S. HRG. 114–611

THE FISCAL YEAR 2017 BUDGET FOR VETERANS' PROGRAMS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED FOURTEENTH CONGRESS

SECOND SESSION

FEBRUARY 23, 2016

Printed for the use of the Committee on Veterans' Affairs

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

U.S. GOVERNMENT PUBLISHING OFFICE

20–470 PDF WASHINGTON : 2017

For sale by the Superintendent of Documents, U.S. Government Publishing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON VETERANS' AFFAIRS

JOHNNY ISAKSON, Georgia, *Chairman*

JERRY MORAN, Kansas
JOHN BOOZMAN, Arkansas
DEAN HELLER, Nevada
BILL CASSIDY, Louisiana
MIKE ROUNDS, South Dakota
THOM TILLIS, North Carolina
DAN SULLIVAN, Alaska

RICHARD BLUMENTHAL, Connecticut, *Ranking Member*
PATTY MURRAY, Washington
BERNARD SANDERS, (I) Vermont
SHERROD BROWN, Ohio
JON TESTER, Montana
MAZIE K. HIRONO, Hawaii
JOE MANCHIN III, West Virginia

TOM BOWMAN, *Staff Director*
JOHN KRUSE, *Democratic Staff Director*

C O N T E N T S

FEBRUARY 23, 2016

SENATORS

WITNESSES

INDEPENDENT BUDGET REPRESENTATIVES

OTHER VETERANS SERVICE ORGANIZATIONS

THE FISCAL YEAR 2017 BUDGET FOR VETERANS' PROGRAMS

TUESDAY, FEBRUARY 23, 2016

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

The Committee met, pursuant to notice, at 10:02 a.m., in room 418, Russell Senate Office Building, Hon. Johnny Isakson, Chairman of the Committee, presiding.

Present: Senators Isakson, Moran, Boozman, Cassidy, Rounds, Tillis, Sullivan, Blumenthal, Brown, Tester, Hirono, and Manchin.

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

Chairman ISAKSON. Welcome to the Senate Committee on Veterans' Affairs. Thank you for being here today. Mr. Secretary, thank you for coming today and bringing your cast of thousands. You have got a lot of support here today. We have got the Secretary—big budget, big support.

We are proud to have Secretary McDonald here today. We are proud to have Danny Pummill, Dr. Shulkin—great to have you here, and thanks for the great job you are doing—Ronald Walters, LaVerne Council, and Ed Murray. We appreciate all of you being here. With all that support, Mr. Secretary, I am sure you are going to do a great job.

I will make my opening statement and then turn to Senator Blumenthal, and then we will go straight to your testimony. As in the last case, Mr. Secretary, I do not want you to feel compelled by our customary 5-minute standard. I want you to be able to say what you have to say, understanding the average attention span of a U.S. Senator is probably about 9 minutes. [Laughter.]

After that, we all start blinking. Speaking for myself; that is a self-imposed limitation.

Thank you very much, Mr. Secretary, for being here today. We are looking forward to discussing the $182 billion budgetary appropriation for the Veterans Administration, an 8.9-percent increase over the fiscal year 2016 budget. Should it be adopted, medical care funding would increase by $3.8 billion, or 6.3 percent.

The Office of Information Technology, or IT, would be increased by $145 million. I am very encouraged that you have embraced a program to merge the non-VA programs to see to it that Choice is delivered correctly and appropriately and funded well. We look forward to hearing your discussion on that.

Your testimony also talks a little bit about accountability. In fact, I read the information. "Accountability" is a word that is used one time, but it is probably the most important thing that this Committee is really interested in.

You and I had a great meeting at your office last week, Mr. Secretary, and I want to acknowledge publicly with the Members of the Committee to thank Senator Blumenthal and Senator Murray's staff for the work they are doing.

I have stated publicly—and I am doing it again right now publicly—that my goal is to see to it that by the end of March we have an accountability bill for the Veterans Administration employees that is right for the veterans and right for those employees, and that we look to the future to see to it, if we have problems in the future—which I hope we will never have them, but life is life; you are going to have them—that we have a defensible accountability system within the Department to correct a wrong and make it not happen again.

We have had too many cases, most of them, if not all of them are pre-your service, Mr. Secretary. The Inspector General reports from 2 and 3 years ago that are impossible to explain, highlight lack of accountability and implementation that is impossible to understand. We want to put that behind us for the future and build a platform that is good for the employees, good for middle management, and good for the Veterans Administration, but, most importantly, good for the veterans themselves. They need to know they are getting quality services and quality accountability. It is very important that we do that. That is the most important thing that we can do.

Last, you talked about reforming the appeals process. I hope you will address that in your remarks. That is something we have talked about many times, have not done, and it is something we rightfully need to do. I would love to know as much specifics about what you are going to recommend as possible.

We are glad you are here today. We appreciate your service to the country. It is an honor for me to now introduce the Ranking Member, Senator Blumenthal.

OPENING STATEMENT OF HON. RICHARD BLUMENTHAL, RANKING MEMBER, U.S. SENATOR FROM CONNECTICUT

Senator BLUMENTHAL. Thanks, Mr. Chairman, and I want to second your remarks about the need for an accountability bill which is, I think, making progress with very close bipartisan cooperation between our staffs and ourselves. I want to thank the Secretary and the President for a very robust and profoundly significant budget. The VA is going through major changes as it looks toward the future and prepares for an even more challenging future so far as the needs of our veterans are concerned in areas of not only health care but also jobs, job training, and skill preparation and, of course, homelessness. Connecticut, I am very delighted to say, is at the forefront of that effort, in fact, announced just last week that we have ended homelessness for veterans in Connecticut. Of course, that is a continuing effort. It is a milestone, not a finish line, and we need to continue to provide permanent housing for all

of our veterans, not just a temporary or transitional forms of housing.

This budget request focuses, fortunately, on a number of areas that I think are important, breakthrough priorities such as community health care, accountability, and the appeals process. I also think that in terms of our medical care, the challenges of Post Traumatic Stress and the research and outreach that needs to be done need to be given priority.

I hope that this hearing will be an opportunity to hear from you about more of the details of this proposal, but I also think that the vision for the future is tremendously important not only this year but looking beyond this year, just as you would at a company like Proctor & Gamble—beyond this quarter, beyond this year—to think about what this enterprise is going to look like in 5 years, in 10 years. Now is the time to build for the veterans who will be coming out of the service, and there will be more and more of them over the next few years as we downsize our active-duty force.

So, I thank you for being here. I am looking forward to hearing from you and from the veterans service organizations that perform such an important and vital role in keeping us informed about veterans' needs while making sure that all of us are held accountable.

Thank you.

Chairman ISAKSON. Thank you, Senator Blumenthal.

Mr. Secretary, it is all yours.

STATEMENT OF HON. ROBERT A. MCDONALD, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY HON. DAVID J. SHULKIN, M.D., UNDER SECRETARY FOR HEALTH; DANNY PUMMILL, ACTING UNDER SECRETARY FOR BENEFITS; RONALD E. WALTERS, INTERIM UNDER SECRETARY FOR MEMORIAL AFFAIRS; HON. LAVERNE COUNCIL, ASSISTANT SECRETARY FOR INFORMATION AND TECHNOLOGY AND CHIEF INFORMATION OFFICER; AND ED MURRAY, INTERIM SECRETARY FOR MANAGEMENT AND INTERIM CHIEF FINANCIAL OFFICER

Secretary MCDONALD. Thank you, Mr. Chairman.

Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee, thanks for the opportunity to present the President's 2017 budget and 2018 advance appropriations requests for the Department of Veterans Affairs. I have a written statement that I ask be submitted for the record, Mr. Chairman.

Mr. Chairman, the President's proposal is another strong, tangible sign of his devotion to veterans and their families. It proposes $182.3 billion for the Department in fiscal year 2017, which includes $78.7 billion in discretionary funding, a 4.9-percent increase above the 2016 enacted level, largely for health care. It includes $12.2 billion for care in the community and a new medical community care budget account consistent with the VA budget and Choice Improvement Act. It includes $103.6 billion in mandatory funding for veterans benefit programs and $103.9 billion in advance appropriations for our three major mandatory veterans benefit accounts.

It supports VA's four agency priority goals and our five MyVA transformational objectives to modernize VA and improve the veteran experience, improve the employee experience, improve inter-

nal support services, establish a culture of continuous improvement, and expand strategic partnerships. Those five transformational objectives are about growing VA into the high-performance organization veterans deserve and taxpayers expect.

I learned over three decades in the private sector at Procter & Gamble what makes a high-performance organization. It takes a clear purpose, strong values, enduring principles, and technical competence. High-performance organizations depend on sound strategies. They thrive with passionate leaders who are willing to take tough decisions and make bold changes to improve. High-performance organizations require responsive systems and processes designed and managed in a high-performing culture.

Well, VA has a clear purpose in our most noble mission to care for those who have borne the battle. We have strong core values: integrity, commitment, advocacy, respect, and excellence. Our strategic plan makes clear that we are a customer service organization. We serve veterans.

Our 5 MyVA transformational objectives and our 12 breakthrough priorities for 2016 are about accomplishing that strategy. Ten of our top 16 executives are new since I became Secretary. They are part of a growing team of talented, enthusiastic former business leaders and experienced Government and health care professionals. They are making innovative changes and creating opportunities for even greater progress.

We are making the sweeping changes necessary for VA to be a high-performing organization, and we will know we are getting there when, by design, veterans' needs shape our systems, our processes, and our culture.

For example, a responsive health care system for veterans means: veterans have 24/7 access to VA systems and know where to get accurate answers, whether that is their Veteran Contact Center or the Veterans Crisis Line; veterans calling or visiting primary care facilities and medical centers have their clinical needs addressed the very same day; veterans calling for new mental health appointments receive suicide risk assessments and immediate care, if needed; and veterans already engaged in mental health care who need urgent attention speak to a provider the very same day.

For employees serving veterans, it means a high-performing culture where continuous improvement drives responsive, forward thinking and innovative change. It means training our workforce on advanced business techniques. It means responsive performance management systems that resonate with employees and encourage rather than discourage continuous improvement and excellence. It means proper employee placement, clear performance expectations, continuous feedback, and employees equipped with the tools to achieve excellence. It means executive performance ratings and bonuses that reflect actual performance and take into account relevant inputs like veteran outcomes, results of employee surveys, and 360-degree feedback. It means modern automated systems in place of antiquated, cumbersome, and costly paper processes. These are a few characteristics of high-performing systems, processes, and culture. We are advancing along these lines and many others.

We launched our cascading Leading Developing Leaders training last year with 450 senior field leaders. It is not a single event. It is a continuous enterprise-wide process of leaders teaching leaders teaching leaders in order to inculcate lasting change. So far, we have trained more than 5,000 employees. By the year's end, we will have trained over 12,000 senior leaders, empowering teams to dramatically improve care and service delivery to veterans while creating better work environments for employees.

Private sector leadership experts are developing VA teams in new ways with cutting-edge business skills like Lean Six Sigma and Human Centered Design. We are using Human Centered Design and Lean Six Sigma right now to redesign the compensation and pension process because veterans find it confusing and burdensome. We are looking at industry best practices and planning for an automatic performance management solution for general schedule employees. We can streamline that process, improve rating accuracy, and interface with OPM. All of this is focused on moving VA into the ranks of high-performing organizations. That goal is in reach, but we need your continued support to achieve it.

I appreciate our extensive discussion at the end of January on our MyVA 12 breakthrough priorities for 2016. The proposed budget continues support of those priorities into 2017. It provides $65 billion for veterans' medical care, a 6.3-percent increase over 2016. It provides $66.4 billion in advance appropriations for the VA medical care programs in 2018. That is a 2.2-percent increase above the 2017 request. It provides $7.8 billion for mental health, funds Veteran Contact Centers in the field and Veterans Crisis Line modernization. It funds telehealth access, enhances health programs for women veterans, and provides an incredibly effective hepatitis C treatment to an expected 35,000 veterans.

To help integrate all the MyVA initiatives across the enterprise, it provides $2.6 million for the MyVA program office. To continue training field employees on advanced business skills and establishing high customer service standards, it increases funding for our Veteran Experience Office by 47 percent.

We will continue doing all we can to squeeze as much as possible out of every single budget dollar.

Our pharmacy benefits management program avoided $4.2 billion in unnecessary drug expenditures last year. We saved over half a billion dollars in travel spending since 2013, exceeding goals of the President's campaign to cut waste. We have reduced employee award spending $150 million, and we have reduced SES bonuses 64 percent between 2011 and 2015 by rigorously linking awards to performance.

Since 2011, we have saved $16.6 million using more efficient training and meeting methods. We are already saving $10 million annually under our MyVA's five-district structure that we announced in January 2015.

We have saved approximately $5.5 million from 2011 to 2015 by strengthening controls over permanent change-of-station moves. Now that we have implemented electronic claims processing, we will save millions of dollars each year in paper storage.

We are committed to doing everything we can with everything we are given, but many, many important priorities for meaningful

change require substantial congressional action. There are more than 100 legislative proposals in the budget. Over 40 of them are new this year, and some are absolutely critical just to maintain our current ability to purchase non-VA care.

It is critical that VA is competitive with the private sector so we can attract top talent. Nowhere is that more important than in health care. So, among other VHA personnel authority adjustments, we are proposing flexibility on the maximum 80-hour pay period requirement for certain medical professionals. It will help improve hospital operations and attract the best possible hospital staff who prefer more flexible schedules. We are proposing critical compensation reforms for network and hospital directors.

Likewise, the Title 38 SES proposal we are working on is about being competitive with the private sector in recruiting and in compensation. It is not just about firing people. It is about treating VA career executives more like their private sector counterparts. It is the kind of flexibility that attracts top performers in the private sector as well. VA needs that flexibility, too.

We need your help to transform and streamline VA's care in the community systems and programs to best serve veterans. We need your help modernizing and clarifying VA's purchase care authorities to maintain veterans' access to timely community care everywhere in the country. We have provided Congress with detailed legislation addressing this challenge more than 9 months ago, and I have consistently identified it as a top legislative priority. Above all, this needs to get done in this Congress to ensure that strong foundation for access to community care.

Artificial funding restrictions are unresponsive to veterans' needs, so we are proposing a general transfer authority that allows me some measured spending flexibility to respond to the veterans' emerging needs.

The appeals process set by statute is archaic, unresponsive, and not serving veterans well. Last year, the Board was still adjudicating an appeal that originate 25 years ago and had been decided more than 27 times. The budget proposes a simplified, streamlined, and fair appeals process so that 5 years from now veterans have appeals resolved within 1 year of filing. While requiring short-term staffing increases to contend with the 445,000 pending appeals, legislating a simplified appeals process can save more than $139 million beginning in 2022.

We need congressional authorization of 18 leases submitted in VA's 2015 and 2016 budget request as well as authorization of eight major construction projects included in the fiscal year 2016 budget.

We need your support for six additional replacement major medical facility leases, two major construction projects, and four cemetery projects in the 2017 budget. Passing special legislation for VA's West Los Angeles campus will get us positive results for veterans in that community who are most in need.

