us the very best answer, I am sure, that you can give us at the time, and then the next meeting comes up, and we have the same tiny, little waltz.

It just occurred to me when I read that email that it would be great to invite us down and say, "Look, this is where we are having trouble; have you guys got any ideas?" Because rather than us always being the critics in the peanut gallery, we can get down on the ground floor with you and see what those things really are.

I think outreach is important, and I think it ought to be inclusive of all those who have a stake in the game. That was my reason for asking the question.

Secretary SHINSEKI. Thanks, Senator. Great offer on your part, and we are happy to take you up on it.

Senator ISAKSON. One last thing; a question for me. The Veterans Benefits Management System request is for $155 million in this year's budget. Is that right?

Secretary SHINSEKI. That is correct.

Senator ISAKSON. And I think $32.8 million is for development of the system. What would the other $122 million be used for? Personal services or personnel or payroll or what?

Mr. WARREN. Thank you, Senator, for that question.

The balance is to pay for sustainment costs. So the systems that we have been bringing online for the past 2 years—you have to pay the bills, to pay the licensing on it, as well as the operations cost to continue the program going forward.

Senator ISAKSON. When you say licensing, I guess you are talking about a site license for the use of the software.

Mr. WARREN. It would be the software license, the hardware maintenance, and system maintenance as well.

Senator ISAKSON. And that is an ongoing cost, correct?

Mr. WARREN. Yes, it is, sir.

Senator ISAKSON. OK. I just wanted to be sure.

Thank you, Mr. Secretary.

Chairman SANDERS. Thank you, Senator Isakson.

Senator Begich.

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

Again, Secretary Shinseki, thank you very much for being here.

I know you have said it in your prepared comments and so forth, but let me just ask you to restate it. In regards to the disability claims, restate your goal on when you think you will have as much as you feel comfortable to have under control in the sense of the backlog.

I know you have a target. Can you restate that for me, and then tell us what is your confidence level in that? That's what I guess I want to ask you.

Secretary SHINSEKI. Well, there are assumptions——

Senator BEGICH. It is a tricky question because whatever you say I am going to keep track of it.

Secretary SHINSEKI. Well, I would like to provide a more specific answer to you, Senator, but again, this is based on our experience with the Post-9/11 GI Bill which, as you know, we started building in 2009. And by the spring of 2010 we had Version 1, and we have been building on it ever since. And Secretary Hickey described sort of this lift when it all kicked in.

We are still in the process of fielding VBMS. We are 30 and soon to be 36 out of 56. So we are moving as fast as we can.

We started in September in last year. We are barely 6 months into it, and we are looking at a fielding much earlier than December this year, which is the plan. I think once we are fielded, fully fielded, we are going to begin to see production impacts.

We are also tied with DOD providing us electrons beginning in January 2014.

Senator BEGICH. If I can interrupt you on that, how much faith do you have that DOD will actually perform what you need them to do—because I know that has been a struggle in the past. So do you believe they will meet the goals that you have for the information flow so it becomes more seamless and electronic, that DOD will do actually what they say?

Secretary SHINSEKI. They have committed to date and time specific. We have the date and time here.

Senator BEGICH. Let me here that.

Ms. HICKEY. They have committed to give me immediately, point forward, full——

Senator BEGICH. So all new that are leaving from now forward, they are going to complete electronically.

Ms. HICKEY. They are going to first give it to me in paper, which I would rather not have——

Senator BEGICH. Right.

Ms. HICKEY [continuing]. But they are committed to building a system called HAIMS, the Health Artifact Information Management System.

They are right now, today, giving me something we have never had in VBA before, which is they are going through and finding their medical records, going out and reaching out to TRICARE and pulling those medical records in, and they are pulling in their contract medical records. And they are doing the business on their end of pulling all that together, certifying it is 100 percent complete

and handing me, for the first time ever, a fully complete medical record.

Senator BEGICH. So that will be a complete written record. Then when will they go to electronic?

Ms. HICKEY. In December of this year.

Senator BEGICH. Of this year? And that is of cases from that date forward? Then you have the backlog which is the longer challenge. Am I reading that right?

Secretary SHINSEKI. That is correct.

Senator BEGICH. OK. So now DOD is doing all the combining of the work, which is important because you have Guard and other folks all kind of in this mix now. That will come to you immediately. In December, the electronic efforts of anyone who then leaves after December 31 will be coming to you electronically. And then they will commit to move those others in which way?

How will all the backlog information——

Ms. HICKEY. Essentially, the backlog information, I am handling by——

Senator BEGICH. It is all piled on you now.

Ms. HICKEY [continuing]. Turning it to a scanning environment.

Senator BEGICH. Your target for getting that moved into full implementation of electronic will be?

Ms. HICKEY. I am doing it right now. I have 116,000 that are already in an electronic folder right now, today, since January 28 of this year.

I am also committed to any new claim that comes in the door gets immediately scanned by one of our two vendors—they are doing a very good job—turned into an electronic claim and worked through the VBMS electronically.

If you are a veteran who is not going to come back to us, then I will not expend the resources to turn you into an electronic claim.

Senator BEGICH. Can I try to ask two more quick things?

First off, I know you have your patient-centered care program. You have budgeted 250-some million dollars for that investment, which we think is great. It is part of the implementation of your Patient Aligned Care Teams—PAC Teams.

I know your PAC Teams went up to Alaska and looked at a system that we use, called NUCA, which is our native tribal system, which is very similar to what that hopefully will do. Can you tell me about a connection—if there are resources in there to try to utilize the NUCA model within the VA?

I do not know who would like to answer that.

Secretary SHINSEKI. Dr. Petzel.

Dr. PETZEL. Thank you, Mr. Secretary.

Senator Begich, we are very much enamored of the NUCA model. It is very similar to what we want to do in terms of patient-centered care, proactive, personalized health care, but it is doing some things that we, frankly, had not thought about. We have sent four teams up there so far, for educational experience with them, and we plan on continuing that effort.

I am going to be meeting with Kathleen Gottlieb——

Senator BEGICH. Excellent.

Dr. PETZEL [continuing]. The CEO of NUCA.

Senator BEGICH. You see a value in that program?

Dr. PETZEL. Absolutely. We can learn from them.

Senator BEGICH. OK. The last question is, you had $52 million, I think, in your budget for reimbursement to Indian Health Services for some of the new programs which you are doing now on reservations as well as within the Alaska rural component. Is that enough, or do you have a sense on that at this point?

Again, I want to thank you for reaching out for first people in this country, especially Alaska Native and American Indians, and trying to do something very different with health care systems that exist already.

Is that enough reimbursement or is it hard to say? Give me a sense.

Secretary SHINSEKI. I think at this moment we are just standing up the agreements and beginning to activate them. I think that is a good start point.

Let me ask Dr. Petzel and see if he has any more details.

Dr. PETZEL. No more details, but I would agree with the Secretary. We think that this is enough. There are 10 pilots that are being developed to get the business rules fixed for this environment, and we think that this $52 million will be sufficient in 2014, yes.

Senator BEGICH. Very good. I will end there. I have some other questions for the record.

Mr. Chairman, that last question I asked was something that I know you and I have talked about—of how to maximize this delivery to veterans in very tough locations, rural locations. So we will see more on that.

I really do thank VA for that effort.

Chairman SANDERS. Senator Blumenthal.

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

Senator BLUMENTHAL. Thank you, Mr. Chairman, and I apologize for being late, but I have been following some of the testimony.

I want to thank you all for your service and, Mr. Secretary, particularly for your active duty service to our Nation and now in the Department of Veterans Affairs; and I thank the President for increasing the resources available to our veterans in a very difficult time, fiscally.

Let me begin with Senator Begich's area of inquiry relating to the electronic health records. I understood that you described what was going to happen, Ms. Hickey, but I am not sure that I heard what the target date was. Senator Begich asked for a target date for completing the program.

Secretary SHINSEKI. We are talking about claims here? Completing the claims?

Senator BLUMENTHAL. The electronic medical records system.

Ms. HICKEY. I think we are talking two different issues. There is the electronic health record, and there is this other effort I am doing with the fully complete certified——

Senator BLUMENTHAL. Well, maybe you are not the right one to ask.

The electronic health record system——

Secretary SHINSEKI. Yes.

Senator BLUMENTHAL [continuing]. Is still going forward?

Secretary SHINSEKI. As far as VA is concerned, we are committed to it, and we await the Department of Defense's signaling to us that we have agreement here, but I believe we are on track. Secretary Hagel has asked for the opportunity to get into and review his structure and process, and that is what he is doing right now.

Senator BLUMENTHAL. So you have no assurance right now from the Department of Defense as to when or whether it will go forward?

Secretary SHINSEKI. I do not have when, other than both secretaries are pushing very hard on this.

Senator BLUMENTHAL. Both you and Secretary Hagel have indicated that you are agreed to go forward but no other details?

Secretary SHINSEKI. For VA, it is we have chosen VistA as our core. We are committed to a 2014 initial operating capability of this integrated electronic health record in two locations that we have specified and then to follow on, full operating capability in 2017. That's the plan, and that is what both departments have agreed to.

Senator BLUMENTHAL. So the departments have agreed to that plan and have both committed to VistA?

Secretary SHINSEKI. DOD is looking and reviewing what their decision on a core is going to be. We have selected VistA and offered VistA for their consideration, so Secretary Hagel and his acquisition folks at DOD are reviewing VistA at this time.

Senator BLUMENTHAL. Forgive me for revealing my limited IT knowledge, but how would the system work if you are committed to VistA and they are not; in other words, if they go to a different system?

Secretary SHINSEKI. Well, we today have two different electronic records, health records. What we have committed to is solving that problem, that challenge, by coming up with a single, joint, common, integrated, electronic health record. And all of those terms are code words to get us on the same sheet of music.

Senator BLUMENTHAL. I apologize again for belaboring a point that may be obvious to everyone else in the room, but it strikes me from what you are saying that the details have not yet been resolved. Is that fair to say?

Secretary SHINSEKI. We await a decision by DOD on their selection of a core.

We have offered consideration of VistA, which is government-owned, government-operated. We have also put VistA into the open architecture, so anyone else can use the code that goes with VistA and will not have to pay for it.