I have outlined a few opportunities for change here. This Congress, with today's VA's leadership, can make these changes and more for all veterans and for veterans in the future. Then we can look back on this year as the year that we turned the corner.

I appreciate the support you have shown veterans, the Department, and the MyVA transformation. On behalf of veterans and the VA employees serving them every single day, thank you for this opportunity. We look forward to your questions.

Thank you, Mr. Chairman.

[The prepared statement of Secretary McDonald follows:]

PREPARED STATEMENT OF HON. ROBERT A. MCDONALD, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Good morning, Chairman Isakson, Ranking Member Blumenthal, and Distinguished Members of the Senate Veterans' Affairs Committee. Thank you for the opportunity to present the President's 2017 Budget and 2018 Advance Appropriations (AA) requests for the Department of Veterans Affairs (VA). This budget continues the President's faithful support of Veterans and their families and survivors, and it sustains VA's historic transformation. It will provide the funding needed to enhance services to Veterans in the short term, while strengthening the transformation of VA that will better serve Veterans in the future.

A VISION FOR THE FUTURE

VA's vision for the future is to be the No. 1 customer-service agency in the Federal Government. The American Customer Satisfaction Index already rates our National Cemetery Administration No. 1 with respect to customer service. In addition, for the sixth year in a row, VA's Consolidated Mail Outpatient Pharmacy received J.D. Power's highest customer satisfaction score among the Nation's public and private mail-order pharmacies. These are compelling examples of excellence. We aim to make that so for all of VA.

We are transforming the entire Department, not just making incremental changes to parts of it. We began in July 2014 by immediately reinforcing the importance of our inspiring mission—caring for those "who shall have borne the battle," their families, and their survivors. Then, we re-emphasized our commitment to our exceptional I-CARE Values—Integrity, Commitment, Advocacy, Respect, and Excellence. To provide timely quality care and benefits for Veterans, everything we are doing is built, and must be built, on the rock-solid foundation of mission and values.

MyVA is the catalyst making VA a world-class service provider. It is a framework for modernizing VA's culture, processes, and capabilities so we put the needs, expectations, and interests of Veterans and their families first, and put Veterans in control of how, when, and where they wish to be served.

Listening to others' perspectives and insights has been, and remains, instrumental in shaping our transformation. We have taken advantage of an unprecedented level of outreach to the field and our stakeholders.

In my first months as Secretary, I assessed VA and recognized that we would need to change fundamental aspects of every part of VA in order to rise to excellence. I shared my assessment's results with President Obama and received his guidance. I discussed my findings with you and other Members of Congress—privately and during hearings. And I consulted with literally thousands of Veterans, VA clinicians, VA employees, and Veteran Service Organizations (VSOs) and other stakeholders in dozens of meetings.

Since my July 29, 2014, confirmation, I have made 277 visits to VA field sites in more than 100 cities, including 47 visits to VA medical centers, 30 visits to homeless Veterans program sites, 16 visits to Community Based Outpatient Clinics, 15 Regional Offices, and 9 Cemeteries. I have attended 61 Veteran engagements through public and private partnerships and 60 stakeholder events to hear firsthand the problems and concerns impacting our Veterans. To recruit individuals to work for VA as medical professionals and in other critical fields, I have visited 50 medical schools, universities, and other educational institutions. This kind of outreach, partnership, and collaboration underpins our department-wide transformation to change VA's culture and make the Veteran the center of everything we do.

Progress

Transforming an organization of this size is an enormous undertaking. It will not happen overnight. But we are now running the government's second largest Department like a $166 billion Fortune 6 organization should be run. That is, balancing near term performance improvements while rebuilding VA's long-term organizational health.

Effective change often requires new leadership, and we have made broad changes. Of our top 16 executives, 10 are new to their positions since I became Secretary.

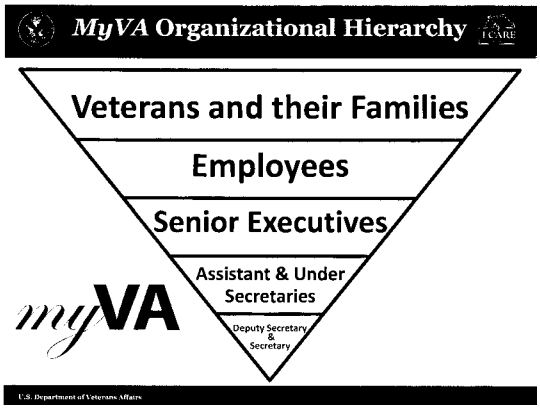
Our team today includes extensive executive expertise from the private sector: a former banking industry Chief Financial Officer and President of the USO; the former Chief Executive Officer of Beth Israel Medical Center in New York City and Morristown Medical Center in New Jersey; a former Chief Executive of Jollibee Foods and President of McDonald's Europe; a former Chief Information Officer of Johnson & Johnson and Dell Inc.; a former partner in McKinsey & Company's Transformational Change and Operations Transformation Practices; a retired partner in Accenture's Federal Services Practice; a former Chief Customer Officer for the city of Philadelphia who previously spent 10 years at United Services Association of America (USAA), one of the best and foremost customer-service organizations in the country; a former entrepreneur and CEO of multiple technology companies; and a retired Disney executive who spent 2010–2011 at Walter Reed National Military Medical Center enhancing the patient experience.

Most members of the executive leadership team are Veterans themselves. They have served from Vietnam to Iraq and Afghanistan, and each is here because he or she demonstrates a personal commitment to our mission. These fresh, diverse perspectives, combined with our more experienced government and health care executives, will continue to catalyze innovation and change.

Thanks to the continuing support of Congress, VSOs, union leaders, our dedicated employees, states, and private industry partners, we have made tremendous headway over the past 18 months. In 2015, we made notable progress building the momentum that will begin delivering transformational changes that VA needs.

Congress has passed key legislation—such as the Veterans Access, Choice, and Accountability Act and the Clay Hunt Suicide Prevention for American Veterans Act—that gives VA more flexibility to improve our culture and ability to execute effectively.

Consistent with the culture of a High Performance Organization that serves Veterans and their families, we have turned VA's structural pyramid upside down. Veterans and their families are at the top. The Office of the Secretary is at the bottom, *supporting* subordinate leaders and the workforce who are serving Veterans. This method of thinking and operating is a reminder to all employees and stakeholders that we are here to support our Veterans, not our bosses.



While reinforcing our I-CARE Values, we are transitioning from a rules-based culture that may neglect the human dimension of service to a principles-based culture grounded in values, sound judgment, and the courage and opportunity "to choose the harder right instead of the easier wrong. . . ."

We formed a *MyVA* Advisory Committee (MVAC) to advise us on our transformation. The MVAC is comprised of a diverse group of business leaders, medical professionals, experienced government executives, and Veteran advocates. The Chairman is retired Major General Joe Robles, former Chairman and CEO of USAA. The Vice Chairman is Dr. J. Michael Haynie, Air Force Veteran, Vice Chancellor of Syracuse University and founder of the Institute for Veteran and Military Families (IVMF). The MVAC includes executives with deep customer service and transformation expertise from organizations such as Amazon, The Cleveland Clinic, McKinsey & Company, Johns Hopkins, Mayo Clinic, as well as a former Surgeon General, a former White House doctor for three US Presidents, a university president who was a Rhodes Scholar from the Air Force Academy who currently serves

as a reserve Air Force Lieutenant Colonel, and advocates for both the traditional VSOs and post-9/11 Veterans' organizations.

Private sector leadership experts are bringing cutting-edge business skills and developing VA teams in new ways. We are training critical pockets of our workforce on advanced techniques like Lean and Human Centered Design. For example, working with the University of Michigan, we have already trained more than 5,000 senior leaders across the Nation in our "Leaders Developing Leaders." The Veterans Benefits Administration (VBA), Veterans Health Administration (VHA), and our Veterans Experience team collaborated using Human Centered Design and Lean techniques to redesign the Compensation and Pension Examination (C&P Exam) process because we received consistent feedback that the process—often, a Veteran's first impression of the VA when separating from service—can be a confusing and uncomfortable experience.

Across VA, we are encouraging different perspectives and listening to all of our key stakeholders, even those who are critical of VA. To benchmark and capture ideas and best practices along our transformation journey, we have been working collaboratively with world-class institutions like Procter & Gamble, USAA, Cleveland Clinic, Wegmans, Starbucks, Disney, Marriott and Ritz-Carlton, NASA, Kaiser Permanente, Hospital Corporation of America, Virginia Mason, DOD, and GSA, among others.

VA named the Department's first Chief Veteran Experience Officer and began staffing the office that will work with the field to establish customer service standards, spread best practices, and train our employees on advanced business skills.

Rather than asking Veterans to navigate our complicated internal structure, we are redesigning functions and processes to fit Veteran needs in the spirit of General Omar Bradley's 1947 proposition that "We are dealing with Veterans, not procedures; with their problems, not ours."

We are realigning VA to facilitate internal coordination and collaboration among business lines—from nine disjointed, disparate organizational boundaries and organizational structures to a single framework. That means down-sizing from 21 service networks to 18 that are aligned in five districts and defined by state boundaries, except in California. This realignment means opportunities for local level integration, and it promotes consistently effective customer service. Veterans from Florida to California, Puerto Rico to Maine, Alaska and Guam, and all parts in between, will see one VA.

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

At VA, we know that serving Veterans is a collaborative exercise, so we will not function in a vacuum. We are operating as part of a community of care, forming

strategic partnerships with external organizations to leverage the goodwill, resources, and expertise of valuable partners to better serve our Nation's Veterans and help address a wide variety of Veteran needs, including employment, homelessness, wellness, and mental health. Partners include respected organizations like the YMCA, the Elks, the PenFed Foundation, LinkedIn, Coursera, Google, Walgreens, academic institutions, other Federal agencies, and many more. These partnerships reflect our commitment to re-thinking how VA does business so we can leverage the strengths of others who also care for Veterans.

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

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

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

We continue to listen, learn, and grow.

VA'S AGENCY PRIORITY GOALS

In 2015, we were guided by and made notable progress toward reaching our three Agency Priority Goals (APGs)—(1) Improve Veteran Access to VA Benefits and Services, (2) End Veteran Homelessness, and (3) Eliminate the Disability Backlog. These accomplishments toward achieving our APGs demonstrate VA's commitment to using our resources effectively to improve care and benefits for Veterans.

Access

We expanded capacity by focusing on staffing, space, productivity, and VA Community Care.

Access. Since discovering the access challenges in Phoenix, Arizona, we have aggressively improved access to care, not just in Phoenix but across VA as a whole. For instance, in the first 12 months after discovering the Phoenix appointment backup, from June 2014 to June 2015, we completed 7 million more appointments than during the same period the year prior: 2.5 million of those appointments were at VA; 4.5 million appointments were in the community. Altogether in FY 2015, we completed 56.7 million appointments, nearly 2 million more than FY 2014. More than 97 percent (55 million) of those 56.7 million appointments were completed within 30 days of the clinically indicated or Veteran's preferred date, an increase of 1.4 million over FY 2014 numbers.

Veteran access is one of the five critical priorities supporting VA health care transformation with far-reaching impact across VA that Under Secretary for Health, Dr. David J. Shulkin announced in September 2015. With the Access Stand Downs, VHA is empowering each facility to focus on the needs of its specific population and refocusing people, tools, and systems on a journey of continuous improvement toward same-day access for primary care and urgent specialty care. The immediate goal is that no patients with urgent appointment requests in VA clinics with the

most critical clinical needs, such as cardiology, urology, and mental health, are waiting more than 30 days.

From November 9, through November 13, 2015, VHA conducted a complete review of all Veterans waiting for appointments—with a focus on those Veterans waiting for clinically important and acute services—to ensure that the wait was clinically appropriate as determined by the Veteran's treatment team. This process culminated with the VHA's first Access Stand Down on November 14th—a nationwide effort to ensure Veterans get the right care at the right time.

In the first Access Stand Down, VHA reviewed nearly 55,800 of the more than 56,000 Level One, stat, consults that were open more than 30 days (as of November 6, 2015), a herculean effort. Of those 55,800 urgent open consults reviewed, 82 percent (45,849) were scheduled or closed by the end of that first Stand Down.

Building on the November 14th Access Stand Down momentum and success, VHA is continuing to maximize accessibility to outpatient services with the coming February 27th, 2016 Access Stand Down. The February Stand Down is an opportunity to make another significant leap in dramatically enhancing Veterans' access to care. Clinical operations will meet customer demand through resource-neutral, continuous improvement at the facility-level and scaling-up excellence across the enterprise.

VetLink data is another way we are listening to Veterans. Since September 2015, VHA has analyzed preliminary data from VetLink, our kiosk-based software that allows us to collect real-time customer satisfaction information. In all three separate VetLink surveys to date—related to nearly half-a-million appointments—Veterans told us that about 90 percent of the time, they are either "completely satisfied" or "satisfied" with getting the appointment when they wanted it. However, about 3 percent of Veterans who participated in the survey were either "dissatisfied" or "completely dissatisfied," so we have more work to do.

Staffing. We increased net VHA staffing. VHA hired 41,113 employees, for a net increase of 13,940 health care staff, a 4.7 percent increase overall. That increase included 1,337 physicians and 3,612 nurses, and we filled several critical leadership positions, including the Under Secretary of Health.

Space. We activated 2.2 million square feet in FY 2015, adding to more than 1.7 million square feet of clinical space activated in FY 2014.

Productivity. We increased physician work Relative Value Units (RVUs) by 9 percent. VA completed more than 1.4 million extended hour completed encounters in primary care, mental health and specialty care in FY 2014 and more than 1.5 million in FY 2015, an increase of 5.7 percent in extended hour encounters.

Care in the Community

In 2015, VA obligated $10.5 billion for Care in the Community, including resources provided through the Veterans Choice Act—an increase of $2.3 billion (28 percent) over the 2014 level—which resulted in nearly 2.4 million authorizations for Veterans to receive Care in the Community from December 3, 2014 through December 2, 2015. Programmatically, this included care in the community for Veterans' dialysis, state home programs, community nursing care, Veterans home programs, emergency care, private medical facilities care, and care delivered at Indian health clinics. It also includes care under VA's CHAMPVA program for certain dependents who were entitled for that care.

Homelessness

Veteran homelessness has continued to decline, thanks in large part to unprecedented partnerships and vital networks of collaborative relationships across the Federal Government, across state and local government, and with both non-profit and for-profit organizations. Ending and preventing Veteran homelessness is now becoming a reality in many communities, including: the Commonwealth of Virginia; the State of Connecticut; New Orleans, Louisiana, Houston, Texas; Las Vegas, Nevada; Philadelphia, Pennsylvania; Syracuse, New York; Winston-Salem, North Carolina; and Las Cruces, New Mexico. In collaboration with our Federal and local partners, we have greatly increased access to permanent housing; a full range of health care including primary care, specialty care, and mental health care; employment; and benefits for homeless and at-risk for homeless Veterans and their families.