Senator BLUMENTHAL. Thank you.

To shift subjects here, unemployment among veterans is one of my major and paramount concerns. I wonder if you could tell us about new initiatives that you are contemplating to address unemployment among veterans.

Secretary SHINSEKI. Yes. Well, Senator, we have taken the leadership of the White House in this as well. Joining forces has been a magnificent initiative—reaching out to the private sector for corporations to commit to hiring veterans as a part of their campaign to help us reduce the unemployment numbers for veterans, especially our youngest veterans. The request of the private sector was

100,000 new jobs for veterans or military spouses before the end of 2013. That goal was exceeded in late 2012, as I understand, and there are more commitments now to increase to something in the neighborhood of 250,000. So the commitment is there.

I would also say that across government, we in the departments, we hire veterans. We have hired—we have over 100,000 veterans as part of our workforce, fully 30 percent, and our goal is 40 percent.

We have also held hiring fairs for veterans interested in employment. We have held three of them. It is not something we have expertise in, but we have learned with each of these how to bring together veterans looking for work and the employers with the jobs.

We also encourage veterans who own small businesses to stand up. Our experience is a veteran business owner is more willing to hire veterans. So, the more successful small business owners we have, which is where the hiring really goes on, the more churn we have in the job market.

Senator BLUMENTHAL. And are there additional resources in your project for those types of efforts?

Secretary SHINSEKI. We have resourced at least our hiring fairs, and as part of our hiring campaign for veterans, we continue to increase that within our allocations—budget and FTE allocations.

Senator BLUMENTHAL. Thank you.

And if I could get from you at some point—I do not know that you have them here today—the latest numbers on employment among veterans in different age groups and so forth, any of the demographics that you have, I would appreciate it.

Secretary SHINSEKI. We can do that.

Senator BLUMENTHAL. Thank you.

Secretary SHINSEKI. The numbers are generally improving. We have month-to-month variations, but over time the unemployment rate for veterans overall has been below the national average for unemployment.

For younger veterans, this is still a challenge for us, and we have to do more. All of us have to do more to take this on.

Senator BLUMENTHAL. Thank you.

Thank you all—all the members of the panel—for your service to our country and thank you for your testimony.

Chairman SANDERS. Senator Moran.

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

Senator MORAN. Mr. Chairman, thank you.

Mr. Secretary, thank you very much.

To follow on what Senator Blumenthal was talking about—jobs for veterans—one of the aspects that we have focused on is entrepreneurship and startup businesses. In this Committee on Thursday, we will have a roundtable discussion in regard to the VA, to veterans' opportunities to support entrepreneurship and startup businesses as a method of earning a living and providing for families.

So I appreciate that that is occurring, Mr. Chairman. Thank you very much.

Mr. Secretary, when we last visited, which I think was in January, I, as usual, highlighted the shortage of professional health care providers within the VA system, especially at least what I am most familiar with is in Kansas. We talked about CBOCs.

Kansas is a very rural State—long distances to travel to the VA hospital. We have been successful with the VA's help in opening CBOCs, but we have a tremendous shortage of physicians, nurse practitioners, and physician assistants. And most of our CBOCs no longer have a physician.

And my understanding is that has not changed since we visited in January. So I want to highlight that problem once again.

I also raise the topic of mental health professionals. The VA's plan in April was to hire 1,600 new clinical mental health staff, including marriage and family therapists and licensed professional counselors. And my understanding is—and maybe you have included this in your testimony—that a significant number of that 1,600, a little over 1,000, have been hired.

But the numbers in Kansas are surprising, or discouraging, to me. And Kansas, again because of our rural nature, that is not an atypical way of providing mental health services, either utilizing MFTs or LPCs. From August 2011 to August 2012, there were no MFTs and no LPCs hired at any Kansas facility.

On USAJobs.gov, VA has posted zero positions in Kansas for either one of those professions, for either one of those professional licenses.

VISN 15, as a whole, in Kansas City, MO, had two MFTs and zero LPCs on staff.

St. Louis had two LPCs and zero MFTs.

These two groups represent 40 percent of the mental health professionals in the United States but only 1 percent of the VA workforce. I would be interested in your response and your suggestions of how we can provide mental health services to more Kansas veterans.

Secretary SHINSEKI. Let me call on Dr. Petzel.

Senator MORAN. Thank you.

Dr. PETZEL. Thank you, Senator Moran.

The MFTs and family counselors are new positions, relatively new positions to the VA. Less than 2 years ago we certified them and got them into the mix of people that we can hire. And we are behind the power curve in terms of hiring these people.

I do not know specifically the numbers about Kansas. I will go back and find out and get back to you.

[The information requested was received in July 2014 by Senator Moran's office and is not being reproduced here.]

And you make an excellent point; hiring these people who are recruitable in rural areas, I think, is a very good alternative to the difficulty that we have in hiring psychologists and psychiatrists in those areas. So, I will be in communication with you about Kansas specifically and what we might be able to do.

Senator MORAN. I appreciate that and look forward to your response.

It reminds me of the effort when I was the sponsor of legislation in the House, now years ago, to incorporate chiropractic care within

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the VA. Can you, Secretary Petzel, bring me up to date on chiropractic services within the VA?

Dr. PETZEL. I would like to take that for the record if you do not mind.

We do employ them at virtually every one of our medical centers and a substantial amount of referral business outside.

[The information requested during the hearing follows:]

FROM THE PREPARED STATEMENT OF ROBERT L. JESSE, M.D., PH.D., PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS AT THE MAY 9, 2013, HEARING ON PENDING HEALTH CARE LEGISLATION

* * * * * * *

S. 422, CHIROPRACTIC CARE AVAILABLE TO ALL VETERANS ACT OF 2013

S. 422 would require VA to establish programs for the provision of chiropractic care and services at not fewer than 75 medical centers by not later than December 31, 2014, and at all VAMCs by not later than December 31, 2016. Currently, VA is required (by statute) to have at least one site for such program in each VHA geographic services area.

Section 3(a) would amend the statutory definition of "medical services" in section 1701 of chapter 17, U.S.C., to include chiropractic services. Subsection (b) would amend the statutory definition of "rehabilitative services" in that same section to include chiropractic services. Finally, subsection (c) would amend the statutory definition of "preventive health services" in that same section to include periodic and preventive chiropractic examinations and services.

The bill would also make technical amendments needed to effect these substantive amendments.

In general, VA supports the intent of S. 422, but believes the decision to provide on-site or fee care should be determined based on existing clinical demands and business needs. Chiropractic care is available to all Veterans and is already part of the standard benefits package.

As VA increases the number of VA sites providing on-site chiropractic care, we will be able to incrementally assess demand for chiropractic services and usage, and to best determine the need to add chiropractic care at more sites.

Currently, VA does not have an assessment that would support providing on-site chiropractic care at all VAMCs by the end of 2016. Such a mandate could potentially be excessive, given the availability of resources for on-site chiropractors and non-VA care to meet the current need for services. VA does not object to sections 3(a) and (b) as those changes reflect VA's consideration of chiropractic care as properly part of what should be considered medical and rehabilitative services. VA, however, cannot support section 3(c) for lack of a conclusive consensus on the use of chiropractic care as a preventative intervention.

Senator MORAN. It remains a priority for me. Again, the rural nature of Kansas chiropractic care is a significant way that health care services are delivered, and it may be the same pattern.

The VA, in my view, was very slow. This is before either one of your time, but very slow in incorporating the mandate, the requirement that the VA provide for chiropractic care within the VA system.

Let me raise one more topic before my time expires. I asked this question last January and I have not received a reply. It is apparently not in the fiscal year 2014 budget.

There has been considerable planning for a joint VA/DOD medical facility at McConnell Air Force Base and not in the budget, and I asked for a status update last January about McConnell and the Dole VA in Wichita. And perhaps, again for the record—or if you have the information today, I would be pleased to know—what, if any, progress is being made?

Secretary SHINSEKI. Dr. Petzel.

Dr. PETZEL. Thank you, Senator Moran.

There is a proposal that has been developed for a major construction project that would be a joint venture with, as you point out, McConnell Medical Center. It is $154 million. It was submitted. It was in the mix of those projects that were rated in the SCIP process, which rates the construction projects. It did not score high enough to be funded in 2014.

Senator MORAN. And that scoring takes place at the VA or within the Administration? Where is that scoring done?

Dr. PETZEL. The scoring is done by the Department of Veterans Affairs.

Senator MORAN. OK. And what does that mean then for the future of this project?

Dr. PETZEL. Well, the expectation would be that this project will be submitted again and will be scored again.

Senator MORAN. I would like to follow up with you and see if I can find out where perhaps the need for greater information or any deficiencies that we ought to be addressing in regard to this project.

Dr. PETZEL. Certainly.

Senator MORAN. Thank you.

Secretary SHINSEKI. What usually happens on the Strategic Capital Investment Plan—this rank ordering, this prioritizing—is the ones that are funded get worked off, and then there is a review, and then others move up in subsequent cycles.

Senator MORAN. We would like to work with you to see that it moves up as quickly as possible.

Thank you, Mr. Secretary.

Thank you.

Chairman SANDERS. Thank you, Senator Moran.

Senator Hirono.

STATEMENT OF HON. MAZIE HIRONO, U.S. SENATOR FROM HAWAII

Senator HIRONO. Thank you, Mr. Chairman.

Secretary Shinseki, of course, I join my colleagues in thanking you and the rest of the panel for your service.

I do apologize for missing some of the hearing, but I did have a chance to talk with you earlier, General Shinseki. So I appreciate that.

I want to focus on women veterans' health. In your testimony, you noted that nearly 50 percent of VA facilities do have comprehensive women's clinics and that you have asked for more money for an increase in the budget for gender-specific medical care for women veterans.

So is it your intention and goal that 100 percent of VA facilities will have these kinds of comprehensive care for our women veterans?

Secretary SHINSEKI. I am going to call on Dr. Petzel for the specifics.

But, Senator, I would just say today I believe women are maybe 6 percent of our veteran enrolled population, and we know in the active force they represent 15 percent of the population; in the reserve components, maybe 17 percent. So we know growth is going to occur, and we are doing everything we can to put in place the

decisions that when they arrive we are not playing catch-up as has been previous experience of mine.

So, if we were to look at women veterans' funding since 2009, between 2009 and 2014, we have increased that by 134 percent, and we will continue to put emphasis on this as one of our key areas.

Dr. Petzel.

Dr. PETZEL. Thank you, Mr. Secretary.

Senator, the specific question you asked about women's comprehensive clinics—there are three ways that we try to provide the primary basic care that women veterans might need.

In our large medical centers, where we have large numbers of women, we have comprehensive clinics that bring together not only primary care providers but obstetricians, gynecologists, mental health professionals, endocrinologists, all in the same clinic—the same clinic area.

Senator HIRONO. Yes.

Dr. PETZEL. In places that are smaller, where we do not have—may not even have—all of that specialty expertise, we have primary care clinics that are devoted exclusively to women's issues and to women veterans. Those practitioners are trained to recognize and take care of the primary care needs of women veterans.

And then in very small areas, where we might have a CBOC with only one or two providers, we train those primary care providers in the needs of women.

I think there will be some increase in the number of comprehensive clinics, but I think most of the medical centers that have a large enough population to do that probably have already done that.

I do want to point out that we have an obligation here to provide the kind of an atmosphere where women feel safe and feel as if the providers understand their specific needs, which are different than our male patients. And I think the VA has worked hard over the last 10 years to try to accomplish that. We still have work to do.

Senator HIRONO. Thank you.

I think that that is really important, and I commend you for the steps you are taking to recognize that this is a different population of veterans than perhaps—so do you do outreach efforts to make sure that they are aware of the services and the kind of services that are available to women veterans?

Dr. PETZEL. Yes, we do. Under the direction of Dr. Patricia Hayes, who runs our women's program, we have an extensive outreach program including help lines, public service announcements and advertisements, first of all, trying to make women understand they are veterans. In many instances, they do not necessarily view themselves as being veterans, and then on top of that they do not necessarily see the VA as a friendly place for them to get health care.

So we work hard to try to bring that message to them.

Senator HIRONO. Thank you.

Secretary Shinseki, I know that one of your major priorities is to address the needs of homeless veterans, and that is a challenge. So, are there particular programs or things that you are doing that work with this population?

I realize that it is not a monolithic group of folks. But any particular successes, programmatic successes, that can be ramped up?

Secretary SHINSEKI. We committed to ending the rescue phase of veterans' homelessness in 2015. What that means is when you hear the word homeless you think of people on the street. That is a visible—it is an estimate, but that is a visible population.

There is a larger invisible population of homeless veterans at risk—one paycheck, one more missed utility payment, away from being a foreclosure.

So, while we are committed to ending the rescue phase, which is get out and find our veterans and ensure that we are moving them to treatment and safe housing—and to do that we have partnered with many of the experts in communities across the country, provided funding for supportive services to veterans' families, shelter grant per diem support where at the same time we are doing yeoman work on the prevention piece.

GI Bill, the most generous education program we have—any youngster who does not complete schooling is at risk.

Last year, we had 70,000 veterans who had defaulted on their home loans and at risk of foreclosure. Our analysts became involved, worked with them to lower payments and extend their payment periods with financial institutions. Those 70,000 were kept in their homes and precluded from foreclosure.

Part of the homeless issue is mental health and substance abuse. In our Veterans Health Administration—very large and aggressive programs to deal with depression, substance abuse and other issues of mental health. We want to get veterans in early and get them into treatment. Our experience is when we diagnose and treat, people generally get better.

You know, this is a broad effort.

Senator HIRONO. That makes a lot of sense. Perhaps you can give us some data on how these prevention programs are working and the number of people you talk to or work with and what the outcomes are.

Secretary SHINSEKI. Dr. Petzel.

Senator HIRONO. Thank you.

You can send me the information or send the Committee the information.

Secretary SHINSEKI. All right.

Senator HIRONO. Thank you, Mr. Chairman.

Chairman SANDERS. We have gone through the first round. I would like to ask a few more questions if we can keep it brief.

Senator Burr, do you want to—all right. So, if it is OK with you, we will just ask a few more questions, and then we will get out of here.

I wanted to pick up on a question that Senator Moran asked. He was concerned about chiropractic care. I am concerned more generally about complementary medicine, and I think people would be surprised to know that the VA has been a leader in that area, in this country.

Recently I was at the VA facility in Brooklyn and the VA facility in Los Angeles, and the directors there told me that at both facilities complementary medicine is widely used and appreciated by veterans.

I want to work with you to expand those concepts, to be more aggressive, because I think you have a lot of folks out there who are concerned about overmedication, the ways that we can deal with pain without a lot of drugs, et cetera.

Can you tell us, Dr. Petzel, briefly, what ideas you have as to how we can expand complementary medicine? And I am talking about acupuncture, guided imagery, meditation, chiropractic care, yoga, et cetera.

Dr. PETZEL. Thank you, Mr. Chairman.

I just wanted to point out that 89 percent of our facilities, 125 of them, actively have CAM programs.

Chairman SANDERS. That may be true, and correct me if I am wrong. If somebody is a well trained, qualified acupuncturist, for example—that person as an acupuncturist as opposed to, say, being an M.D. who practices acupuncture—that acupuncturist, himself or herself, could not be hired under that definition. That is my understanding. Is that correct?

Dr. PETZEL. I will have to find out, Mr. Chairman. I am not aware that that is the case.

Chairman SANDERS. That is my understanding.

Dr. PETZEL. I know that the places that I am familiar with that do acupuncture happen to have anesthesiologists who are acupuncturists and do acupuncture.

We, as you mentioned, do a number of different things—yoga, hypnosis, acupuncture, animal-assisted therapy, biofeedback, stress management, relaxation therapy and meditation.

Chairman SANDERS. Let me interrupt you. I am aware of that, and I think you guys should be very proud of that.

My question is that while you are sitting here supporting those initiatives, there is also an argument that it has not quite filtered down with as much excitement and appreciation as it might. Is that a fair statement?

Dr. PETZEL. I think that is a fair statement, Mr. Chairman.

And I think that one of the crucial parts of helping that to filter down is something that we are also engaged in, and that is research to demonstrate the efficacy in specific circumstances of certain alternative medicine therapies.

Meditation would be an example. We are spending $5 million this year looking at meditation and its role in treating PTSD—3 pilot projects and 4 research projects to, indeed, look at the 3 different kinds of meditation and how they work.

And I think we need to do, quite frankly, more of that to demonstrate to the treating public—to the treating physicians that, indeed, these things are effective and do work.

Chairman SANDERS. I believe you are also looking at guided imagery in terms of sexual assaults and so forth.

Dr. PETZEL. Yes.

Chairman SANDERS. Sexual trauma.

Dr. PETZEL. That is also correct.

Chairman SANDERS. OK, Senator Burr.

Senator BURR. Secretary, you said earlier that we will move out of the rescue phase on homelessness. Would that be the reason that there is a reduction between 2014's and 2015's budget for homelessness? We have got a drop from $1.2 billion to $857 million.

Secretary SHINSEKI. I believe that adjustment is based on the fact that we think we will be making good progress toward our 2015 targets, and so the adjustment is in the level of energy here.

Senator BURR. OK. A letter from the VA dated February 2012 included the timeline of VA's homelessness reduction strategy, 2009 to 2015. This timeline included decisions regarding increasing or decreasing budget requests, reallocating funding, and a decision as to whether to extend the timeline. Have any of those decisions been made to date?

Secretary SHINSEKI. To extend the timeline?

Senator BURR. Increasing or decreasing budget requests, reallocating funding, and a decision as to whether to extend the timeline.

Secretary SHINSEKI. I am sure there may have been some discussions, but I have not participated in extending the timeline. Twenty fifteen remains our target.

Senator BURR. OK. Mr. Warren, according to the fiscal year 2014 Budget Fast Facts information sheet, VA has allocated $344 million for the integrated electronic medical records system. In addition, the Office of Information and Technology's budget requests $252 million for the development, modernization, and enhancement of iEHR and VLER. Does the $344 million include the $252 million for the development of iEHR and VLER, or is the $252 million additional funding for those two?

Mr. WARREN. Thank you for the question, Senator Burr.

The 344 includes the 250 for development.

Senator BURR. Two fifty-two, OK.

The Project Management Accountability System, or PMAS, creates and monitors milestones for IT projects to reduce risk associated with the development of large IT systems. How many milestones have iEHR and VLER missed?

Mr. WARREN. Let me take that for the record instead of flipping through the spreadsheet, which was delivered to your staff today, sir. We will get back to you.

Senator BURR. I appreciate that.

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. RICHARD BURR TO STEPHEN W. WARREN, ACTING ASSISTANT SECRETARY FOR THE OFFICE OF INFORMATION AND TECHNOLOGY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Response. As a follow up to our prior correspondence to Senators Burr and Murray on September 12, 2102, VA provides the following update to its scheduling procurement efforts:

VA will procure a scheduling solution in two phases. In the first phase, currently ongoing, VA is running a risk-reduction contest under the America Competes Act calling for scheduling application submissions. The purpose of this contest will be to reduce procurement and deployment risk. VA will offer up to three prizes for scheduling packages that demonstrate their compatibility with the Open Source version of VA's electronic health record, VistA. Contest submissions are due in June, and VA is scheduled to announce winners in September.

The second phase will include the actual procurement of a scheduling solution. As this risk-reduction activity proceeds, VA will continue working with the Department of Defense and the Interagency Program Office to determine joint requirements and a master development and acquisition plan. The master development and acquisition plan will be based upon an evaluation of contestant responses for proposed functionality and compliance with iEHR architecture.

Office of Information and Technology
May 2013

Senator BURR. Mr. Warren, according to the fiscal year 2014 Budget Fast Facts information sheet, again, the Department of Veterans Affairs has allocated $155 million for the total development and implementation of the Veterans Benefits Management System. I am getting to a question that Senator Isakson talked to you about.

The President's request includes roughly $33 million for the development of VBMS, a $71 million decrease.

I think you answered that, if I remember correctly. If you did not, I will allow you to do it, but I also want a clarification. Did you tell the Committee that it was going to cost $122 million a year to sustain that program, in fees?