In FY 2015 alone, VA provided services to more than 365,000 homeless or at-risk Veterans in VHA's homeless programs. Nearly 65,000 Veterans obtained permanent housing through VHA Homeless Programs interventions, and more than 36,000 Veterans and their family members, including 6,555 children, were prevented from becoming homeless.

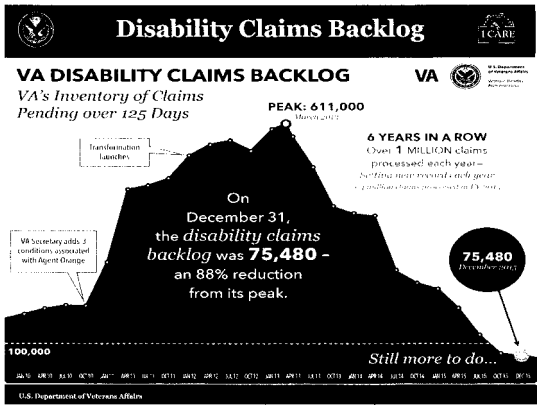
Overall Veteran homelessness dropped by 36 percent between 2010 and 2015, based on data collected during the annual Point-in-Time (PIT) Count conducted on a single night in January 2015. We saw a nearly 50 percent drop in unsheltered

Veteran homelessness. Since 2010, more than 360,000 Veterans and their family members have been permanently housed, rapidly rehoused, or prevented from falling into homelessness.

Backlog

VA transitioned disability compensation claims processing from a paper-intensive process to a fully electronic processing system; as a result, 5,000 tons of paper per year were eliminated.

In FY 2015, VA decided a record-breaking 1.4 million disability compensation and pension (rating) claims for Veterans and their survivors—the highest in VA history for a single year. As of December 31, 2015, VA had driven down the disability claims backlog to 75,480, from a peak of over 611,000 in March 2013.



2016–2017 VA's Agency Priority Goals

In a collaborative, analytic process, VA has established our four new Agency Priority Goals (APGs). In FYs 2016 and 2017, our four APGs buildupon and preserve progress we made in 2015. The new APGs will help accelerate transformation to *MyVA* and advance our framework for allocating resources to improve Veteran outcomes. Our new APGs are to (1) Improve Veterans Experience with VA, (2) Improve VA Employee Experience, (3) Improve Access to Health Care as Experienced by the Veteran, and (4) Improve Dependency Claims Processing. While no longer APGs, VA will continue to buildupon the progress it has already made related to ending Veterans' Homelessness and eliminating the compensation rating claims backlog.

FY 2017 BUDGET REQUEST

Our 2017 budget requests the necessary resources to allow us to serve the growing number of Veterans who selflessly served our Nation.

The 2017 Budget requests $182.3 billion for VA—$78.7 billion in discretionary funding (including medical care collections) and $103.6 billion in mandatory funding for Veterans benefit programs. The discretionary request reflects an increase of $3.6 billion (4.9 percent) over the 2016 enacted level. The budget also requests 2018 advance appropriations (AAs) of $66.4 billion for Medical Care and $103.9 billion for three mandatory accounts that support Veterans benefit payments (i.e., Compensation and Pensions, Readjustment Benefits, and Insurance and Indemnities).

We value the support that Congress has demonstrated in providing the resources needed to honor our Nation's Veterans. We are seeking your support for legislative proposals contained in the 2017 Budget—including many already awaiting Congressional action—to enhance our ability to provide Veterans the benefits and services they have earned through their service. The Budget also proposes a new General Transfer Authority that would allow VA to move discretionary funds across line items. Flexible budget authority would give VA greater ability to avoid artificial restrictions that impede our delivery of care and benefits to Veterans.

RISING DEMAND FOR VA CARE AND BENEFITS

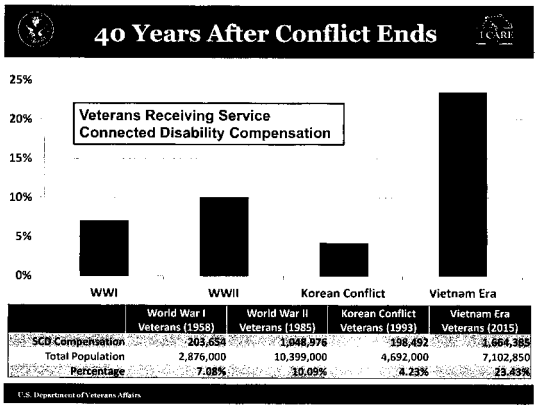
Veterans are demanding more services from VA than ever before. As VA becomes more productive, the demand for benefits and services from Veterans of all eras con-

tinues to increase, and Veterans' demand for benefits has exceeded VA's capacity to meet it.

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

Despite these extraordinary measures to increase capacity, VA was unable to absorb Veterans' increasing demand for health care. The number of Veterans waiting for appointments more than 30 days rose by about 50 percent, to roughly 450,000 between 2014 and 2015, so we are aggressively working on innovative ways to address that challenge, and VHA's new Access Stand Downs are central to VHA's healthcare transformation efforts and addressing that challenge.

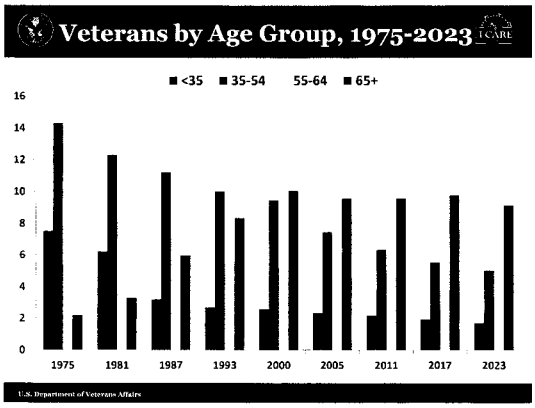
The trend of a growing demand for VA health care is fueled by more than a decade of war, Agent Orange-related disability claims, an unlimited claim appeal process, demographic shifts, increased medical issues claimed, and other factors. Additionally, survival rates among Americans who served in conflicts have increased, and more sophisticated methods for identifying and treating Veteran medical issues continue to become available. And, VA now serves a population that is older, has more chronic conditions, and is less able to afford care in the private sector. Workload will continue to increase as the military downsizes and Veterans regain trust in VA.



In 2017, the number of Veterans receiving medical care at VA will be over 6 million. VA expects to provide more than 115 million outpatient visits in 2017, an increase of 8.4 million visits over 2016, through both VA and Care in the Community.

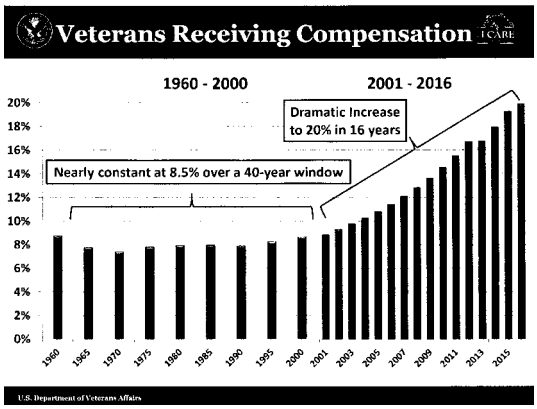
Compared to FY 2009, the number of patients is projected to increase by 22 percent by FY 2017. And, as Veterans see the results of VA's transformation, we are confident that the number of Veterans utilizing VA services will continue to rise. Currently, 11 million of the 22 million Veterans in this country are registered, enrolled, or use at least one VA benefit or service.

Veterans' health care and benefit requirements continue to increase decades after conflicts' end, and this fact is a fundamental, long-term challenge for VA. Forty years after the Vietnam War ended, the number of Vietnam Era Veterans receiving disability compensation has not yet peaked. VA anticipates a similar trend for Gulf War Era Veterans, only 26 percent of whom have been awarded disability compensation.

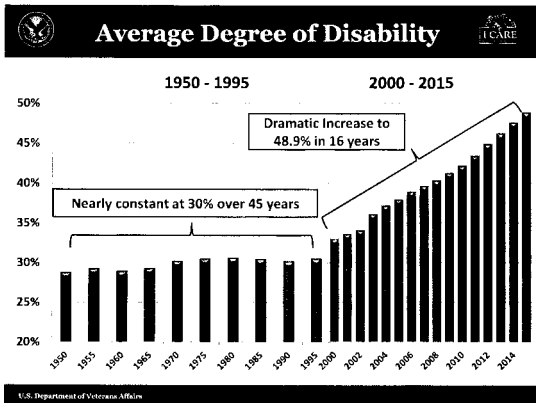


Today, there are an estimated 22 million Veterans. The number of Veterans is projected to decline to around 15 million by 2040. However, while the absolute number may decline, an aging Veteran population requires greater care, services, and benefits. In 2017, 46 percent (or 9.8 million) of the 22 million Veteran population will be 65 years old or older, a dramatic increase since 1975 when only 7.5 percent (or 2.2 million) of the Veteran population was 65 years old or older.

While the percent of the Veteran population receiving compensation was nearly constant at 8.5 percent for more than 40 years, over the past 15 years there has been a striking increase to 20 percent. The total number of service-connected disabilities for Veterans receiving compensation grew from 11.8 million in 2009 to 19.7 million in 2015, an increase of more than 67 percent in just six years. This dramatic growth, combined with estimates based on historic trends, predicts an even greater increase in claims for more benefits as Veterans age and disabilities become more acute.



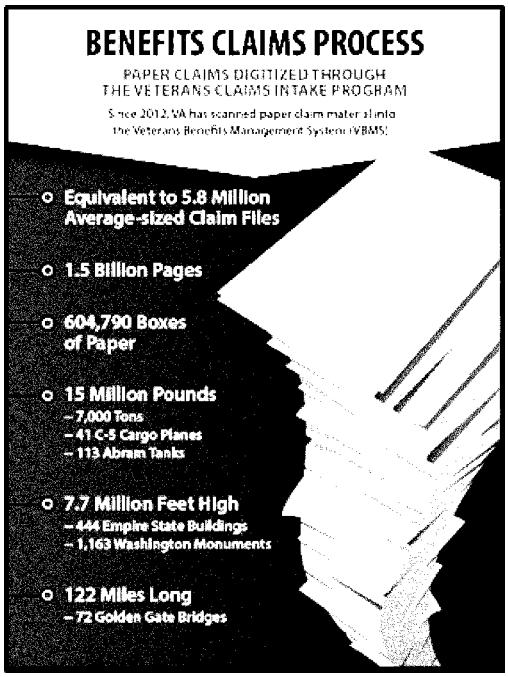
The increase in Veterans receiving compensation is accompanied by a significant increase in the average degree of disability granted to Veterans for disability compensation. For 45 years, from 1950 to 1995, the average degree of disability held steady at 30 percent. But, since 2000, the average degree of disability has risen to 49 percent. VBA's mandatory request for 2017 is $103.6 billion, twice the amount spent in FY 2009.



As VA continues to improve access and quality of care, more Veterans will come to VA for more of their care. Veterans today often choose VA for care either because of personal preference or because of VA's economic edge. Some 78 percent of enrolled Veterans at VA have other choices like Medicare, Medicaid, TRICARE, or private insurance. Out-of-pocket cost for Veterans at VA is often lower, and cost considerations are a key factor in Veterans' demand for VA health care. In 2014, Veteran enrollees received only 34 percent of their total health care through VA, accounting for about $53 billion in 2014 costs. Just a one percent increase in Veteran reliance on VA health care will increase costs by $1.4 billion.

PRODUCTIVITY IMPROVEMENTS AND STEWARDSHIP

The *MyVA* transformation will ensure VA is a sound steward of the taxpayer dollar. We are instituting operational efficiencies, cost savings, productivity improvements, and service innovations to support this and future budget requests. We are assessing all aspects of VA operations using a business lens and pursuing changes so VA will deliver care and services more efficiently and effectively at the highest value to Veterans and taxpayers. For instance, few realize that when it comes to the general operating expense of distributing over a hundred-billion dollars in benefits to over 5.3 million Veterans and survivors, VBA spends only about 3 cents on the dollar. By any measure, that's an excellent return on investment. Our Reports, Approvals, Meetings, Measurements, and Policies (RAMMPs) process identifies practices to streamline or, in some cases, eliminate entirely. To free capacity and empower employees to identify counter-productive or wasteful activities that management can eliminate, VA leaders at all levels of the organization are using RAMMP to address opportunities for improvement that employees have identified.



To boost efficiency and employee productivity, VA is quickly moving to paperless claims processing from its historically manual, paper-intensive process. Modernizing to an electronic claims processing system has helped VBA increase claim productivity per claims processor by 25 percent since 2011 and medical issue productivity by 82 percent per claims processor since 2009. This significant productivity increase helped mitigate the effects of the 131 percent increase in workload between 2009 and 2015, when the number of medical issues rose from 2.7 million to 6.4 million. VA's shift to electronic claims processing has meant converting paper files to eFolders. Between 2012 and 2015, the Veterans Claims Intake Program (VCIP) scanned nearly 6 million claims files into Veterans' eFolders in the Veterans Benefits Management System (VBMS). VBA has removed more than 7,000 tons of claims-related papers formerly undermining efficiency, hampering productivity, and cluttering workspace.

In FY 2015, VBA deployed its innovative Centralized Mail Initiative to 56 regional offices (ROs) and one pension management center (PMC). Centralized Mail reroutes inbound compensation and pension claims-related mail directly to Claims and Evidence Intake Centers at document conversion services vendor sites, an innovation that improves productivity and enabled digital analysis of more than four million mail packets. Through Centralized Mail, VBA can more efficiently manage the claims workload, and prioritize and distribute claims electronically across the entire RO network, maximizing resources and improving processing timeliness.

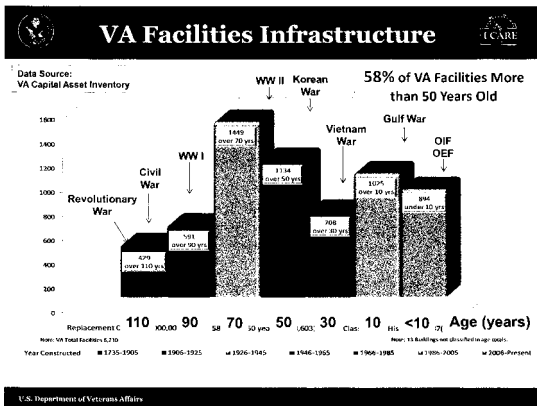
To strengthen financial management and stewardship, in FY 2015 VA launched its multi-year effort to replace VA's antiquated, 30-year-old core Financial Management System (FMS) with a 21st century system that will vastly improve VA financial management accuracy and transparency. The modernization effort requires robust enterprise-wide support across the Department. In FY 2015, VA committed to using a shared service solution and engaged the Department of Treasury's Office of Financial Innovation and Transformation (FIT) to pursue a Federal Shared Service Provider that leverages existing, successful investments and infrastructure across the government and meets our financial management system needs while supporting VA's mission of serving Veterans. VA also stood up a Program Management Office, initially staffed with 5 FTE from existing resources to lead and manage the effort, and identified an OIT Project Manager. VA has worked to compile lessons-learned from other agencies engaged in this effort and from VA's previous attempts to modernize the FTE, to ensure the effort is successful. Tasks ahead include strate-

gies, roadmaps, and project plans, business process re-engineering, and engaging in significant change management activities.