Mr. WARREN. No. The question was, of the amount stated, is it all development or did it include sustainment? It does include sustainment.

Senator BURR. What is the estimated sustainment cost?

Mr. WARREN. For which year, Senator, please?

Senator BURR. On an ongoing basis.

Mr. WARREN. One of the challenges we have, Senator Burr, is if you look at the elimination of the backlog and you think in terms of the ingest or the input of information, moving from paper to electrons, the engine—in terms of how do we make the decision about what the benefit is and then the payment process that comes out the end—so there is a multitude of systems out there.

When you ask the question, based upon where you draw the boundaries, the dollars either go up or down. So, when we talk about the 155, it picks up $32 million to pay for the development of the engine, also portions of the payment piece once a decision is made through to the check.

If I add all of the pieces up—so the multiple entries in the budget that cover not just the engine, which is the VBMS system, but includes all of the ingests in terms of e-benefits that portal that we use to bring the information in, that the veteran uses for self-service; the SEP or the VSOs are able to assist the veteran and do that work; the unified desktop or our call centers are able to give a complete view of the status as well as the output.

The sum total is $275 million in fiscal year 2014, which is VBMS and VRM. So it is a large investment to make sure that not only the engine is working, once we get the electrons, but to pay for that change from paper to electrons.

Senator BURR. Are we going to have to pay for any more of the engine after 2014?

Mr. WARREN. The program——

Senator BURR. Or is the engine complete?

Mr. WARREN. The program plan today, as we turn the automation on, as we look at what the rules engines are and we get the same pick-up, the kick that we are able to get from chapter 33, it is possible that we are going to see more areas where we can automate.

It is also subject to any change in laws passed as well as any court rulings in terms of needing to add automation for our partners in the benefits administration.

Secretary SHINSEKI. Senator, I think we will continue to improve VBMS as we go forward where those opportunities show them-

selves. I do not think that the VBMS we field by 2014 is the end state.

Senator BURR. I appreciate that, Mr. Secretary, and I encourage it. I do not want to bog us down, staying here any longer.

But let me suggest, Mr. Warren, maybe you need to come up and meet with some of us on the Committee. We would like to know, of its original design, when will this program be paid for? When will we be fully invested?

Hopefully, that coincides with some period before 2015 since in 2015 it is our answer to backlog. There is not a plan B. This is plan A, B, C, D, E, and F.

Mr. WARREN. Glad to come up, Senator.

Senator BURR. But, more importantly, I think we need to understand better, what is our long-term annual commitment to a program of this magnitude?

I realize that there are parameters that might change that—court rulings, benefits, scope of benefits, that type of thing. But I think we need to better understand it, if, in fact, we provide fair but effective oversight to an IT program of this size.

Mr. Chairman, you have been awfully generous.

I know Under Secretary Muro is dying for me to ask him a question, but I am going to forego that today.

[Laughter.]

Chairman SANDERS. I am sure he is deeply disappointed.

Senator BURR. He is always neglected in these hearings, and I have asked him not to take it personally. I will follow up with some audit questions in writing, if I may.

Mr. MURO. Thank you.

Senator BURR. Mr. Secretary, thank you and thank you to your entire team.

Chairman SANDERS. OK. Secretary Shinseki, thank you for being here and thank you for your staff being here.

This hearing is now concluded.

[Whereupon, at approximately 4:33 p.m., the hearing was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF JEFFREY C. HALL, ASSISTANT NATIONAL LEGISLATIVE
DIRECTOR, DISABLED AMERICAN VETERANS

Chairman Sanders, Ranking Member Burr and Members of the Committee: On
behalf of the DAV (Disabled American Veterans) and our 1.2 million members, all
of whom are wartime disabled veterans, I am pleased to be here today to present
recommendations of *The Independent Budget* (*IB*) for the fiscal year (FY) 2014 budg-
et related to veterans benefits and the Veterans Benefits Administration (VBA). The
IB is jointly produced each year by DAV, AMVETS, Paralyzed Veterans of America
and Veterans of Foreign Wars. This year's *IB* contains numerous recommendations
to improve veterans benefit programs and the claims processing system; however,
in today's testimony I will highlight just some of the most critical ones for this Com-
mittee to consider.

Mr. Chairman, the timely delivery of earned benefits to the millions of men and
women who have served in our Armed Forces is one of the most sacred obligations
of the Federal Government. The award of a service-connected disability rating does
more than provide compensation payments; it is the gateway to an array of benefits
that support the recovery and transition of veterans, their families and survivors.
However, when these benefits are delayed or unjustly denied, the consequences to
veterans and their families can be devastating. For those wounded heroes who file
claims for disability compensation, the wait to receive an accurate rating decision
and award can take anywhere from a few months to several years; longer if they
have to appeal incorrect decisions.

Today there are about 900,000 claims for compensation and pension awaiting de-
cisions at VBA, more than double the number pending four years ago. Of those, fully
70 percent have been waiting more than 125 days, VBA's official target for meas-
uring the backlog, which is double the number from just two years earlier. More-
over, the length of time it takes to process veterans' claims also continues to rise,
with the average processing time now almost 280 days, far from VBA's target of 80
days. Looking at these numbers, it is clear that the challenges facing VBA are enor-
mous, and in many ways they are the same core problems that have plagued VBA
for decades. The solution will require new technologies and business processes, and
most importantly, a cultural transformation built upon the foundations of quality,
accuracy and accountability.

In early 2010, Secretary Shinseki laid out an extremely ambitious goal for VBA
to achieve by 2015: process 100 percent of claims in less than 125 days, and do so
with 98 percent accuracy. Since that time, VBA has worked to completely transform
their IT systems, business processes and corporate culture, while simultaneously
continuing to process more than a million claims each year. VBA is actively rolling
out new organizational models and practices, and continuing to develop and deploy
new technologies almost daily. In the midst of this massive transformation, it can
be hard to get the proper perspective to measure whether their final systems will
be successful, but we believe there has been sufficient progress to merit continued
support of the current transformation efforts. Now is not the time to stop or change
direction.

We urge this Committee and Congress to provide the support and resources nec-
essary to complete this transformation as currently planned, while continuing to ex-
ercise strong oversight to ensure that VBA remains focused on the long term goal
of creating a new claims processing system that decides each claim right the first
time. In particular, the proposed FY 2014 budget for VBA includes additional fund-
ing for scanning and conversion of existing paper claims files that is absolutely crit-
ical for VBA to complete their transformation from an outdated, paper-based claims
system to a modern, paperless, automated claims system.

Mr. Chairman, one of the most important signs of positive change over the past four years has been VBA's unprecedented openness and partnership with VSOs. Our organizations possess significant knowledge and experience of the claims process and collectively we hold power of attorney (POA) for millions of veterans who are filing or have filed claims. VBA recognized that close collaboration with VSOs could not only reduce its workload but also increase the quality of its work. We make VBA's job easier by helping veterans prepare and submit better claims, thereby requiring less time and resources for VBA to develop and adjudicate them. The IBVSOs have also been increasingly consulted about initiatives proposed or underway at VBA, including Fully Developed Claims (FDC), Disability Benefit Questionnaires (DBQs), the Veterans Benefit Management System (VBMS), the Stakeholder Enterprise Portal (SEP), and the update of the Department of Veterans Affairs (VA) Schedule for Rating Disabilities (VASRD). Both Secretary Shinseki and Under Secretary Hickey have consistently reached out to consult and collaborate with VSOs and we are confident that this partnership will result in better service and outcomes for veterans.

Since 2009, VBA has made some significant changes in how claims are processed. The most important amongst these is the development of the new Veterans Benefits Management System (VBMS), its new IT system. VBMS has been rolled out to 20 Regional Offices and is scheduled to be fully deployed to all remaining Regional Offices (ROs) by mid-year. It is important to remember that VBMS is not yet a finished product; rather, it continues to be developed and perfected as it is deployed so it is still premature to judge whether it will ultimately deliver all of the functionality and efficiency required to meet VBA's future claims processing needs.

Another very important milestone was VBA's decision and commitment to scan all paper claims files for every new or reopened claim requiring a rating-related action, and creating digital e-folders to serve as the cornerstone of the new VBMS system. E-folders facilitate instantaneous transmission and simultaneous reviewing of claims files. At present, there are an estimated 200,000 e-folders and that number will continue to grow as the remaining ROs convert to VBMS this year. In addition, the Appeals Management Center (AMC) is now working in VBMS and able to review e-folders. The Board of Veterans Appeals (BVA) will also begin receiving appeals in VBMS on a pilot basis.

VBA also continues to strengthen its e-Benefits and SEP systems, which allow veterans and their representatives to file claims, upload supporting evidence and check on the status of pending claims. VBA has rolled out a new transformation organizational model (TOM) to every Regional Office that has reorganized workflow by segmenting claims into different processing lanes depending upon the complexity of the issues to be decided for each claim. Other key process improvements that we strongly support include the FDC program, which expedites ready-to-rate claims, and DBQs, which standardize and encourage the collection of private medical evidence to aid in rating decisions. To improve the accuracy of their work, VBA also fulfilled one of our longstanding recommendations by creating local Quality Review Teams (QRTs), whose primary function is to monitor claims processing in real time to catch and correct errors before rating decisions are finalized.

CLAIMS PROCESSING RECOMMENDATIONS

Over the next year, Congress must continue to perform aggressive oversight of VBA's ongoing claims transformation efforts, particularly new IT programs, while actively supporting the completion and full implementation of these vital initiatives. In order for VBA's current transformation plans to have any reasonable chance of success, VBA must be allowed to complete and fully implement them. Congress must continue to fully fund the completion of VBMS, including providing sufficient funding for digital scanning and conversion of legacy paper files, as well as the development of new automation components for VBMS. At the same time, the IBVSOs recommend that Congress encourage an independent, expert review of VBMS while there is still time to make course corrections.