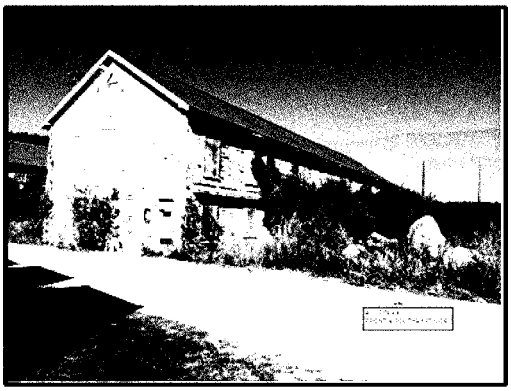
Recent challenges managing non-VA care program finances have demonstrated the great risks and immense burden of the FMS legacy system. FMS failure would severely impede the Department's ability to execute its budget, pay vendors and Veterans, and produce accurate financial statements.

CLOSING UNSUSTAINABLE FACILITIES

It is well-past time to close VA's old, substandard, and underutilized facilities. VA's 2016 Budget testimony last year explained that VA cannot be a sound steward of taxpayer resources with the asset portfolio it carries, and each year of delay makes the situation more costly and untenable. No sound business would carry such a portfolio, and Veterans and taxpayers deserve better.



VA currently has 370 buildings that are fully vacant or less than 50 percent occupied, which are excess to our needs. These vacant buildings account for over 5.2 million square feet of unneeded space. In addition, we have 770 buildings that are underutilized, accounting for more than 6.3 million square feet that are candidates to be consolidated to improve utilization and lower costs. This means we have to maintain over 1,100 buildings and 11.5 million square feet of space that is unneeded or underutilized—taking funding from needed Veteran services. We estimate that it costs VA $26 million annually to maintain and operate these vacant and underutilized buildings. For example, when attempting to demolish the vacant storage facility in Bedford, Massachusetts, VA encountered environmental issues that prevented the demolition, forcing VA to either pay costly remediation costs to demolish a building we no longer need or maintain facilities such as this across the system.



Bedford, Massachusetts—Vacant Storage Building, built in 1939

As the Veteran population has migrated, VA's capital infrastructure has not kept pace. We continue to operate medical facilities where the Veteran population is small or shrinking. Our smallest hospitals often do not have sufficient patient volume and complexity of care requirements to maintain the clinical skills and competencies of physicians and nurses.

ENSURING VETERANS ACCESS TO CARE

The President's 2017 Budget will allow VA to operate the largest integrated health care system in the country, including nearly 1,300 VA sites of health care and approximately 6 million Veterans receiving care; the eleventh largest life insurance provider, covering both active duty Servicemembers and enrolled Veterans; compensation and pension benefit programs serving more than 5.3 million Veterans and survivors; education benefits to more than one million students; vocational rehabilitation and employment benefits to more than 140,000 disabled Veterans; a home mortgage program that will guarantee more than 429,000 new home loans; and the largest national cemetery system that leads the industry as a high-performing organization, with projections to inter more than 132,000 Veterans and family members in 2017.

The 2017 Budget requests $65 billion for medical care, an increase of $3.9 billion (6.3 percent) over the 2016 enacted level. The increase in 2017 is driven by Veterans' demand for VA health care as a result of demographic factors, economic assumptions, investments in access, and high priority investments for caregivers, new Hepatitis C treatments, and support for Veterans Health Information Systems and Technology Architecture (VistA) Evolution. The 2017 request supports programs to end and prevent Veteran homelessness, invests in strategic initiatives to improve the quality and accessibility of VA health care programs, continues implementation of the Caregivers and Veterans Omnibus Health Services Act, and provides for activation requirements for new or replacement medical facilities. The 2017 appropriations request includes an additional $1.7 billion above the enacted 2017 AA for Veterans medical care. The request assumes approximately $3.6 billion annually in medical collections in 2017 and 2018. For the 2018 Advance Appropriations for medical care, the current request is $66.4 billion.

Hepatitis C Treatment

Although the Hepatitis C virus infection (HCV) takes years to progress, it is the main cause of advanced liver disease in the United States. Treatment of this disease remains a high priority because its cure dramatically lowers patients' risk of liver failure, liver cancer, and death.

VA is the largest single provider of care in the Nation for chronic HCV, and over the next five years, VA will strive to provide treatment to all Veterans with HCV who are treatment candidates. For FY 2017, VA is requesting $1.5 billion for the cost of Hepatitis C drugs and clinical resources. With a budget of $1.5 billion in FY 2017, VA expects to treat 35,000 patients with HCV. At the beginning of FY 2016, almost 120,000 Veterans in VA care were awaiting HCV treatment, of whom approximately 30,000 have advanced liver disease.

VA successfully negotiated extremely favorable pricing for both of the new treatments available—Harvoni and Viekira—from two different drug manufacturers by stressing VA's proven ability to deliver market share, VA's large HCV population, and the long-term impact that VA's physician residency programs can have on post-residency prescribing practices.

During FY 2015, VA medical facilities treated more than 30,000 Veterans for HCV with these new drugs with remarkable success, achieving cure rates of 90 percent, similar to those seen in clinical trials.

VA clinicians have rapidly adopted new, more effective therapies for HCV as they have become available. New therapies are costly and require well-trained clinical providers and support staff, presenting resource challenges for the Department. VA will focus resources on the sickest patients and most complex cases and continue to build capacity for treatment through clinician training and use of telehealth platforms. Patients with less advanced disease are being offered treatment through the Veterans Choice program in partnership with community HCV providers.

Care in the Community

VA is committed to providing Veterans access to timely, high-quality health care. The 2017 Budget includes $12.2 billion for Care in the Community and includes a new Medical Community Care budget account, consistent with the VA Budget and Choice Improvement Act (P.L. 114–41). Of the total that will be spent on non-VA care in FY 2017, $7.5 billion will be provided through a transfer of the 2017 enacted AA from the Medical Services account to the new budget account, and $4.7 billion

will be provided through the resources provided in the Veterans Choice Act for implementation of the Veterans Choice Program.

The Choice Act increased VA's in-house capacity by funding medical personnel growth in VA facilities and expanded eligibility for Care in the Community to ensure access to care within 30 days and to provide care closer to home for enrollees residing more than 40 miles from a VA facility (the 40-mile group).

This additional capacity facilitated an increase in enrollees' reliance on VA health care by more than half a percent over the level expected in FY 2015. This growth was the result of enrollees increasing their use of VA funded health care versus their use of other health care options (Medicare, Medicaid, commercial insurance, etc.).

The FY 2015 growth in enrollee reliance was largely in Care in the Community, with the 40-mile group generating a more significant increase in care:

• In FY 2015, enrollees' reliance on VA health care increased by 0.7 percent overall. Reliance for the 40-mile group increased by 2.8 percent from 32.5 percent to 35.3 percent.

• The increase in reliance was mostly driven by growth in Care in the Community. Cost sharing levels in VA are lower than what is typically available elsewhere, which provides an incentive for enrollees to use VA-paid Care in the Community.

Enrollee reliance on VA health care is expected to continue to increase in 2016 and beyond to service the unmet demand that the Choice Act was enacted to address.

On October 30, 2015, VA provided Congress with a plan for the consolidation and improvement of all purchased care programs into one New Veterans Choice Program (New VCP). Consistent with this report, the 2017 Budget will include legislative proposals to streamline and improve VA's delivery of Community Care.

Caregiver Support Program

Caregivers give their time and love in countless behind-the-scenes ways. Whether they are helping with transportation to and from appointments, helping the Veteran apply for benefits, or helping with meals, bathing, clothing, medication, the spectrum of care is wide and compassion runs deep.

The 2017 Budget requests $725 million for the National Caregivers Support Program to support nearly 36,600 caregivers, up from about 30,600 in FY 2016. Funding requirements for caregivers are driven by an increase in the eligible Veteran population, with caregiver enrollment increasing by an average of about 500 each month.

ENDING VETERAN HOMELESSNESS

The ambitious goal of ending Veteran homelessness has galvanized the Federal Government and local communities to work together to solve this important National problem. Our systems are designed to help prevent homelessness whenever possible, and our goal is a systematic end to homelessness, meaning that there are no Veterans sleeping on our streets and every Veteran has access to permanent housing. Should Veterans become homeless or be at-risk of becoming homeless, there will be capacity to quickly connect them to the help they need to achieve housing stability.

The 2017 Budget supports VA's commitment to ending Veteran homelessness by emphasizing rescue for those who are homeless today and prevention for those at risk of homelessness. The 2017 Budget requests $1.6 billion for VA homeless-related programs, including case management support for the Department of Housing and Urban Development (HUD)-VA Supportive Housing program (HUD-VASH), the Grant and Per Diem Program, VA justice programs, and the Supportive Services for Veteran Families program.

In FY 2015 and FY 2016, VA committed more than $1.5 billion annually to strengthen programs that prevent and end homelessness among Veterans. Communities that have reached the goal or are close to effectively ending homelessness rely heavily on VA targeted homeless resources. Communities that have a sustainment plan are depending on those resources to be available as they continue to tackle homelessness and sustain the support for Veterans who have moved into permanent housing, ensuring that they maintain housing stability and do not fall back into homelessness.

VA will continue to advocate for its continuum of homeless services to address the needs associated with preventing first-time homelessness, as well as the needs of those who return to homelessness, and focus on the root causes associated with homelessness, including poverty, addiction, mental health, and disability.

Congress has an important role, as well, in ensuring adequate resources to meet the needs of those most vulnerable Veterans by enacting authorizations and other legislation to provide VA with a full complement of tools to combat homelessness—including legislation that is a prerequisite to carry out dramatic improvements to our West Los Angeles campus centered on the needs of Veterans.

BENEFITS PROGRAMS

The 2017 Budget requests $2.8 billion and 22,171 FTE for VBA General Operating Expenses, an increase of $93.4 million (3.4 percent) over the 2016 enacted level. The request includes an additional 300 full-time equivalent (FTE) employees for non-rating claims.

With the resources requested in the 2017 Budget, VA will provide:

- Disability compensation and pension benefits for 5.3 million Veterans and survivors, totaling $86 billion;
- Vocational rehabilitation and employment benefits to nearly 141 thousand disabled Veterans, totaling $1.4 billion;
- Education benefits totaling $14 billion to more than one million Veterans and family members;
- Guaranty of more than 429,000 new home loans; and
- Life insurance coverage to 1.0 million Veterans, 2.2 million Servicemembers, and 2.8 million family members.

Improving the quality and timeliness of disability claim decisions has been integral to VBA's transformation of benefits delivery. VBA successfully streamlined a complex and paper-bound compensation claims process and implemented people, process, and technology initiatives necessary to optimize productivity and efficiency. In alignment with the *MyVA* initiative, VBA is working to further improve its operations with a focus on the customer experience. We are implementing enhancements to enable integration across our programs and organizational components, both inside and outside of VBA.

VBA has processed an unprecedented number of rating claims in recent fiscal years (nearly 1.4 million in 2015, and more than 1 million per year for the last 6 years). However, its success has resulted in other unmet workload demands. As VBA continues to receive and complete more disability rating claims, the volume of non-rating claims, appeals, and fiduciary field examinations increases correspondingly.

- *Non-rating claims.* VA completed nearly 37 percent more non-rating work in 2015 than 2013—and 15 percent more than 2014. The 2017 Budget requests $29.1 million for an additional 300 non-rating claims processors to reduce the non-rating claims inventory and provide Veterans with more timely decisions on non-rating claims.
- *Appeals.* Over the last 20 years, appeal rates have continued to hold steady at between 11 and 12 percent of completed claims. As VBA continues to receive and complete record-breaking numbers of disability rating claims, the volume of appeals correspondingly increases. As of December 31, 2015, there were more than 440,000 benefits-related appeals pending in the Department at various stages in the multi-step appeals process, which divides responsibility between VBA and the Board of Veterans' Appeals (Board)—355,803 of those benefits-related appeals are in VBA's jurisdiction and 85,682 are within the Board's jurisdiction.

Under current law, VA appeals framework is complex, ineffective, and opaque, and veterans wait on average 5 years for final resolution of an appeal. The 2017 Budget supports the development of a Simplified Appeals Process to provide veterans with a simple, fair, and streamlined appeals procedure in which they would receive a final appeals decision within 365 days from filing of an appeal by FY 2021. The 2017 Budget provides funding to support over 900 FTE for the Board and proposes a legislative change that will improve an outdated and inefficient process which will benefit all veterans through expediency and accuracy. We look forward to working with Congress, Veterans, and other stakeholders to implement improvements.

- *Fiduciary program.* The fiduciary program served 29 percent more beneficiaries in 2015 than it served in 2014. Program growth is primarily due to an increase in the total number of individuals receiving VA benefits and an aging population of beneficiaries. Additionally, in 2015 the fiduciary program changed the way it captures beneficiary population data and now reports all beneficiaries served during the course of the fiscal year. In 2015, fiduciary personnel conducted more than 84,000 field examinations, and VBA anticipates field examination requirements will exceed 97,000 in 2017.

• *Housing program.* The 2017 Budget includes $34 million for the VA Loan Electronic Reporting Interface (VALERI) to manage the 2.4 million VA-guaranteed loans for Veterans and their families. VALERI connects VA with more than 320,000 Veteran borrowers and more than 225,000 mortgage servicer contacts. VA uses the VALERI tool to manage and monitor efforts taken by private-sector loan servicers and VA staff in providing timely and appropriate loss mitigation assistance to defaulted borrowers. Without these resources, approximately 90,000 Veterans and their families would be in jeopardy of losing their homes each year, potentially costing the government an additional $2.8 billion per year. VALERI also supports payment of guaranty and acquisition claims.