Congress must also encourage and support VBA's efforts to develop a new corporate culture based on quality, accuracy and accountability, as well as strengthen the transmission and adoption of these values and appropriate supportive policies throughout all VBA Regional Offices. The long-term success of all of VBA's transformation efforts will depend on the degree to which these changes are institutionalized and disseminated from the national level to the local level. In addition to strengthening training, testing and quality control, VBA must be encouraged to properly align measuring and reporting functions with desired goals and outcomes for both its leadership and employees. For example, as long as the most widely reported metric of VBA's success is the Monday Morning Workload Reports, particu-

larly the weekly update on the size of the backlog, there will remain tremendous pressure throughout VBA to place production gains ahead of quality and accuracy. Similarly, if individual employee performance standards set unrealistic production goals, or fail to properly credit ancillary activity that contributes to quality but not production, those employees will be incentivized to focus on activities that maximize only production. VBA must develop more and better measures of work performance that focus on quality and accuracy, both for the agency as a whole and for individual employees. Furthermore, VBA must ensure that employee performance standards are based on accurate measures of the time it takes to properly perform their jobs.

Congress must also ensure that VBA does not change its reporting or metrics for the sole purpose of achieving statistical gains, commonly referred to as "gaming the system," in the absence of actual improvements to the system. For example, VBA recently announced that they will change how errors are scored for multi-issue claims. Previously, a claim would be considered to have an error if one mistake on at least one issue in the claim was detected during a STAR review. Under the new error policy, if there are 10 issues in the claim and a single error is found on one of the issues, that would now be scored as only 0.1 errors for that claim. While this may be a more valid way of measuring technical accuracy, it also has the effect of lowering the error rate without actually lowering the number of errors committed.

To make the system more efficient, Congress should enact and promote legislation and policies that maximize the use of private medical evidence to conserve VBA resources and enable quicker, more accurate rating decisions for veterans. The IBVSOs have long encouraged VBA to make greater use of private medical evidence when making claims decisions, which would save veterans time and VBA the cost of unnecessary examinations. DBQs, many of which were developed in consultation with IBVSO experts, are designed to allow private physicians to submit medical evidence on behalf of veterans they treat in a format that aids rating specialists. However, we continue to receive credible reports from across the country that many Veterans Service Representatives (VSRs) and Rating Veterans Service Representatives (RVSRs) do not accept the adequacy of DBQs submitted by private physicians, resulting in redundant VA medical examinations being ordered and valid evidence supporting veterans' claims being rejected.

Although there are currently 81 approved DBQs, VBA has only released 71 of them to the public for use by private physicians. In particular, VBA should allow private treating physicians to complete DBQs for medical opinions about whether injuries and disabilities are service-connected, as well as DBQs for PTSD, which current VBA rules do not allow; only VA physicians can make PTSD diagnoses for compensation claims. Congress should work with VBA to make both of these DBQs available to private physicians.

To further encourage the use of private medical evidence, Congress should amend title 38, United States Code, section 5103A(d)(1) to provide that, when a claimant submits private medical evidence, including a private medical opinion, that is competent, credible, probative, and otherwise adequate for rating purposes, the Secretary shall not request a VA medical examination. This legislative change would require VSRs and RVSRs to first document that private medical evidence was inadequate for rating purposes before ordering examinations, which are often unnecessary.

VBA STAFFING AND RESOURCE RECOMMENDATIONS

Over the past five years, the VBA has seen a significant staffing increase because Congress recognized that rising workload, particularly claims for disability compensation, could not be addressed without additional personnel and thus provided additional resources each year to do so. More than 5,000 full time employee equivalents (FTEE) were added to VBA over the past five years, a 33 percent increase, with most of that increase going to the Compensation Service. In fiscal year (FY) 2013, VBA's budget supports an additional 450 FTEE above the FY 2012 authorized level, and the FY 2014 level adds less than 100 new FTEE.

Compensation Service Staffing

Since VBA is in the middle of a comprehensive transformation that makes changes in the roles and responsibilities of its employees, it is difficult to determine whether Compensation Service's staffing levels are sufficient now or will be in the near future. Without knowing the outcome of the transformation, it is difficult to estimate whether they will require additional or even fewer personnel to address the future workload they will need to process. For this reason, the *IB* does not recommend a specific staffing increase for FY 2014, although it is important that Congress and VBA be certain that staffing levels are regularly adjusted to remain aligned with changes in workload and productivity.

In this regard, it is imperative that VBA and Congress continue to closely monitor Compensation Service's actual and projected workload, measurable and documented increases in productivity resulting from the new organizational model and the VBMS, as well as personnel changes, such as attrition, in order to ensure that staffing is sufficient. Furthermore, VBA must develop a better, more consistent and data-driven method of determining future staffing requirements to more accurately inform future funding requirements.

Board of Veterans' Appeals Staffing

Based on historical trends, the number of new appeals to the Board averages approximately 5 percent of all claims received, so as the number of claims processed by the VBA is expected to rise significantly, so too will the Board's workload rise accordingly. Yet the budget provided to the Board has been declining, forcing it to reduce the number of employees. Although the Board had been authorized to have up to 544 FTEE in FY 2011, its appropriated budget could support only 532 FTEE that year. In FY 2012, that number was further reduced to 510. At present, due to cost-saving initiatives, the Board may be able to support as many as 518 FTEE with the FY 2013 budget; however, this does not correct the downward trend over the past several years, particularly as workload continues to rise. The proposed FY 2014 budget actually cuts funding for the Board and further reduces staffing down to just 492 FTEE, despite expected workload increases each year. Even adjusting for projected productivity gains, the IBVSOs believe that the Board should have at least 544 FTEE in FY 2014 in order to reduce its backlog.

Vocational Rehabilitation and Employment Service Staffing

In FY 2012, VA's Vocational Rehabilitation and Employment (VR&E) program, also known as the VetSuccess program, had 121,000 participants in one or more of the five assistance tracks of VR&E's VetSuccess program, an increase of 12.3 percent above the FY 2011 participation level of 107,925 veterans. In FY 2012, VR&E had a total of 1,446 FTEE, and anticipates an increase of approximately 150 FTEE for FY 2013. Given the estimated 10 percent workload increases for both FY 2013 and FY 2014, the *IB* estimates that VR&E would need an additional 230 counselors in FY 2014 in order to reduce their counselor-to-client ratio down to their stated goal of 1:125.

An extension for the delivery of VR&E assistance at a key transition point for veterans is through the VetSuccess on Campus program. This program provides support to student veterans in completing college or university degrees. VetSuccess on Campus has developed into a program that places a full-time Vocational Rehabilitation Counselor and a part-time Vet Center Outreach Coordinator at an office on campus specifically for the student veterans attending that college. These VA officers are there to help the transition from military to civilian and student life. The VetSuccess on Campus program is designed to give needed support to all student veterans, whether or not they are entitled to one of VA's education benefit programs. VA is expected to increase its VetSuccess on Campus program from 34 colleges in FY 2012 to 84 colleges in FY 2013 and Congress must ensure that sufficient funding is provided in the FY 2014 budget for this program.

RECOMMENDATIONS FOR IMPROVEMENTS TO VA BENEFITS

Automatic Annual Cost-of-Living Adjustment (COLA)

Congress has annually authorized increases in compensation and dependency and indemnity compensation (DIC) by the same percent as Social Security is increased. Under current law, the government monitors inflation throughout the year and, if inflation occurs, automatically increasing Social Security payments by the percent of increase for the following year, which the Congress then applies to veterans programs.

While Congress has always increased compensation and DIC based on inflation, there have been years when such increases were delayed, which puts unnecessary financial strain on veterans and their survivors. The *IB* veterans service organizations urge Congress to enact legislation indexing compensation and DIC to Social Security COLA increases.

End Rounding Down of Veterans' and Survivors' Benefits Payments

In 1990, Congress, in an omnibus reconciliation act, mandated that veterans' and survivors' benefit payments be rounded down to the next lower whole dollar. While this policy was initially limited to a few years, Congress eventually made it permanent. The cumulative effect of this provision of the law effectively levies a tax on totally disabled veterans and their survivors. Congress should repeal the current policy of rounding down veterans' and survivors' benefits payments.

Reject Any Proposal to Use the "Chained CPI"

In the past year, there has been much discussion about replacing the current CPI formula used for calculating the annual Social Security COLA with the Bureau of Labor Statistics (BLS) new formula commonly termed the "chained CPI." Such a change would be expected to significantly reduce the rates paid to Social Security recipients, and thereby help to lower the Federal deficit. Since the Social Security COLA is also applied annually to the rates for VA disability compensation, DIC, and pensions for wartime veterans and survivors with limited incomes, its application would mean systematic reductions for millions of veterans, their dependents and survivors who rely on VA benefit payments. The IBVSOs urge Congress to reject any and all proposals to use the "chained CPI" for determining Social Security COLA increases, which would have the effect of significantly reducing the level of vital benefits provided to millions of veterans and their survivors.

The IBVSOs also note that the CPI index used for Social Security does not include increases in the cost of food or gasoline, both of which have risen significantly in recent years. While no inflation index is perfect, the IBVSOs believe that VA should examine whether there are other inflation indices that would more appropriately correlate with the increased cost of living experienced by disabled veterans and their survivors.

End Prohibition against Concurrent Receipt of VA Disability Compensation and Military Longevity Retired Pay

Many veterans retired from the Armed Forces based on longevity of service must forfeit a portion of their retired pay, earned through faithful performance of military service, before they receive VA compensation for service-connected disabilities. This is inequitable—military retired pay is earned by virtue of a veteran's career of service on behalf of the Nation, careers of usually more than 20 years. Entitlement to compensation, on the other hand, is paid solely because of disability resulting from military service, regardless of the length of service. Most nondisabled military retirees pursue second careers after serving in order to supplement their income, thereby justly enjoying a full reward for completion of a military career with the added reward of full civilian employment income. In contrast, military retirees with service-connected disabilities do not enjoy the same full earning potential since their earning potential is reduced commensurate with the degree of service-connected disability.

In order to place all disabled longevity military retirees on equal footing with non-disabled military retirees, there should be no offset between full military retired pay and VA disability compensation. To the extent that military retired pay and VA disability compensation offset each other, the disabled military retiree is treated less fairly than is a nondisabled military retiree by not accounting for the loss in earning capacity. Moreover, a disabled veteran who does not retire from military service but elects instead to pursue a civilian career after completing a service obligation can receive full VA disability compensation and full civilian retired pay—including retirement from any Federal civil service position.

While Congress has made progress in recent years in correcting this injustice, current law still provides that service-connected veterans rated less than 50 percent disabled who retire from the Armed Forces on length of service may not receive disability compensation from VA in addition to full military retired pay. The IBVSOs believe the time has come to remove this prohibition completely. Congress should enact legislation to repeal the inequitable requirement that veterans' military longevity retired pay be offset by an amount equal to the disability compensation awarded to disabled veterans rated less than 50 percent, the same as exists for those rated 50 percent or greater.

SURVIVOR BENEFITS

Increase DIC for Surviving Spouses of Servicemembers

The current rate of compensation paid to the survivors of certain deceased veterans rated permanently and totally disabled and deceased servicemembers is inadequate and inequitable. Under current law, the surviving spouse of a veteran who had a total disability rating is entitled to the basic rate of Dependency and Indemnity Compensation. A supplemental payment is provided to those spouses who were married for at least eight years during which time the veteran was rated permanently and totally disabled. However, surviving spouses of veterans or military servicemembers who die before the eight-year eligibility period, or who die on active duty, respectively, only receive the basic rate of DIC.

Insofar as DIC payments are intended to provide surviving spouses with the means to maintain some semblance of financial stability after losing their loved ones, the rate of payment for service-related deaths of any kind should not vastly

differ. Surviving spouses, regardless of the status of their sponsors at the time of death, face the same financial hardships once deceased sponsors' incomes no longer exists. Congress should authorize DIC eligibility at increased rates to survivors of servicemembers who died either before the eight-year eligibility period passes or while on active duty at the same rate paid to the eligible survivors of totally disabled service-connected veterans who die after the eight-year eligibility period.

Repeal of the DIC-SBP Offset

The current requirement that the amount of an annuity under the Survivor Benefit Plan (SBP) be reduced on account of, and by an amount equal to, DIC is inequitable. A veteran disabled in military service is compensated for the effects of service-connected disability. When a veteran dies of service-connected causes, or following a substantial period of total disability from service-connected causes, eligible survivors or dependents receive DIC from the VA. This benefit indemnifies survivors, in part, for the losses associated with the veteran's death from service-connected causes or after a period of time when the veteran was unable, because of total disability, to accumulate an estate for inheritance by survivors.

Career members of the Armed Forces earn entitlement to retired pay after 20 or more years of service. Survivors of military retirees have no entitlement to any portion of the veteran's military retirement pay after his or her death, unlike many retirement plans in the private sector. Under the SBP, deductions are made from the veteran's military retirement pay to purchase a survivor's annuity. This is not a gratuitous benefit, but is purchased by a retiree. Upon the veteran's death, the annuity is paid monthly to eligible beneficiaries under the plan. If the veteran died from other than service-connected causes or was not totally disabled by service-connected disability for the required time preceding death, beneficiaries receive full SBP payments. However, if the veteran's death was a result of military service or after the requisite period of total service-connected disability, the SBP annuity is reduced by an amount equal to the DIC payment. When the monthly DIC rate is equal to or greater than the monthly SBP annuity, beneficiaries lose the SBP annuity in its entirety.

The IBVSOs believe this offset is inequitable because no duplication of benefits is involved. Payments under the SBP and DIC programs are made for different purposes. Under the SBP, coverage is purchased by a veteran and at the time of death, paid to his or her surviving beneficiary. On the other hand, DIC is a special indemnity compensation paid to the survivor of a servicemember who dies while serving in the military, or a veteran who dies from service-connected disabilities. In such cases, DIC should be added to the SBP, not substituted for it. Surviving spouses of Federal civilian retirees who are veterans are eligible for DIC without losing any of their purchased Federal civilian survivor benefits. The offset penalizes survivors of military retirees whose deaths are under circumstances warranting indemnification from the government separate from the annuity funded by premiums paid by the veteran from his or her retired pay. Congress should repeal the inequitable offset between DIC and the SBP because there is no duplication between these two distinct benefits.

Retention of Remarried Survivors' Benefits at Age 55

Congress should lower the age required for remarriage for survivors of veterans who have died on active duty or from service-connected disabilities to be eligible for retention of DIC to conform with the requirements of other Federal programs. Current law allows retention of DIC on remarriage at age 57 or older for eligible survivors of veterans who die on active duty or of a service-connected injury or illness. Although the IBVSOs appreciate the action Congress took to allow restoration of this rightful benefit, the current age threshold of 57 years is arbitrary.

Remarried survivors of retirees of the Civil Service Retirement System, for example, obtain a similar benefit at age 55. This would also bring DIC in line with SBP rules that allow retention with remarriage at the age of 55. Equity with beneficiaries of other Federal programs should govern Congressional action for this deserving group. Congress should enact legislation to enable survivors to retain DIC on remarriage at age 55 for all eligible surviving spouses.

Mr. Chairman, that concludes my statement and I would be happy to answer any questions you or other Members of the Committee may have.

PREPARED STATEMENT OF TOM TARANTINO, CHIEF POLICY OFFICER, IRAQ AND
AFGHANISTAN VETERANS OF AMERICA

Chairman Sanders, Ranking Member Burr, and Distinguished Members of the Committee: Iraq and Afghanistan Veterans of America (IAVA) would like to thank you for holding this hearing today on the critical priority of properly funding the Department of Veterans Affairs (VA). We also appreciate your continued dedication to improving the functioning and capabilities of the VA, and to improving the lives of America's veterans.

IAVA is the Nation's first and largest nonprofit, nonpartisan organization for veterans of the wars in Iraq and Afghanistan and their supporters. Founded in 2004, our mission is simple—to improve the lives of Iraq and Afghanistan veterans and their families. With a steadily growing base of over 200,000 members and supporters, we strive to help create a society that honors and supports veterans of all generations.

IAVA is acutely aware of our Nation's current fiscal situation. However, I think we are all in agreement that the VA should continue to be fully funded so as to enable the department to adequately care for and support those who have faithfully shouldered the burden of our Nation's defense. Our funding of the VA's budgetary requirements, including its discretionary accounts, is not generosity, it is not charity, and it is not a handout. It is part of a sacred obligation we as a society have to care for our Nation's veterans. It is part of an implicit social contract we entered into when we accepted each and every one of them into the ranks of our military—to provide for their needs should they leave the service less whole than they were when they entered.

In light of this overarching philosophy we espouse in caring for our Nation's veterans, IAVA is pleased to see just over a 10% increase in the President's VA budget request above the previous fiscal year's funding levels, including both mandatory and discretionary accounts. IAVA is especially thankful to see a nearly 14% increase in funding for programs and initiatives that Iraq and Afghanistan veterans need to help them deal with the repercussions of more than a decade of war and to help them successfully transition back into civilian life. These programs, which span issues as diverse as access to mental health care and suicide prevention to job training and employment assistance, continue to be priorities for IAVA because they are priorities for our members.

At IAVA, our broad and diverse membership is the backbone of our organization. As they communicate their needs, frustrations, suggestions, and wishes to us, we in turn translate that feedback into IAVA's policy priorities. And this year, IAVA's top policy priority has become ending the excessive VA disability claims backlog.

This issue is not just a numbers problem for us, although the numbers alone are enough to astound even the most patient and forgiving of observers, including wait time averages on disability claims decisions of 619 days in Los Angeles, 612 days in Indianapolis, 586 days in Houston, 642 days in New York, and 681 days in Reno.

But for us, the problem has a human face and a real voice, like that of IAVA member Rachel McNeil, who joined the Army Reserves in 2002 and deployed to Iraq in December 2004. Rachel filed a claim after she came home from Iraq in 2006, and it has been more than 827 days since the VA even acknowledged that she filed a notice of disagreement with their decision in 2010.

IAVA member John Wypyszinski spent 16 years in the military in both the Army and the Navy as a nuclear, biological, and chemical operations specialist, and later?as a medic and a hospital corpsman with the Marines. He deployed twice to Iraq before he was medically retired in 2007 due to injuries, but he was lost in the VA disability claims process for an excruciating 963 days.

And then there's IAVA member Luis Cardenas Camacho, who served in the Marine Corps from 2004–2008 and deployed to Iraq three times. Upon returning home, Luis found himself fighting new enemies, including PTSD, depression, and his physical injuries. Luis has been dealing with the VA disability claims office for five years and still hasn't received his benefits.

It is stories like these—the real stories and real lives of real heroes—that motivate us here at IAVA, that fuel our outrage at the slow pace of progress on the backlog, and that exacerbate our impatience sometimes with the Veterans Benefits Administration (VBA). So we are pleased to see the President requesting a 13.6% increase in funding for VBA. Yet we remain concerned about whether this is actually sufficient to provide VBA with what it really needs to end the backlog, even by it's protracted goal of 2015 (of which many remain skeptical). If, as the VA has said, the funding level requested for VBA would enable it to process 1.3 million claims in the next fiscal year, yet that amounts to roughly the same number of claims it processed last year, then VBA is simply requesting funding sufficient to tread water.

It is details like this that call into question whether the VA's rhetoric on ending the backlog, even as far out as 2015, is realistic. By its own admission, the problems that led to and exacerbated the backlog were perfectly predictable. Yet what has clearly led to the existence of such a severe problem with the backlog is a failure on the part of the VA to adequately plan and prepare for these predictable spikes in claims. Given this record, we remain seriously concerned about whether the resources currently being requested are indeed sufficient to bring about an end to the backlog. These veterans stuck in this shameful backlog have waited long enough, whether they be Iraq and Afghanistan veterans, Gulf War I veterans, Cold War veterans, Vietnam veterans, Korean War veterans, or even World War II veterans, all of whom are a part of this excessively large backlog.

While we remain gravely concerned about this problem, IAVA is also hopeful that Members of this Committee will use their platform and their power to not only hold the VA accountable, but also equip it with the financial resources it needs to better serve America's veterans. This is our constituency, this is the VA's constituency, and this is this Committee's constituency, and together we can accomplish the goal of ending the backlog, fully caring for veterans and their families, and improving the lives of all who have served.