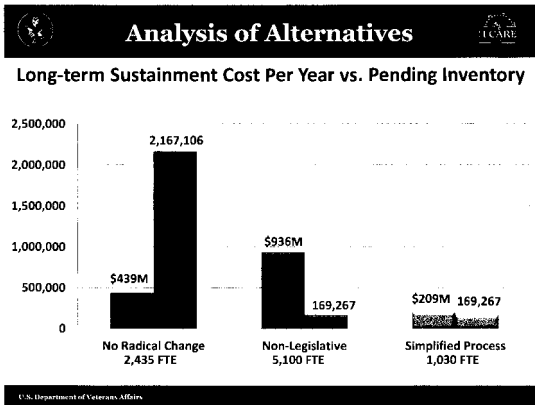
The Budget requests the following advance appropriations amounts for 2018: $90.1 billion for compensation and pensions, $13.7 billion for readjustment benefits, and $107.9 million for insurance and indemnities. VA will continue to closely monitor workload and monthly expenditures in these programs and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

THE SIMPLIFIED APPEALS INITIATIVE

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

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

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

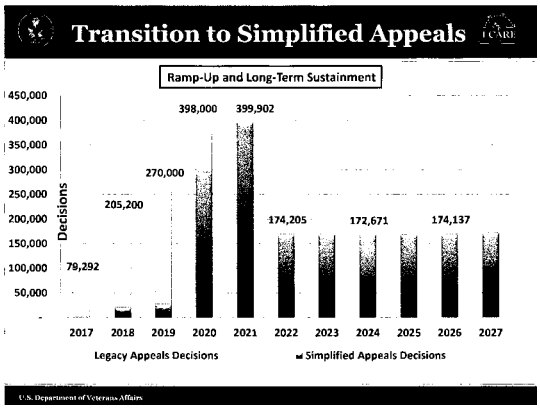


The 2017 Budget proposes a Simplified Appeals Process—legislation and resources (i.e., people, process, and technology) that would provide Veterans with a simple, fair, and streamlined appeals process in which they would receive a final decision on their appeal within one year from filing the appeal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

The 2017 Budget requests $156.1 million and 922 FTE for the Board, an increase of $46.2 million and 242 FTE above the FY 2016 enacted level. This is a down-payment on a long-term, sustainable plan to provide the best services to Veterans. This

policy option also represents the best value to taxpayers (as outlined in the chart, Analysis of Alternatives).

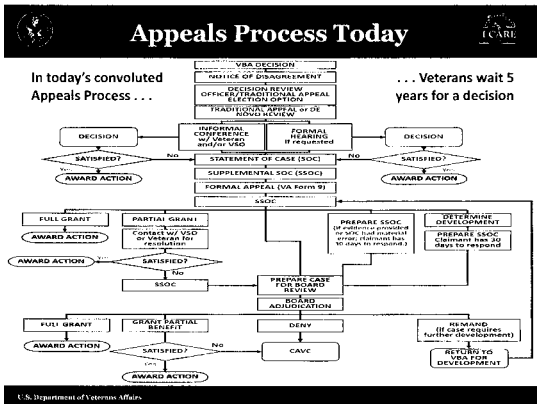
Without legislative change or significant increases in staffing, VA will face a soaring appeals inventory, and Veterans will wait even longer for a decision on their appeal. If Congress fails to enact VA's proposed legislation to simplify the appeals process, Congress would need to provide resources for VA to sustain more than double its appeals FTE, with approximately 5,100 appeals FTE onboard. The prospect of such a dramatic increase, while ignoring the need for structural reform, is not a good result for Veterans or taxpayers.



Simplified Appeals Process: Ramp Up and Long-Term Sustainment

While the Simplified Appeals proposal would require FTE increases for the first several years to resolve the more than 440,000 currently pending appeals, by 2022, VA would be able to reduce appeals FTE to a sustainment level of roughly 1,030 FTE (including 980 FTE at the Board and 50 at VBA), a level sufficient to process all simplified appeals in one year. Notably, such a sustainment level is 1,135 FTE less than the current 2016 budget requires, and is 4,070 FTE less Department-wide than would be required to address this workload with FTE resources alone. In addition, this reform would essentially eliminate the need for appeals FTE at VBA, allowing these resources to be redirected within VBA to other priorities.

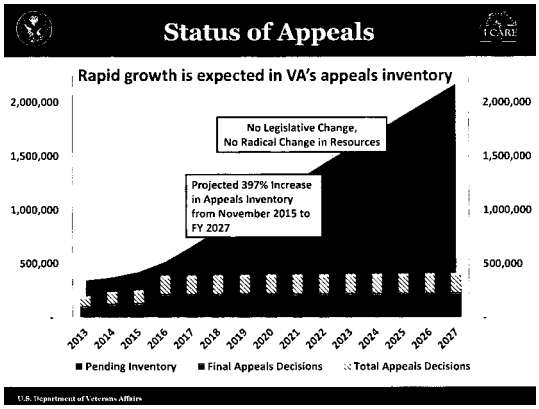
In 2015, the Board was still adjudicating an appeal that originated 25 years ago, even though the appeal had previously been decided by VA more than 27 times. Under the Simplified Appeals Process, most Veterans would receive a final appeals decision within one year of filing an appeal. Additionally, rather than trying to navigate a multi-step process that is too complex and too difficult to understand, Veterans would be afforded a transparent, single-step appeal process with only one entity responsible for processing the appeal.



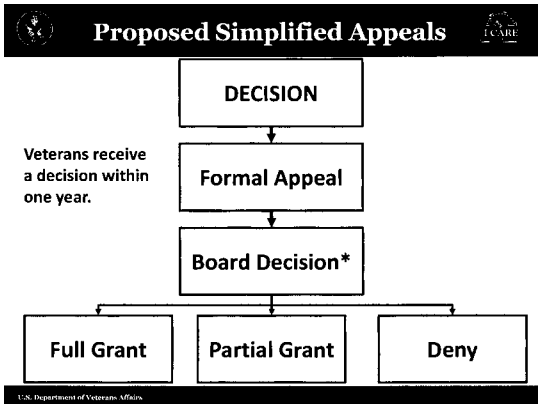
In today's Convoluted Appeals Process, Veterans Wait 5 Years for a Decision

Essentially, under a simplified appeals process, as soon as a Veteran files an appeal, the case would go straight to the Board where a Judge would review the same record considered by the initial decisionmaker and issue a final decision within one year; informing the Veteran whether that initial decision was substantially correct, contained an error that must be corrected, or was simply wrong. If a Veteran disagrees with any or all of the final appeals decision, the Veteran always has the option of filing a new claim for the same benefit once the appeal is resolved, or may pursue an appeal to the Court of Appeals for Veterans Claims.

Rapid growth in the appeals workload exacerbates this challenge. As VBA has produced record-setting claims-decision output over the past five years, appeals volume has grown commensurately. Between December 2012 and November 2015, the number of pending appeals rose by 34 percent. Under current law with no radical change in resources, the number of pending appeals is projected to soar by 397 percent—from 437,000 to 2.17 million (chart, Status of Appeals)—between November 2015 and FY 2027.



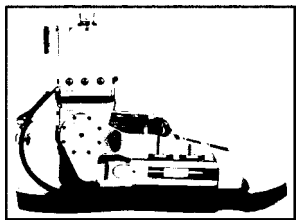
VA firmly believes that justice delayed is justice denied. In the streamlined appeals process proposed in the FY 2017 President's Budget (chart, Proposed Simplified Appeals), there would be a limited exception allowing the Board to remand appeals to correct duty to notify and assist errors made on the part of the Agency of Original Jurisdiction (AOJ) prior to issuance of the initial AOJ decision.



MEDICAL AND PROSTHETIC RESEARCH

The 2017 Budget continues VA's program of groundbreaking, high standard research focused on advancing the health care needs of all Veterans. The 2017 Budget requests $663 million for Medical Research and supports the President's Precision Medicine Initiative (PMI) to drive personalized medical treatment and the evolving science of Genomic Medicine—how genes affect health. In addition to the direct appropriation, Medical Research will be supported through $1.3 billion from VA's Medical Care program and other Federal and non-Federal research grants. Total funding for Medical and Prosthetic Research will be more than $2.0 billion in 2017.

VA research is focused on the U.S. Veteran population and allows VA to uniquely address scientific questions to improve Veteran health care. Most VA researchers are also clinicians and health care providers who treat patients. Thus, VA research arises from the desire to heal rather than pure scientific curiosity and yields remarkable returns.

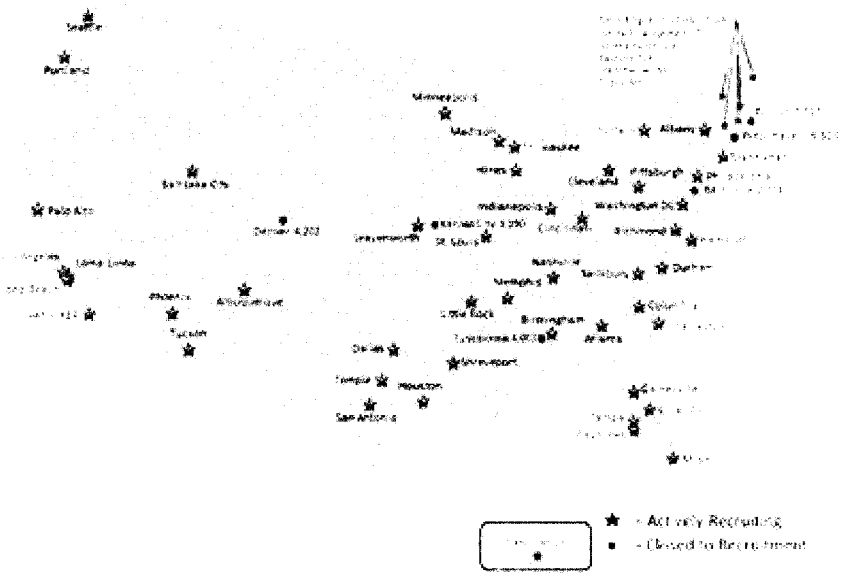


The First Powered Ankle-Foot Prosthesis

For more than 90 years, VA research has produced cutting-edge medical and prosthetic breakthroughs that improve the lives of Veterans and others. The list of accomplishments includes therapies for tuberculosis following World War II, the implantable cardiac pacemaker, computerized axial tomography (CAT) scans, functional electrical stimulation systems that allow patients to move paralyzed limbs, the nicotine patch, the first successful liver transplants, the first powered ankle-foot prosthesis, and a vaccine for shingles. VA researchers also found that one aspirin a day reduces by half the rate of death and nonfatal heart attacks in patients with unstable angina. More recently, VA investigators tested an insulin nasal spray that shows great promise in warding off Alzheimer's disease and found that prazosin (a well-tested generic drug used to treat high blood pressure and prostate problems) can help improve sleep and lessen nightmares for those with Post Traumatic Stress Disorder.

Beyond VA's support of more than 2,200 continuing research projects, VA will leverage our Million Veteran Program (MVP)—already one of the world's largest databases of genetic information—to support several Precision Medicine Initiatives. The first initiative will evaluate whether using a patient's genetic makeup to inform medication selection is effective in reducing complications and getting patients the

most effective medication for them. This initiative will focus on up to 21,500 Veterans with PTSD, depression, pain, and/or substance abuse.



VA's Million Veteran Program Recruitment

The second initiative will focus on additional analysis of DNA specimens already collected in the MVP. More than 438,000 Veteran volunteers have contributed DNA samples so far. Genomic analysis on these DNA specimens allows researchers to extract critical genetic information from these specimens. There are several possible "levels" of genomic analyses, with increasing cost.

Built into the design of MVP and currently funded within the VA research program is a process known as "exome chip" genotyping—the tip of the iceberg in genomic analysis. Exome Chip genotyping provides useful information, but newer technologies promise significantly greater information for improving treatments. VA proposes conducting the next level of analysis, known as "exome sequencing," on up to 100,000 Veterans who are enrolled in MVP. This exome sequencing analyzes the part of the genome that codes for proteins—the large, complex molecules that perform most critical functions in the body. Sequencing efforts will begin with a focus on Veterans with PTSD and frequently co-occurring conditions such as depression, pain, and substance abuse, and expand to other chronic illnesses such as diabetes and heart disease, among others. This more detailed genetic analysis will provide greater information on the biological factors that may cause or increase the risk for these illnesses.

VA's research and development program improves the lives of Veterans and all Americans through health care discovery and innovation.

OTHER PRIORITIES

Information Technology

The 2017 Budget demonstrates VA's commitment to using cutting-edge information technology (IT) to support transformation and ensure that the Veteran is at the center of everything we do. The Budget requests $4.28 billion—an increase of $145 million (3.5 percent) from the 2016 enacted level—to help stabilize and streamline core processes and platforms, eliminate the information security material weakness, and institutionalize new capabilities to deliver improved outcomes for Veterans. The request includes $471 million for new efforts to develop, improve, and enhance clinical and benefits systems and processes and supports VA's strategy to replace FMS. The 2017 Budget was developed through Federal IT Acquisition Reform Act

(FITARA) compliant processes led by the Chief Information Officer (CIO), in concert with the Chief Financial Officer and Chief Acquisition Officer.

In FY 2015, the Office of Information and Technology (OIT) developed an IT Enterprise Strategy and an Enterprise Cybersecurity Strategy. These strategies support OIT's vision to become a world-class organization that provides a seamless, unified Veteran experience through the delivery of state-of-the-art technology. OIT is implementing a new IT Security Strategy to improve VA's security posture and eliminate the Federal Information Security Management Act/Federal Information System Controls Audit Manual material weakness.

The 2017 Budget includes $370.1 million for information security, an increase of 105 percent over the FY 2016 funding level. In addition, the 2017 Budget includes $50 million to launch a new Data Management program to use data as a strategic resource. Under this program, VA will inventory its data collection activities—with the objective of requesting data from the Veteran only once—and dispose expired information in a secure and timely way. These two aspects will reduce VA costs for data storage and support safeguards for Veterans' information.

National Cemetery Administration

The National Cemetery Administration (NCA) has the solemn duty to honor Veterans and their families with final resting places in national shrines and with lasting tributes that commemorate their service and sacrifice to our Nation. The 2017 Budget requests $286 million, an increase of $15 million (5.5 percent) to allow VA to provide perpetual care for more than 3.5 million gravesites and more than 8,800 developed acres. The Budget supports NCA's efforts to raise and realign gravesites and repair turf in order to maintain cemeteries as national shrines. The Budget also continues implementation of a Geographic Information System to enable enhanced accounting of remains and gravesites and enhanced gravesite location for visitors. The Budget positions NCA to meet Veterans' emerging burial and memorial needs in the decades to come by ensuring that Veterans and their families continue to have convenient access to a burial option in a National, state, or tribal Veterans cemetery and that the service they receive is dignified, respectful, and courteous.

VA INFRASTRUCTURE

The 2017 Budget requests $900.2 million for VA's Major and Minor construction programs. The Budget invests in infrastructure projects at existing campuses that will lead to seismically safe facilities, ensuring that Veterans are safe when they seek care. The capital asset budget request demonstrates VA's commitment to address critical Major construction projects that directly affect patient safety and seismic issues, and reflects VA's promise to provide safe and secure facilities for Veterans. The 2017 Budget also requests funding to ensure that VA has the ability to provide eligible Veterans with access to burial services through new and expanded cemeteries, and prevent the closure to new interments in existing cemeteries.

VA acknowledges the transformation underway in the landscape for health care delivery. Our future space needs may be impacted by the changes we are already implementing in how we deliver care for Veterans. In addition, we plan to potentially incorporate any recommendations from the Commission on Care and their impact on our changing service delivery into our long-term infrastructure strategy.