We again appreciate the opportunity to offer our views to the Committee on the VA's budget request, and we look forward to continuing to work with each of you, your staff, and the VA to improve the lives of America's veterans and their families.

Thank you for your time and attention.

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PREPARED STATEMENT OF PARALYZED VETERANS OF AMERICA

Chairman Sanders, Ranking Member Burr, and Members of the Committee, As one of the four co-authors of *The Independent Budget* (*IB*), Paralyzed Veterans of America (PVA) is pleased to present the views of *The Independent Budget* regarding the funding requirements for the Department of Veterans Affairs (VA) for FY 2014.

As the country faces a difficult and uncertain fiscal future, the VA likewise faces significant challenges ahead. Congress and the Administration continue to face immense pressure to reduce Federal spending. With these thoughts in mind, we cannot emphasize enough the importance of ensuring that sufficient, timely and predictable funding is provided to the VA. Unfortunately, we do not believe that the Administration's FY 2014 Budget Request, which includes advance appropriations for medical care for FY 2015, meets that standard. In fact, analyzing the projected increase in funding for all medical care in the Administration's budget from FY 2014 (based on the assumption of $157 million additional needed dollars) to the advance appropriations recommendation for FY 2015 suggests that the VA budget will not begin to meet the projected needs of veterans already in the system and those coming to the VA for the first time. In fact, we believe that the $1.1 billion increase that the Administration projects from FY 2014 to FY 2015 does not even meet current services increases impacted by inflation (conservatively estimated to be around 3.0 percent for general medical care). With that thought in mind, the Administration's budget would certainly not be sufficient to address the needs of new utilization.

Meanwhile, *The Independent Budget* co-authors are particularly concerned that the broken appropriations process continues to have a negative impact on the operations of the VA. Once again this year Congress failed to fully complete the appropriations process in the regular order, instead choosing to fund the Federal Government through a 6-month Continuing Resolution and subsequently completing the appropriations work for the current fiscal year nearly 6 months into the year. As a result of the enactment of advance appropriations, the health care system is generally shielded from the difficulties associated with late appropriations (an occurrence that has become the rule, not the exception). However, we cannot be certain that health care operations have not been negatively impacted by this 6-month continuing resolution. Moreover, the rest of the operations of the VA have most certainly been hampered by this broken process.

The Independent Budget co-authors remain concerned about steps VA has taken in recent years in order to generate resources to meet ever-growing demand on the VA health-care system. In fact, once again this year the Administration continues to rely upon "management improvements," a popular gimmick that was used by previous Administrations to generate savings and offset the growing costs to deliver care. The FY 2014 Budget Request includes estimates for savings as a result of presumed "management improvements." As a result, the Administration concludes that it can reduce appropriations requirements for FY 2014 and FY 2015. The budget specifically outlines $482 million in proposed savings for both FY 2014 and FY 2015. Additionally, the budget projects $1.328 billion in operational improvements for both

FY 2014 and FY 2015. This is a wholly unacceptable way to fund the operations of the VA health care system. These savings are often never realized leaving VA short of necessary funding to address ever-growing demand on the health-care system.

Additionally, the VA continues to overestimate and underperform in its medical care collections. Overestimating collections estimates affords Congress the opportunity to appropriate fewer discretionary dollars for the health care system. However, when the VA fails to achieve those collections estimates, it is left with insufficient funding to meet the projected demand. As long as this scenario continues, the VA will find itself falling farther and farther behind in its ability to care for those men and women who have served and sacrificed for this Nation. The fact that the VA continues to experience problems with its medical care collections reflects an even greater need to Congress to properly analyze, and if necessary, revise the advance appropriations from the previous year to ensure that the VA health care system is getting the resources it needs.

FUNDING FOR FY 2014

For FY 2014, *The Independent Budget* recommends approximately $58.8 billion for total medical care, an increase of $3.3 billion over the FY 2013 operating budget. Meanwhile, the Administration recommended, and Congress recently approved in Public Law 113–6, the "Full-Year Continuing Appropriations Act," an advance appropriation for FY 2014 of approximately $54.4 billion in discretionary funding for VA medical care. When combined with the $3.1 billion Administration projection for medical care collections, the total available operating budget recommended for FY 2014 is approximately $57.5 billion. We believe that this level is insufficient to fully meet the continually growing demand for the wide range of health care services in the VA. Unfortunately, the Administration only recommends an additional $158 million for funding for FY 2014. Once again, it appears that the Administration has offered limited analysis and only minor revision of those estimates originally recommended in the advance appropriations estimate for FY 2014 last year.

The medical care appropriation includes three separate accounts—Medical Services, Medical Support and Compliance, and Medical Facilities—that comprise the total VA health-care funding level. For FY 2014, *The Independent Budget* recommends approximately $47.4 billion for Medical Services, approximately $800 million more than the advance appropriations (when medical care collections are also taken into account) included in Public Law 113–6, the "Full-Year Continuing Appropriations Act for FY 2013." Our Medical Services recommendation includes the following recommendations:

Current Services Estimate	$45,552,079,000
Increase in Patient Workload	1,184,999,000
Additional Medical Care Program Costs	675,000,000
Total FY 2014 Medical Services	$47,412,078,000

Our growth in patient workload is based on a projected increase of approximately 81,200 new unique patients—priority groups 1–8 veterans and covered nonveterans. We estimate the cost of these new unique patients to be approximately $827 million. The increase in patient workload also includes a projected increase of 96,500 new Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF), as well as Operation New Dawn (OND) veterans at a cost of approximately $358 million. Our recommendations represent an increase in projected workload in this population of veterans over previous years as a result of the withdrawal of forces from Iraq, the drawdown of forces in Afghanistan, and a potential drawdown in the actual number of servicemembers currently serving in the Armed Forces. And yet, we believe that growth in demand for this cohort specifically could be far greater given the changing military policies mentioned above. In fact, we believe that recent reporting from the VA suggests that the actual number of new unique OEF/OIF/OND veterans is greater than 120,000. This leads us to conclude that our estimate of cost for this population should be even greater.

Finally, *The Independent Budget* believes that there are additional projected funding needs for VA. Specifically, we believe there is real funding needed to address issues in the VA's long-term care program and to provide additional centralized prosthetics funding (based on actual expenditures and projections from the VA's prosthetics service). In order to support the rebalancing of VA long-term care in FY 2014, we believe $112 million should be provided. Additionally, we believe $75 million should be targeted at the VA's Veteran Directed-Home and Community Based Services (VD-HCBS) program. The remainder of the $375 million that the *IB* rec-

ommends for long-term care services would begin to restore the VA's long-term care capacity to the level mandated by Public Law 106–117, the "Veterans Millennium Health Care and Benefits Act." In order to meet the increase in demand for prosthetics, the *IB* recommends an additional $300 million. This increase in prosthetics funding reflects an increase in expenditures from FY 2012 to FY 2013 and the expected continued growth in expenditures for FY 2014.

For Medical Support and Compliance, *The Independent Budget* recommends approximately $5.84 billion. This recommendation is approximately $189 million less than the advance appropriation amount recently included in Public Law 113–6. Finally, for Medical Facilities, *The Independent Budget* recommends approximately $5.57 billion. While our recommendation does not include an additional increase for Non-Recurring Maintenance (NRM), it does reflect a FY 2014 baseline of approximately $750 million. While we appreciate the significant increases in the NRM baseline over the last couple of years, total NRM funding still lags behind the recommended two to four percent of plant replacement value. In fact, VA should actually be receiving at least $1.7 billion annually for NRM. Meanwhile, we are very disappointed that the advance appropriation amount included in Public Law 113–6 significantly reduces funding for Medical Facilities, particularly with regards to the NRM portion of that account. This level of funding, particularly if the trend continues in the coming years, will have a devastating impact on the ability of the VA to meet the maintenance needs of the health care system. The impact will be even more pronounced given the fact that the Administration's FY 2014 Budget Request decimates funding for Major Construction and provides only a marginal increase for Minor Construction. Given the current condition of VA's existing infrastructure, Congress and the Administration need to show greater commitment to these needs and provide truly adequate funding.

For Medical and Prosthetic Research, *The Independent Budget* recommends $611 million. This represents approximately a $28 million increase over the FY 2013 appropriated level, and approximately $25 million more than the Administration's FY 2014 recommendation. The VA research program is a jewel within the VA that we support without hesitation or reservation. That program and its nearly 4,000 principal investigators have made myriad improvements not only to veterans' health in VA care, but have elevated the standard of health care of the Nation and the world. Despite scientific discoveries and prosthetic inventions too numerous to mention here but that are well known, the Administration now for the fourth year in a row has requested essentially flat funding for VA research, and Congress has effectively acquiesced. From FY 2011 through the FY 2013 appropriation, virtually nothing has been added by Congress to that program's budget baseline. No allowance has been made to cover uncontrollable research inflation, which averages around 3 percent annually; no funds have been provided for new initiatives beyond the baseline; and no funds have been requested or provided to help repair or upgrade VA's research laboratories, concerning which a 2012 independent evaluation estimated that almost $800 million would be required to bring them up to par. And disappointingly, no funds have been requested for special research initiatives focused on the needs of Iraq and Afghanistan veterans. These are major lapses that deserve correction.

ADVANCE APPROPRIATIONS FOR FY 2015

As explained previously, Public Law 111–81 required the President's budget submission to include estimates of appropriations for the medical care accounts for FY 2013 and subsequent fiscal years. With this in mind, the VA Secretary is required to update the advance appropriations projections for the upcoming fiscal year (FY 2014) and provide detailed estimates of the funds necessary for the medical care accounts for FY 2015.

For the first time this year, *The Independent Budget* offers baseline projections for funding for the medical care accounts for FY 2015. While we have previously deferred to the Administration and Congress to provide sufficient funding through the advance appropriations process, we have growing concerns that this responsibility is not being taken seriously. The fact that for two fiscal years in a row the Administration recommended funding levels that were not changed in any appreciable way upon review, and the fact that Congress simply signed off on those recommendations without thorough analysis, leads us to conclude that VA funding is falling farther and farther behind the growth in demand for services. We believe the continued feedback from veterans around the country about long wait times and lack of access to services affirms this belief. As such, we have decided to offer our own estimates of what we believe the true resource needs will be for the VA health care system in FY 2015.

For FY 2015, *The Independent Budget* recommends approximately $61.6 billion for total medical care, approximately $2.8 billion more than what the Administration has recommended for advance appropriations for FY 2015. We believe that this recommendation by the Administration is woefully inadequate to address the future needs of veterans seeking health care services from the VA. Our recommendation includes approximately $49.8 billion for Medical Services, approximately $1.6 billion more than the advance appropriations recommendation (when a medical care collections estimate of $3.2 billion is taken into account). Our Medical Services recommendation includes the following recommendations:

Current Services Estimate	$48,042,797,000
Increase in Patient Workload	1,105,821,000
Additional Medical Care Program Costs	675,000,000
Total FY 2015 Medical Services	$49,823,618,000

Our growth in patient workload is based on a projected increase of approximately 60,000 new unique patients—priority groups 1–8 veterans and covered nonveterans. We estimate the cost of these new unique patients to be approximately $737 million. The increase in patient workload also includes a projected increase of 96,500 new OEF/OIF/OND veterans at a cost of approximately $369 million. Meanwhile, we are particularly interested to see the trends that the VA Budget Request projects for new utilization in the coming years. While the growth in utilization of some new unique patients seems to be trending downward, we believe that the OEF/OIF/OND population will continue to trend upward as the military services drawdown their forces and as worldwide conflicts end. Additionally, it remains to be seen what impact the full implementation of the Affordable Care Act will have on utilization of VA health care services.

As with FY 2014, *The Independent Budget* believes that there are additional projected funding needs for VA. In FY 2015, the *IB* once again believes that $375 million should be directed toward VA's long-term care program. Additionally, we believe that a continued increase in centralized prosthetics funding will be essential. In order to meet the continued increase in demand for prosthetics, the *IB* recommends an additional $300 million.

Finally, for Medical Support and Compliance, *The Independent Budget* recommends approximately $6.14 billion, approximately $266 million more than the advance appropriation recommendation for FY 2015. Of greater concern to *The Independent Budget* is the continued effort to slash funding for Medical Facilities and particularly for NRM. For Medical Facilities, *The Independent Budget* recommends approximately $5.69 billion, nearly $950 million more than the advance appropriation for FY 2015. If the Administration, and ultimately Congress, continues this trend of woefully underfunding Medical Facilities, the long term condition of the infrastructure of VA will collapse. It is time for Congress to correct this wrong before it persists for too long.

Additionally, GAO's responsibility is more important than ever, particularly in light of their findings concerning the FY 2012 budget submission last year. The GAO report that analyzed the FY 2012 Administration budget identified serious deficiencies in the budget formulation of VA. Yet these concerns were not appropriately addressed by Congress or the Administration. This analysis and the subsequent lack of action to correct these deficiencies simply affirm the ongoing need for the GAO to evaluate the budget recommendations of VA. For this reason, we urge the Senate VA Committee to consider legislation similar to H.R. 806, the "Veterans Healthcare Improvement Act." This legislation permanently establishes the Government Accountability Office's reporting requirements as a part of VA advance appropriations.

Finally, we would also like to urge the Committee to consider legislation similar to H.R. 813, the "Putting Veterans Funding First Act of 2013," introduced by House Committee on Veterans' Affairs Chairman Jeff Miller (R-FL) and Ranking Member Mike Michaud (D-ME). This legislation requires all accounts of the VA to be funded through the advance appropriations process. It would provide protection for the operations of the entire VA from the political wrangling that occurs as a part of the appropriations process every year.

Ultimately, the health care, research, and construction accounts of the Administration's FY 2014 Budget Request and FY 2015 advance appropriations are totally unacceptable. Those funding levels specifically do not properly reflect the obligation that this country has to "care for him who shall have borne the battle, and his widow and his orphan."

Once again, we thank you for the opportunity to submit our views for the record. The co-authors of *The Independent Budget* would be happy to answer any questions that you might have.

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PREPARED STATEMENT OF WOUNDED WARRIOR PROJECT

Chairman Sanders, Ranking Member Burr and Members of the Committee: Thank you for inviting Wounded Warrior Project to submit our views on the President's VA budget for Fiscal Year 2014, and for your timely focus on this plan.

WWP welcomes the commitment to veterans reaffirmed in this budget, and deeply appreciates the broad recognition it provides to the debt this country owes those who served and sacrificed. That recognition, manifest in funding increases at a time of fiscal constraint for important programs within the Department of Veterans Affairs signals an ongoing effort to stand by America's veterans.

Nevertheless, one can rightly look deeper and ask—more than a decade into a war that continues to shatter bodies and minds—whether this budget truly meets the very profound needs experienced by many of our wounded warriors. This surely is an apt lens through which the Committee can look.

VA does certainly have additional programmatic resource needs. Importantly, however, we see this budget as falling short in some key areas—both with respect to its failure to make timely programmatic investments in strategically important areas, and in maintaining a largely unchanging course in areas where we would have hoped for new and bolder vision.

To illustrate the point, it is noteworthy that this budget asks Congress to make permanent two tax credits to encourage employers to hire veterans. For many warriors, however, military careers were cut short by life-altering injuries, and the challenge of finding employment is compounded by the need to develop new skills, tools, training or education, even as they attempt to re-integrate into their communities and rebuild their lives. While the Post-9/11 GI Bill is an answer for some, many others need good counseling and support. VA's vocational rehabilitation and education program (VR&E) should be an answer, a key transitional pathway. VA has failed, however, to give this program the priority and resource support needed for this generation of wounded warriors to get the kind and extent of help they need. For too long, for example, the size of counselors' caseloads has limited their ability to provide the extent of support needed, particularly for those with PTSD and Traumatic Brain Injury. It is disappointing, therefore, to see that VR&E staffing levels under this budget remain flat, despite a projected increase in workload. But absent any plan to increase funding for this important program, we urge consideration of another approach to better ensure adequate support for wounded warriors—establish a system of prioritization. Consistent with the system of prioritization already in law with regard to enrollment in the VA health care system,[1] the vocational rehabilitation program could be structured to establish relative priorities, such that the most severely injured would have higher priority for receiving needed rehabilitative services than a veteran with a substantially lower percentage of disability.

Last year, adopting provisions on long-term TBI care that originated in legislation introduced by Senator Boozman and Congressman Tim Walz, this Committee approved and Congress enacted the Honoring America's Veterans and Caring for Camp Lejeune Families Act. The Boozman-Walz provision requires that VA provide veterans suffering from TBI with the opportunity to maximize independence through community-based services such as supported employment and life-skills coaching. It further requires that rehabilitation focus not only on achieving functional gains but on sustaining them. This important provision was intended to remedy VA's failure to meet such basic expectations of TBI rehabilitation. We see no indication in the fiscal plan for FY 2014, however, that VA is in any way budgeting to implement this important provision.

In contrast, VA points with some pride to a significant increase in funding for mental health. While we applaud the commitment reflected in that budgeting decision, we do not see a commensurate basis for confidence that the funding will have the decisive impact for which one would hope. Nor do we see evidence of a clear strategic plan underlying the $7 billion mental health budget. Instead we see relatively little in the way of course-correction beyond a plan to increase funding. We see little in the budget to foster a belief, for example, that those warriors who need, but have been reluctant to seek, behavioral health care from VA will now visit VA facilities. Many warriors have begun—only to drop out of—treatment; the budget suggests nothing to win them back or to keep others from following that course. One

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[1] 38 U.S. Code section 1705.

resource that many of our warriors cite with approval is the Vet Center program. But despite the drawdown and the likelihood of greater numbers in need of help, the budget projects no growth in that program. The mental health challenges facing wounded warriors alone would lead one to believe that VA should look beyond its own facilities and plan to work with the communities where our warriors live. But the budget is devoid of a real strategy for engaging communities, or even of a plan to increase substantially the numbers of veterans who would be afforded mental health care through fee or contract arrangements. We do, however, see two promising signs: the hiring and training of veterans to provide peer-support services is a very encouraging step, as is the steady growth in tele-mental health services. These are dwarfed, however, by a seeming need to be "doing something," that translates into a plan simply to increase funding.

In a similar vein, the budget proposes increases in funding in a number of high-visibility programmatic areas, several of keen importance to wounded warriors. To illustrate, the budget proposes increases in funding for prosthetics. What it does not do, however, is acknowledge the need to improve prosthetics care—an area in which VA's leadership role has declined and where a vision for change has yet to be realized.

Finally, we welcome the priority given VA's effort to remedy the long-festering compensation and pension claims backlog. Wounded warriors certainly suffer as the result of shortcomings in a system intended to provide timely disability compensation. We encounter too many warriors who after sustaining severe wounds, receive only limited military retired pay (often because of too-hurried military processing), and too often experience many months of severe financial need while VA completes the process of adjudicating the warrior's claim. While we at WWP have provided monetary and other supports to individuals who find themselves in such straits, there should be no excuse for leaving combat-wounded warriors in limbo. It bears noting, however, that these problems are not exclusively of VA's making. While VA does "own" serious claims-adjudication problems, we should be cautious in believing that additional funding alone will produce an optimal system. (We recognize that VA has instituted some important streamlining efforts, though the promise in those efforts will take time to realize.) Not only are there "upstream" problems that require DOD resolution, but long experience persuades us that timely, effective claims-adjudication will continue to elude the Veterans Benefits Administration (VBA) until it effectively grapples with some underlying managerial problems. Indeed, in framing the challenge numerically—viewing determinations of service-incurrence and extent of disability solely as work to be counted and sped through a system—VBA risks cementing in place a system that does not necessarily serve either the veteran or its workforce well. These are not after all assembly-line "widgets," but determinations critical to the well-being of a wounded individual. Understandably, the singular focus on "moving claims" has bred morale problems among adjudication staff. While appreciating that VBA is redesigning systems and harnessing technology to eliminate a claims backlog, there is room as well for a complementary focus—one aimed at instilling in leadership and management the goal of empowering employees to do good work, rather than instilling a fear of punishment for failing to meet numerical indicators. Leadership is a first step in establishing that much-needed cultural change.

Thank you for considering our views.

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