Leasing provides flexibility and enables VA to more quickly adapt to changes in medical technology, workload, new programs, and demographics. VA is also looking to Congress for authorization of 18 leases submitted in VA's FY 2015 and 2016 Budget requests. The pending major medical facility lease projects will replace, expand, or create new outpatient clinics and research facilities and are critical for providing access for Veterans and enhancing our research capabilities nationwide. The 2017 Budget includes a request to authorize six additional replacement major medical facility leases under VA's authority in 38 U.S.C. §§ 8103 and 8104 and with the anticipated delegation of leasing authority from the General Services Administration. The Department is awaiting authorization of its request to expand the definition of "Medical Facilities" in VA's authorizing statutes to allow VA to more easily partner with other Federal agencies. Another proposal that deserves attention is authorization of enhanced use lease (EUL) authority to encompass broader possibilities for mixed-use projects. This change would give VA more opportunities to engage the private sector, local governments, and community partners by allowing VA to use underutilized property that would benefit Veterans and VA's mission and operations.

Major Construction

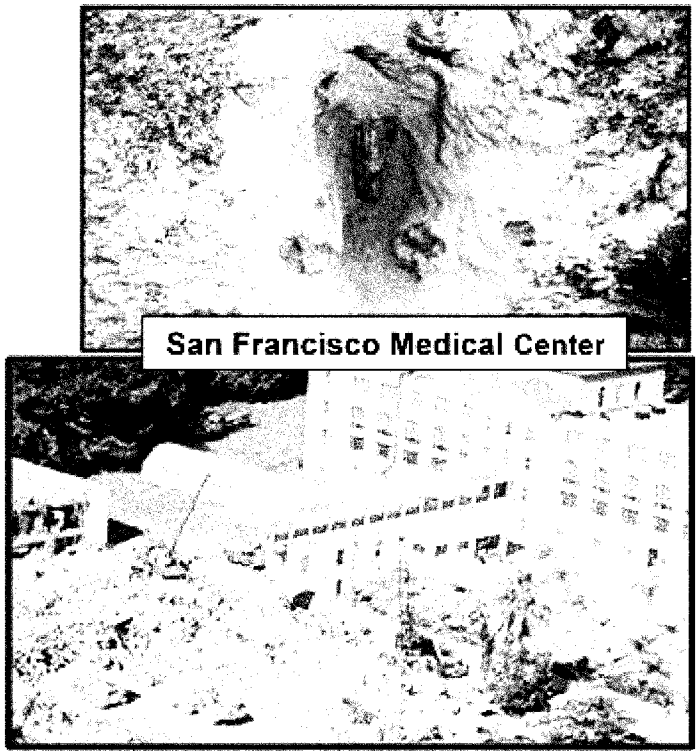
The 2017 Budget requests $528.1 million for Major Construction. The request includes funds to address seismic problems in facilities in Long Beach, California, and

Reno, Nevada. These projects will correct critical safety and seismic deficiencies that pose a risk to Veterans, VA staff, and the public. Consistent with Public Law 114–58, the Department must identify a non-VA entity to execute these two projects, as they are more than $100 million. We have identified the U.S. Army Corps of Engineers as our construction agent to execute these projects.

We must prevent the devastation and potential loss of life that may occur because our facilities are vulnerable to earthquakes—such as the one that occurred in 1971 in San Fernando, California. As shown, a 6.5-magnitude earthquake caused two buildings in the San Fernando Medical Center to collapse and 46 patients and staff to lose their lives.

San Fernando Medical Center collapse, 1971

These images show a known seismic deficiency at the San Francisco Medical Center—built in 1933—wherein the rebar does not extend into the "pile cap."



San Fernando Medical Center collapse, 1971

The request also includes funding for new national cemeteries in western New York and southern Colorado, and national cemetery expansions in Jacksonville, Florida and South Florida. These cemetery projects support NCA's goal to ensure that eligible Veterans have access to a burial option within a reasonable distance from their residences.

- The new western New York national cemetery will establish a dignified burial option for more than 96,000 Veterans plus eligible family members in the western New York region.
- The new southern Colorado national cemetery will establish a dignified burial option for more than 95,000 Veterans plus eligible family members in the southern Colorado region.
- The Jacksonville National Cemetery expansion will develop approximately 30 acres of undeveloped land to provide approximately 20,200 gravesites.
- The South Florida National Cemetery expansion will develop approximately 25 acres of undeveloped land to provide approximately 21,750 gravesites.

Minor Construction

In 2017, the Budget requests $372 million for Minor Construction. The requested amount would provide funding for ongoing projects that renovate, expand and improve VA facilities, while increasing access for our Veterans. Examples of projects include enhancing women's health programs; providing additional domiciliaries to further address Veterans' homelessness; improving safety; mitigating seismic deficiencies; transforming facilities to be more Veteran-centric; enhancing patient privacy; and enhancing research capabilities.

The Minor Construction request will also provide funding for gravesite expansion and columbaria projects to keep existing national cemeteries open, and will support NCA's urban and rural initiatives. It will also provide funding for projects at VBA regional offices nationwide and will fund infrastructure repairs and enhancements to improve operations for the Department's staff offices.

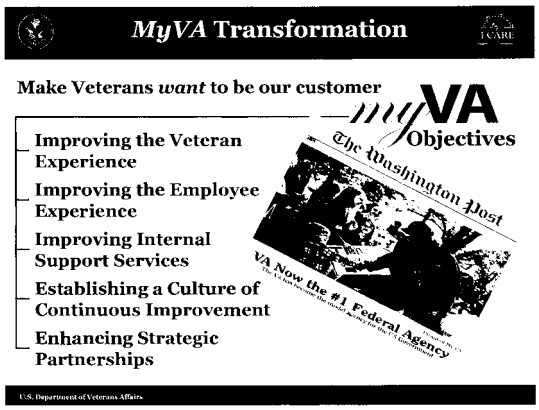
Leasing

The 2017 Budget includes a request to authorize six replacement major medical facility leases located in Corpus Christi, Texas; Jacksonville, Florida; Pontiac, Michigan; Rochester, New York; Tampa, Florida; and Terre Haute, Indiana. These leases will allow VA to provide continued access to Veterans that are served in these locations.

MyVA TRANSFORMATION

MyVA puts Veterans in control of how, when, and where they wish to be served. It is a catalyst to make VA a world-class service provider—a framework for modernizing VA's culture, processes, and capabilities to put the needs, expectations, and interests of Veterans and their families first. A Veteran walking into any VA facility should have a consistent, high-quality experience.

MyVA will buildupon existing strengths to promote an environment where VA employees see themselves as members of one enterprise, fortified by our diverse backgrounds, skills, and abilities. Moreover, every VA employee—doctor, rater, claims processor, custodian, or support staffer, or the Secretary of Veterans Affairs—will understand how they fit into the bigger picture of providing Veteran benefits and services. VA, of course, must also be a good steward of public resources. Citizens and taxpayers should expect to see efficiency in how we run our internal operations.



The FY 2017 budget will make investments toward the five critical *MyVA* objectives:

1. *Improving the Veteran experience:* At a bare minimum, every contact between Veterans and VA should be predictable, consistent, and easy; however, we are aiming to make each touchpoint exceptional. It begins with receptionists who are pleasant to our Veteran clients, but there is also a science to this experience. We are focusing on human-centered design, process mapping, and working with leading design firms to learn and use the technology associated with improving every interaction with clients.

2. *Improving the employee experience—so we can better serve Veterans:* VA employees are the face of VA. They provide care, information, and access to earned benefits. They serve with distinction daily. We cannot make things better for Veterans without improving the work experience of our dedicated employees. We must train them. We must move from a rules/fear-based culture to a principles/values-based culture. I learned in the private sector that it is absolutely not a coincidence that the very best customer-service organizations are almost always among the best places to work.

3. *Improving internal support services:* We will let employees and leaders focus on assisting Veterans, rather than worrying about "back office" issues. We must bring our IT infrastructure into the 21st century. Our scheduling system, where many of our issues with access to care were manifest, dates to 1985. Our Financial Management System is written in COBOL, a language I used in 1973. This is simply unacceptable. It impedes all of our efforts to best serve Veterans.

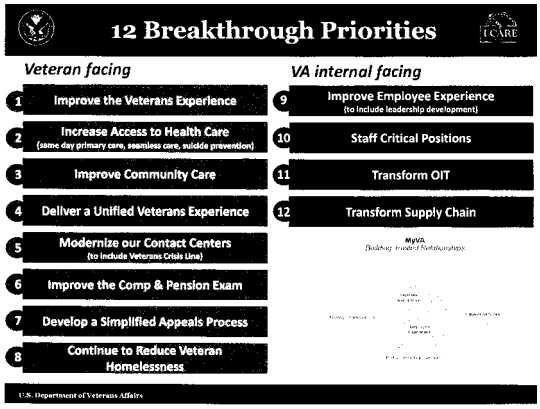
4. *Establishing a culture of continuous improvement:* We will apply Lean strategies and other performance improvement capabilities to help employees examine their processes in new ways and build a culture of continuous improvement.

5. *Enhancing strategic partnerships:* Expanding our partnerships will allow us to extend the reach of services available for Veterans and their families. We must work effectively with those who bring capabilities and resources to help Veterans.

Breakthrough Priorities for CY 2016

While we have made progress, we are still on the first leg of a multi-year journey. We have narrowed down our near-term focus to 12 "breakthrough priorities."

Many of these reflect issues which are not new—they have been known problems, in some cases, for years. We have already seen some progress in solving many of them. However, we still have much work to do.



The following are our 12 priorities and the 2016 outcomes to which we aspire. We understand that it will be a challenge to accomplish all of these goals this year, but we have committed ourselves to producing results for Veterans and creating irreversible momentum to continue the transformation in future years.

VETERAN FACING GOALS:

1. Improve the Veteran Experience.

- Breakthrough Outcome for 2016:

  – Strengthen the trust in VA to fulfill our country's commitment to Veterans; currently measured at 47 percent, we want it to be 70 percent by year end.
  – Establish a Department-wide customer experience measurement framework to enable data-driven service improvements.
  – Make the Veterans Experience office fully operational.
  – Expand the network of Community Veteran Engagement Boards to more than 100.
  – Additionally, in order to deliver experiences to Veterans that are effective, easy, and in which Veterans feel valued, medical centers will ensure that they are fully staffed at the frontline with well-prepared employees who have been selected for their customer service. Functionally, this means new frontline staff will be assessed through a common set of customer service criteria, hired within 30 days of selection, and provided a nationally standardized onboarding and training program.

2. Increase Access to Health Care.

- Breakthrough Outcome for 2016:

  – When Veterans call or visit primary care facilities at a VA Medical Center, their clinical needs will be addressed the same day.
  – When Veterans call for a new mental health appointment, they receive a suicide risk assessment and immediate care if needed. Veterans already engaged in mental health care identifying a need for urgent attention will speak with a provider the same day.

– Utilizing existing VistA technology, Veterans will be able to conveniently get medically necessary care, referrals, and information from any VA Medical Center, in addition to the facility where they typically receive their care.

3. Improve Community Care.

• Breakthrough Outcome for 2016: Improve the Veterans' experience with Care in the Community. Following enactment of our requested legislation, by the end of the year:

– VA will begin to consolidate and streamline its non-Department Provider Network and improve relationships with community providers and core partners.
– Veterans will be able to see a community provider within 30 days of their referral.
– Non-Department claims will be processed and paid within 30 days, 85 percent of the time.
– Health care claims backlog will be reduced to less than 10 percent of total inventory.
– Referral and authorization time will be reduced.

4. Deliver a Unified Veteran Experience.

• Breakthrough Outcome for 2016:

– Vets.gov will be able to provide Veterans, their families, and caregivers with a single, easy-to use, and high-performing digital platform to access the VA benefits and services they have earned.
– Vets.gov will be data-driven and designed such that the top 100 search terms will be available within one click from search results. The top 100 search terms will all be addressed within one click on the site.
– All current content, features and forms from the current public-facing VA websites will be redesigned, rewritten in plain language, and migrated to Vets.gov, in priority order based on Veteran demand.
– Additionally, we will have one authoritative source of customer data; eliminating the disparate streams of Administration-specific data that require Veterans to replicate inputs.

5. Modernize our Contact Centers (Including Veterans Crisis Line).

• Breakthrough Outcome for 2016:

– Veterans will have a single toll free phone number to access the VA Contact Centers, know where to call to get their questions answered, receive prompt service and accurate answers, and be treated with kindness and respect. VA will do this by establishing the initial conditions necessary for an integrated system of customer contact centers.
– By the end of this year, every Veteran in crisis will have his or her call promptly answered by an experienced responder at the Veterans Crisis Line.

6. Improve the Compensation & Pension (C&P) Exam Process.

• Breakthrough Outcome for 2016:

– Improved Veteran satisfaction with the C&P Exam process. We have a baseline satisfaction metric in place and have established a goal for significant improvement.
– VA will have a national rollout of initiatives to ensure the experience is standardized across the Nation.

7. Develop a Simplified Appeal Process.

• Breakthrough Outcome for 2016:

– Subject to successful legislative action, put in place a simplified appeals process, enabling the Department to resolve 90 percent of appeals within one year of filing by 2021.
– Increase current appeals production to more rapidly reduce the existing appeals inventory.

8. Continue Progress in Reducing Veteran Homelessness.

• Breakthrough Outcome for 2016:

– Continue progress toward an effective end to Veteran homelessness by permanently housing or preventing homelessness for an additional 100,000 Veterans and their family members,

VA INTERNAL FACING GOALS:

9. Improve the Employee Experience (Including Leadership Development).

- Breakthrough Outcome for 2016:

– Continue to improve the employee experience by developing engaged leaders at all levels who inspire and empower all employees to deliver a seamless, integrated, and responsive VA customer service experience.
– More than 12,000 engaged leaders skilled in applying LDL principles, concepts, and tools will work projects and/or initiatives to make VA a more effective and efficient organization.
– Improve VA's employee experience by incorporating LDL principles into VA's leadership and supervisor development programs and courses of instruction.
– VA Senior Executive performance plans will include an element that targets how to improve employee engagement and customer service, and all VA employees will have a customer service standard in their performance plans.
– All VA supervisors will have a customer service standard in their performance plans.
– VA will begin moving from paper-based individual development plans to a new electronic version, making it easier for both supervisors and employees.

10. Staff Critical Positions.

- Breakthrough Outcome for 2016:

– Achieve significantly improved critical staffing levels that balance access and clinical productivity, with targets of 95 percent of Medical Center Director positions filled with permanent appointments (not acting) and 90 percent of other critical shortages addressed—management as well as clinical.
– Work to reduce "time to fill" hiring standards by 30 percent.

11. Transformation the Office of Information & Technology (OIT).

- Breakthrough Outcome for 2016: Achieve the following key milestones on the path to creating a world-class IT organization that improves the support to business partners and Veterans.

– Begin measuring IT projects based on end product delivery, starting with a near-term goal to complete 50 percent of projects on time and on budget.
– Stand up an account management office.
– Develop portfolios for all Administrations.
– Tie all supervisors' and executives' performance goals to strategic goals.
– Close all current cybersecurity weaknesses.
– Develop a holistic Veteran data management strategy.
– Implement a quality and compliance office.
– Deploy a transformational vendor management strategy.
– Ensure implementation of key initiatives to improve access to care.
– Establish one authoritative source for Veteran contact information, military service history, and Veteran status.
– Finalize the Congressionally mandated DOD/VA Interoperability requirements.

12. Transform Supply Chain.

- Breakthrough Outcome for 2016:

– Build an enterprise-wide integrated Medical-Surgical supply chain that leverages VA's scale to drive an increase in responsiveness and a reduction in operating costs. More than $150 million in cost avoidance will be redirected to priority Veteran programs.

We are rigorously managing each of these "breakthrough priorities" by instituting a Department level scorecard, metrics, and tracking system. Each priority has an accountable and responsible official and a cross-functional, cross-Department team in support. Each team meets every other week in person with either the Secretary or Deputy Secretary to discuss progress, identify roadblocks, and problem solve solutions. This is a new VA—more transparent, collaborative, and respectful; less formal and bureaucratic; more execution and outcome-focused; principles based, not rules-based.

LEGISLATIVE PRIORITIES

The Department is grateful for your continuing support of Veterans and appreciates your efforts to pass legislation enabling VA to provide Veterans with the high-quality care they have earned and deserve. We have identified a number of nec-

essary legislative items that require action by Congress in order to best serve Veterans going forward:

1. *Improve Care in the Community:* We need your help, as discussed on many occasions, to help overhaul our Care in the Community programs. VA staff and subject matter experts have communicated regularly with congressional staff to discuss concepts and concerns as we shape the future plan and recommendations. We believe that together we can accomplish legislative changes to streamline Care in the Community programs before the end of this session of Congress.

2. *Flexible Budget Authority:* We need flexible budget authority to avoid artificial restrictions that impede our delivery of care and benefits to Veterans. Currently, there are more than 70 line items in VA's budget that dedicate funds to a specific purpose without adequate flexibility to provide the best service to Veterans. These include limitations within the same general areas, such as health care funds that cannot be spent on health care needs. These restrictions limit VA's ability to deliver Veteran care and benefits based on demand, rather than specific funding lines. The 2017 Budget proposes language to provide VA with new authority to transfer up to two percent of the discretionary appropriations for fiscal year 2017 between any of VA's discretionary appropriations accounts. This new authority would give VA greater ability to address emerging needs and overcome artificial funding restrictions on providing Veterans' care and benefits.

3. *Support for the Purchased Health Care Streamlining and Modernization Act:* This legislation would clarify VA's ability to contract with providers in the community on an individual basis, outside of Federal Acquisition Regulations (FAR), without forcing providers to meet excessive compliance burdens, while maintaining essential worker protections. The proposal allows this option only when care directly from VA or from a non-VA provider with a FAR-based agreement in place is not feasibly available. Already, we have seen certain nursing homes not renew their agreements with VA because of the excessive compliance burdens, and as a result, Veterans are forced to find new nursing home facilities for residence.

VA further requests your support for our efforts to recruit and retain the very best clinical professionals. These include, for example, flexibility for the Federal work period requirement, which is inconsistent with private sector medicine, and special pay authority to help VA recruit and retain the best talent possible to lead our hospitals and health care networks.

4. *Special Legislation for VA's West Los Angeles Campus:* VA has requested legislation to provide enhanced use leasing authority that is necessary to implement the Master Plan for our West Los Angeles Campus. That plan represents a significant and positive step for Veterans in the Greater West Los Angeles area, especially those who are most in need. We appreciate the Committee's hearing in December 2015 on legislation to implement that Master Plan, and VA urges your support for expedited consideration of this bill to secure enactment of it in this session of Congress. Enactment of the legislation will allow us to move forward and get positive results for the area's Veterans after years of debate in the community and court action. This bill would reflect the settlement of that litigation, and truly be a win-win for Veterans and the community. I believe this is a game-changing piece of legislation as it highlights the opportunities that are possible when VA works in partnership with the community.

5. *Overhaul the Claims Appeals Process:* As mentioned earlier, VA needs legislation that sets out structural reforms that will allow VBA and the Board to provide Veterans with the timely, fair, and quality appeals decisions they deserve thereby addressing the growing inventory of appeals.

Last, let me again remind everyone that the vast majority of VA employees are hard workers who do the right thing for Veterans every day. However, we need your assistance in supporting the cultural change we are trying to drive. We are working to change the culture of VA from one of rules, fear, and reprisals to one of principles, hope, and gratitude. We need all stakeholders in this transformation to embrace this cultural transformation, including Congress. In fact, I think Congress, above all, recognizes the policy window we have at hand and must have the courage to make the type of changes it is asking VA and our employees to make. Congress can only put Veterans first by caring for those who serve Veterans.

Our dedicated VA employees, if given the right tools, training, and support, can and go out of their way to provide the best care possible to our Veterans and their families.

CLOSING

VA exists to serve Veterans. We have spent the last year and a half working to find new and better ways to provide high quality care and administer benefits effec-

tively and efficiently through responsible use of taxpayer dollars. We will continue to face enormous challenges, and this budget request will provide the resources needed to continue the transformation of this Department.

This budget and associated legislative proposals will allow us to streamline care for Veterans and improve access by addressing existing gaps, develop a simplified appeals process, further the progress we have made to eliminate the VBA claims backlog and end Veteran homelessness, and improve our cyber security posture to protect Veteran and employee data. It will also allow us to continue implementing *MyVA* to guide overall improvements to VA's culture, processes, and capabilities.

I have pledged that VA will ensure that the funds Congress appropriates to VA will be used to improve both the quality of life for Veterans and the efficiency of our operations. I am proud to continue this work and recognize there is much left to be done. We have made great strides and are grateful for the support of Congress through this transformation.

Thank you for the opportunity to appear before you today and for your continued steadfast support of Veterans. We look forward to your questions.

RESPONSE TO PREHEARING QUESTIONS SUBMITTED BY HON. JOHNNY ISAKSON TO THE U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. Women veteran gender-specific health care increased $40.4 million between fiscal years 2016 and 2017. Please break out the amount allocated to each category included under gender-specific health care for fiscal year 2016 as well as projections for fiscal year 2017.

Please see attached.

Sub Categories of Women's Gender Specific Care

	FY 2015	FY 2016	FY 2017	$ Increase	% Increase
Genitourinary Care	$155,805	$167,175	$180,943	$13,768	7.6%
Neoplasms	$76,458	$82,550	$90,313	$7,763	8.6%
Osteoporosis	$13,330	$14,352	$15,686	$1,334	8.5%
Pregnancy and Childbirth	$73,138	$82,986	$94,041	$11,055	11.8%
Women's Clinics	$120,095	$127,953	$134,405	$6,452	4.8%
Subtotal	$438,825	$475,016	$515,387	$40,371	

Percent of Gender Specific Care Provided through non-VA care

	FY 2015	FY 2016	FY 2017
Genitourinary Care	14%	15%	15%
Neoplasms	42%	43%	44%
Osteoporosis	16%	17%	19%
Pregnancy and Childbirth	72%	73%	73%
Women's Clinics	0%	0%	0%

Days from Birth to last service provided in VHA or non-VA care

	FY 2015	FY 2016	FY 2017
Neonates	9.74	9.74	9.74

Question 2. What percentage of women veteran specific care is provided at Department of Veterans Affairs (VA) facilities and what percentage is provided through non-VA care? Please break out each category included under gender-specific health care for fiscal year 2016 as well as projections for fiscal year 2017.

Response. Below are the disbursements for the following categories of women Veteran specific care as of February 13, 2016 as well as projections for the remainder of FY 2016 and FY 2017.

	FY16 YTD	FY 16 Total (Projected)	FY 17 (Projected)
Inpt/Outpt Services related to Pregnancy and Childbirth	$ 8,483,152.46	$ 23,107,000.00	$ 21,858,000.00
Inpt Services related to the Female Reproductive System	$ 1,259,301.84	$ 4,114,000.00	$ 3,985,700.00
Outpt Services related to Female Reproductive System and Genitalia	$ 2,041,762.03	$ 7,930,000.00	$ 8,947,300.00
Mammography Services	$ 1,525,786.73	$ 7,939,000.00	$ 7,329,000.00
Cervical Cancer Screening/HPV Services	$ 51,282.41	$ 201,500.00	$ 208,000.00
Total	$ 13,361,285.47	$ 43,291,500.00	$ 42,327,700.00

Question 3. Please detail the total number of medical centers that have a gynecologist on staff and whether they are full-time, part-time, or contracted. Please provide a break out of facilities and their surgical complexity.

Response. As of February 11, 2016, there are 80 health care systems with at least one full-time or part-time gynecologist on staff. A listing of all Inpatient and Ambulatory VHA surgery programs and their operative complexity designations is below, and available on the internet at the following web site http://www.va.gov/health/surgery/

VHA Surgical Program Location	Veterans Integrated Service Network (VISN)	Operative Complexity Designation
Anchorage, AK	20	Ambulatory-Basic
Birmingham, AL	7	Complex
Montgomery, AL	7	Standard
Fayetteville, AR	16	Intermediate
Little Rock, AR	16	Complex
Phoenix, AZ	18	Complex
Tucson, AZ	18	Complex
Fresno, CA	21	Intermediate
Martinez, CA	21	Ambulatory-Advanced
Sacramento, CA	21	Complex
Palo Alto, CA	21	Complex
San Francisco, CA	21	Complex
Loma Linda, CA	22	Complex
Long Beach, CA	22	Complex
San Diego, CA	22	Complex
West Los Angeles, CA	22	Complex
Denver, CO	19	Complex
Grand Junction, CO	19	Standard
West Haven, CT	1	Complex
Washington, DC	5	Complex
Wilmington, DE	4	Intermediate
Bay Pines, FL	8	Complex
Cape Coral, FL	8	Ambulatory-Basic
Gainesville, FL	8	Complex
Jacksonville, FL	8	Ambulatory-Basic
Lake City, FL	8	Ambulatory-Advanced
Miami, FL	8	Complex
Lake Baldwin, FL	8	Ambulatory-Advanced
Tampa, FL	8	Complex
Viera, FL	8	Ambulatory-Basic
West Palm Beach, FL	8	Intermediate
Augusta, GA	7	Complex
Atlanta, GA	7	Complex
Dublin, GA	7	Standard
Des Moines, IA	23	Intermediate
Iowa City, IA	23	Complex
Boise, ID	20	Intermediate
Danville, IL	11	Ambulatory-Basic
Chicago-Jesse Brown, IL	12	Complex
Hines, IL	12	Complex
North Chicago, IL	12	Intermediate
Marion, IL	15	Standard
Evansville, IN	15	Ambulatory-Basic

VHA Surgical Program Location	Veterans Integrated Service Network (VISN)	Operative Complexity Designation
Fort Wayne, IN	11	Standard
Indianapolis, IN	11	Complex
Leavenworth, KS	15	Intermediate
Topeka, KS	15	Standard
Wichita, KS	15	Intermediate
Lexington, KY	9	Complex
Louisville, KY	9	Complex
New Orleans, LA	16	Ambulatory-Advanced
Pineville, LA	16	Ambulatory-Advanced
Shreveport, LA	16	Complex
Boston-Jamaica Plain, MA	1	Ambulatory-Advanced
West Roxbury, MA	1	Complex
Baltimore, MD	5	Complex
Togus, ME	1	Intermediate
Ann Arbor, MI	11	Complex
Detroit, MI	11	Complex
Saginaw, MI	11	Ambulatory-Basic
Iron Mountain, MI	12	Ambulatory-Basic
Minneapolis, MN	23	Complex
St. Cloud, MN	23	Ambulatory-Basic
Columbia, MO	15	Complex
Kansas City, MO	15	Complex
St. Louis, MO	15	Complex
Biloxi, MS	16	Intermediate
Jackson, MS	16	Complex
Billings, MT	19	Ambulatory-Basic
Fort Harrison, MT	19	Intermediate
Asheville, NC	6	Complex
Durham, NC	6	Complex
Fayetteville, NC	6	Standard
Salisbury, NC	6	Intermediate
Fargo, ND	23	Intermediate
Omaha, NE	23	Complex
Manchester, NH	1	Ambulatory-Basic
East Orange, NJ	3	Complex
Albuquerque, NM	18	Complex
Reno, NV	21	Intermediate
Las Vegas, NV	22	Intermediate
Albany, NY	2	Complex
Buffalo, NY	2	Complex
Syracuse, NY	2	Complex
Bronx, NY	3	Complex
Brooklyn, NY	3	Complex
Northport, NY	3	Complex
New York, NY	3	Complex
Cincinnati, OH	10	Complex
Cleveland-ASC, OH	10	Ambulatory-Basic
Cleveland, OH	10	Complex
Columbus, OH	10	Ambulatory-Advanced
Dayton, OH	10	Intermediate
Muskogee, OK	16	Intermediate
Oklahoma City, OK	16	Complex
Portland, OR	20	Complex
Roseburg, OR	20	Ambulatory-Basic
Erie, PA	4	Ambulatory-Advanced
Lebanon, PA	4	Intermediate

VHA Surgical Program Location	Veterans Integrated Service Network (VISN)	Operative Complexity Designation
Philadelphia, PA	4	Complex
Pittsburgh, PA	4	Complex
Wilkes-Barre, PA	4	Intermediate
San Juan, PR	8	Complex
Providence, RI	1	Intermediate
Charleston, SC	7	Complex
Columbia, SC	7	Intermediate
Fort Meade, SD	23	Standard
Hot Springs, SD	23	Ambulatory-Basic
Sioux Falls, SD	23	Intermediate
Memphis, TN	9	Complex
Mountain Home, TN	9	Intermediate
Murfreesboro, TN	9	Ambulatory-Advanced
Nashville, TN	9	Complex
Houston, TX	16	Complex
Dallas, TX	17	Complex
Harlingen, TX	17	Ambulatory-Basic
San Antonio, TX	17	Complex
Temple, TX	17	Complex
Amarillo, TX	18	Intermediate
El Paso, TX	18	Ambulatory-Basic
Salt Lake City, UT	19	Complex
Clarksburg, WV	4	Intermediate
Hampton, VA	6	Intermediate
Richmond, VA	6	Complex
Salem, VA	6	Intermediate
White River Junction, VT	1	Intermediate
Seattle, WA	20	Complex
Spokane, WA	20	Standard
Tacoma, WA	20	Ambulatory-Basic
Green Bay, WI	12	Ambulatory-Basic
Madison, WI	12	Complex
Milwaukee, WI	12	Complex
Martinsburg, WV	5	Intermediate
Beckley, WV	6	Standard
Huntington, WV	9	Complex
Cheyenne, WY	19	Standard

Number of Full Time and Part Time Gynecologists at VHA facilities

Data Source: PAID data excluding Veteran Canteen Service (VCS), non-pay, medical residents, and trainees with assign codes T0-T9 current as of February 11, 2016.

Number of Gynecologists by Facility

	Full-Time	Part-Time	Grand Total
VISN 01	**2**	**3**	**5**
Boston HCS (523)	1	0	1
Boston HCS West Roxbury Campus (523 W)	1	0	1
Connecticut HCS (689)	0	1	1
Togus VAMC (402)	0	1	1
White River Jct VAMC (405)	0	1	1
VISN 02	**2**	**7**	**9**
Albany VAMC (528 D)	1	0	1
Bronx VAMC (526)	0	1	1
New Jersey HCS (561)	0	1	1
Northport VAMC (632)	0	1	1
NY Harbor HCS (630)	0	1	1
NY Harbor HCS Brooklyn Campus (630 E)	1	0	1
Syracuse VAMC (528 E)	0	2	2
Western NY HCS Buffalo (528)	0	1	1
VISN 04	**1**	**2**	**3**
Philadelphia VAMC (642)	0	2	2
Wilkes-Barre VAMC (693)	1	0	1
VISN 05	**1**	**1**	**2**
Clarksburg VAMC (540)	1	0	1
Huntington VAMC (581)	0	1	1
VISN 06	**5**	**6**	**11**
Asheville VAMC (637)	0	1	1
Durham VAMC (558)	0	4	4
Fayetteville (NC) VAMC (565)	1	0	1
Hampton VAMC (590)	1	0	1
Richmond VAMC (652)	1	1	2
Salem VAMC (658)	1	0	1
Salisbury VAMC (659)	1	0	1
VISN 07	**5**	**8**	**13**
Atlanta VAMC (508)	1	4	5
Augusta VAMC (509)	1	0	1
Birmingham VAMC (521)	0	2	2
Central AL HCS Tuskegee Campus (619 T)	1	0	1
Charleston VAMC (534)	0	2	2
Columbia (SC) VAMC (544)	1	0	1
Dublin VAMC (557)	1	0	1
VISN 08	**11**	**4**	**15**
Bay Pines VAMC (516)	0	2	2
Miami HCS (546)	1	0	1

Number of Gynecologists by Facility

	Full-Time	Part-Time	Grand Total
North Florida-South Georgia HCS (573)	4	0	4
Orlando VAMC (675)	2	1	3
San Juan HCS (672)	1	1	2
Tampa VAMC (673)	3	0	3
VISN 09	**0**	**5**	**5**
Louisville VAMC (603)	0	1	1
Memphis VAMC (614)	0	1	1
TN Valley HCS (626)	0	2	2
TN Valley HCS Murfreesboro Campus (626 E)	0	1	1
VISN 10	**2**	**5**	**7**
Cincinnati VAMC (539)	0	2	2
Cleveland VAMC (541)	1	1	2
Columbus OPC (757)	0	1	1
Indianapolis VAMC (583)	1	1	2
VISN 12	**0**	**5**	**5**
Hines VAMC (578)	0	1	1
Madison VAMC (607)	0	1	1
Milwaukee VAMC (695)	0	3	3
VISN 15	**1**	**2**	**3**
Eastern Kansas HCS (589 EA)	1	0	1
Kansas City VAMC (589)	0	1	1
St. Louis HCS (657)	0	1	1
VISN 16	**6**	**5**	**11**
Central Arkansas HCS (598)	1	0	1
Gulf Coast Veterans HCS (520)	2	0	2
HCS of the Ozarks, Fayetteville, AR (564)	1	0	1
Houston VAMC (580)	1	1	2
Jackson VAMC (586)	1	1	2
Shreveport VAMC (667)	0	1	1
Southeast LA HCS (629)	0	2	2
VISN 17	**4**	**2**	**6**
Central Texas HCS (674)	1	2	3
El Paso HCS (756)	1	0	1
North Texas HCS (549)	1	0	1
South Texas HCS (671)	1	0	1
VISN 18	**2**	**4**	**6**
Phoenix HCS (644)	1	3	4
Southern AZ HCS (678)	1	1	2
VISN 19	**1**	**4**	**5**
Cheyenne VAMC (442)	0	1	1
Eastern CO HCS (554)	1	1	2
Montana HCS (436)	0	1	1
Salt Lake City HCS (660)	0	1	1
VISN 20	**4**	**0**	**4**
Boise VAMC (531)	1	0	1

Number of Gynecologists by Facility

	Full-Time	Part-Time	Grand Total
Puget Sound HCS (663)	3	0	3
VISN 21	**2**	**5**	**7**
Central California HCS (570)	0	1	1
Northern California HCS (612)	0	1	1
Northern California HCS East Bay Division (612 M)	1	0	1
Palo Alto HCS (640)	0	1	1
San Francisco VAMC (662)	0	2	2
Southern Nevada HCS (593)	1	0	1
VISN 22	**0**	**9**	**9**
Greater Los Angeles HCS (691)	0	3	3
Loma Linda HCS (605)	0	2	2
Long Beach HCS (600)	0	4	4
VISN 23	**1**	**5**	**6**
Black Hills HCS (568)	0	1	1
Fargo HCS (437)	1	0	1
Iowa City HCS (636 I)	0	1	1
Minneapolis HCS (618)	0	1	1
Nebraska-Western Iowa HCS (636)	0	1	1
Sioux Falls HCS (438)	0	1	1
Grand Total	**50**	**82**	**132**

Number of Full Time, Part Time, Intermittent, and Fee Basis Gynecologists at VHA facilities
Data Source: PAID - excluding medical residents and non-pay status

Number of Gynecologists by Facility

	Full-Time	Part-Time	Intermittent	Fee Basis	Grand Total
VISN 01	**2**	**3**	**2**	**0**	**7**
Boston HCS (523)	1	0	0	0	1
Boston HCS West Roxbury Campus (523 W)	1	0	0	0	1
Connecticut HCS (689)	0	1	2	0	3
Togus VAMC (402)	0	1	0	0	1
White River Jct VAMC (405)	0	1	0	0	1
VISN 02	**2**	**7**	**1**	**2**	**12**
Albany VAMC (528 D)	1	0	1	0	2
Bronx VAMC (526)	0	1	0	0	1
New Jersey HCS (561)	0	1	0	0	1
Northport VAMC (632)	0	1	0	0	1
NY Harbor HCS (630)	0	1	0	0	1
NY Harbor HCS Brooklyn Campus (630 E)	1	0	0	0	1
Syracuse VAMC (528 E)	0	2	0	0	2
Western NY HCS Buffalo (528)	0	1	0	2	3
VISN 04	**1**	**2**	**0**	**2**	**5**
Altoona VAMC (503)	0	0	0	2	2
Philadelphia VAMC (642)	0	2	0	0	2
Wilkes-Barre VAMC (693)	1	0	0	0	1
VISN 05	**1**	**1**	**0**	**0**	**2**
Clarksburg VAMC (540)	1	0	0	0	1
Huntington VAMC (581)	0	1	0	0	1
VISN 06	**5**	**6**	**0**	**0**	**11**
Asheville VAMC (637)	0	1	0	0	1
Durham VAMC (558)	0	4	0	0	4
Fayetteville (NC) VAMC (565)	1	0	0	0	1
Hampton VAMC (590)	1	0	0	0	1
Richmond VAMC (652)	1	1	0	0	2
Salem VAMC (658)	1	0	0	0	1
Salisbury VAMC (659)	1	0	0	0	1
VISN 07	**5**	**8**	**1**	**0**	**14**
Atlanta VAMC (508)	1	4	1	0	6
Augusta VAMC (509)	1	0	0	0	1
Birmingham VAMC (521)	0	2	0	0	2
Central AL HCS Tuskegee Campus (619 T)	1	0	0	0	1
Charleston VAMC (534)	0	2	0	0	2
Columbia (SC) VAMC (544)	1	0	0	0	1
Dublin VAMC (557)	1	0	0	0	1
VISN 08	**11**	**4**	**1**	**0**	**16**
Bay Pines VAMC (516)	0	2	1	0	3
Miami HCS (546)	1	0	0	0	1
North Florida-South Georgia HCS (573)	4	0	0	0	4
Orlando VAMC (675)	2	1	0	0	3
San Juan HCS (672)	1	1	0	0	2
Tampa VAMC (673)	3	0	0	0	3
VISN 09	**0**	**5**	**0**	**0**	**5**
Louisville VAMC (603)	0	1	0	0	1
Memphis VAMC (614)	0	1	0	0	1
TN Valley HCS (626)	0	2	0	0	2
TN Valley HCS Murfreesboro Campus (626 E)	0	1	0	0	1
VISN 10	**2**	**5**	**0**	**1**	**8**
Cincinnati VAMC (539)	0	2	0	0	2
Cleveland VAMC (541)	1	1	0	1	3
Columbus OPC (757)	0	1	0	0	1

Number of Gynecologists by Facility

	Full-Time	Part-Time	Intermittent	Fee Basis	Grand Total
Indianapolis VAMC (583)	1	1	0	0	2
VISN 12	**0**	**5**	**0**	**0**	**5**
Hines VAMC (578)	0	1	0	0	1
Madison VAMC (607)	0	1	0	0	1
Milwaukee VAMC (695)	0	3	0	0	3
VISN 15	**1**	**2**	**0**	**3**	**6**
Eastern Kansas HCS (589 EA)	1	0	0	2	3
Kansas City VAMC (589)	0	1	0	0	1
St. Louis HCS (657)	0	1	0	0	1
Wichita VAMC (589 WA)	0	0	0	1	1
VISN 16	**6**	**5**	**0**	**1**	**12**
Central Arkansas HCS (598)	1	0	0	0	1
Gulf Coast Veterans HCS (520)	2	0	0	0	2
HCS of the Ozarks, Fayetteville, AR (564)	1	0	0	0	1
Houston VAMC (580)	1	1	0	0	2
Jackson VAMC (586)	1	1	0	0	2
Shreveport VAMC (667)	0	1	0	0	1
Southeast LA HCS (629)	0	2	0	1	3
VISN 17	**4**	**2**	**0**	**0**	**6**
Central Texas HCS (674)	1	2	0	0	3
El Paso HCS (756)	1	0	0	0	1
North Texas HCS (549)	1	0	0	0	1
South Texas HCS (671)	1	0	0	0	1
VISN 18	**2**	**4**	**0**	**0**	**6**
Phoenix HCS (644)	1	3	0	0	4
Southern AZ HCS (678)	1	1	0	0	2
VISN 19	**1**	**4**	**2**	**0**	**7**
Cheyenne VAMC (442)	0	1	0	0	1
Eastern CO HCS (554)	1	1	0	0	2
Montana HCS (436)	0	1	0	0	1
Salt Lake City HCS (660)	0	1	2	0	3
VISN 20	**4**	**0**	**0**	**0**	**4**
Boise VAMC (531)	1	0	0	0	1
Puget Sound HCS (663)	3	0	0	0	3
VISN 21	**2**	**5**	**1**	**2**	**10**
Central California HCS (570)	0	1	0	0	1
Northern California HCS (612)	0	1	0	0	1
Northern California HCS East Bay Division (612 M)	1	0	0	0	1
Pacific Islands HCS (459)	0	0	0	2	2
Palo Alto HCS (640)	0	1	0	0	1
San Francisco VAMC (662)	0	2	0	0	2
Sierra Nevada HCS (654)	0	0	1	0	1
Southern Nevada HCS (593)	1	0	0	0	1
VISN 22	**0**	**9**	**1**	**0**	**10**
Greater Los Angeles HCS (691)	0	3	0	0	3
Loma Linda HCS (605)	0	2	0	0	2
Long Beach HCS (600)	0	4	0	0	4
San Diego HCS (664)	0	0	1	0	1
VISN 23	**1**	**5**	**0**	**0**	**6**
Black Hills HCS (568)	0	1	0	0	1
Fargo HCS (437)	1	0	0	0	1
Iowa City HCS (636 I)	0	1	0	0	1
Minneapolis HCS (618)	0	1	0	0	1
Nebraska-Western Iowa HCS (636)	0	1	0	0	1
Sioux Falls HCS (438)	0	1	0	0	1
Grand Total	**50**	**82**	**9**	**11**	**152**

FACILITY GYNECOLOGISTS RAW DATA

VISN	Facility	Work Schedule	Nbr Gynecologists
VISN 01	Boston HCS (523)	Full-Time	1
VISN 01	Boston HCS West Roxbury Campus (523 W)	Full-Time	1
VISN 01	Connecticut HCS (689)	Intermittent	2
VISN 01	Connecticut HCS (689)	Part-Time	1
VISN 01	Togus VAMC (402)	Part-Time	1
VISN 01	White River Jct VAMC (405)	Part-Time	1
VISN 02	Albany VAMC (528 D)	Full-Time	1
VISN 02	Albany VAMC (528 D)	Intermittent	1
VISN 02	Bronx VAMC (526)	Part-Time	1
VISN 02	New Jersey HCS (561)	Part-Time	1
VISN 02	Northport VAMC (632)	Part-Time	1
VISN 02	NY Harbor HCS (630)	Part-Time	1
VISN 02	NY Harbor HCS Brooklyn Campus (630 E)	Full-Time	1
VISN 02	Syracuse VAMC (528 E)	Part-Time	2
VISN 02	Western NY HCS Buffalo (528)	Fee Basis	2
VISN 02	Western NY HCS Buffalo (528)	Part-Time	1
VISN 04	Altoona VAMC (503)	Fee Basis	2
VISN 04	Philadelphia VAMC (642)	Part-Time	2
VISN 04	Wilkes-Barre VAMC (693)	Full-Time	1
VISN 05	Clarksburg VAMC (540)	Full-Time	1
VISN 05	Huntington VAMC (581)	Part-Time	1
VISN 06	Asheville VAMC (637)	Part-Time	1
VISN 06	Durham VAMC (558)	Part-Time	4
VISN 06	Fayetteville (NC) VAMC (565)	Full-Time	1
VISN 06	Hampton VAMC (590)	Full-Time	1
VISN 06	Richmond VAMC (652)	Full-Time	1
VISN 06	Richmond VAMC (652)	Part-Time	1
VISN 06	Salem VAMC (658)	Full-Time	1
VISN 06	Salisbury VAMC (659)	Full-Time	1
VISN 07	Atlanta VAMC (508)	Full-Time	1
VISN 07	Atlanta VAMC (508)	Intermittent	1
VISN 07	Atlanta VAMC (508)	Part-Time	4
VISN 07	Augusta VAMC (509)	Full-Time	1
VISN 07	Birmingham VAMC (521)	Part-Time	2
VISN 07	Central AL HCS Tuskegee Campus (619 T)	Full-Time	1
VISN 07	Charleston VAMC (534)	Part-Time	2
VISN 07	Columbia (SC) VAMC (544)	Full-Time	1
VISN 07	Dublin VAMC (557)	Full-Time	1
VISN 08	Bay Pines VAMC (516)	Intermittent	1
VISN 08	Bay Pines VAMC (516)	Part-Time	2
VISN 08	Miami HCS (546)	Full-Time	1
VISN 08	North Florida-South Georgia HCS (573)	Full-Time	4
VISN 08	Orlando VAMC (675)	Full-Time	2
VISN 08	Orlando VAMC (675)	Part-Time	1
VISN 08	San Juan HCS (672)	Full-Time	1
VISN 08	San Juan HCS (672)	Part-Time	1
VISN 08	Tampa VAMC (673)	Full-Time	3

VISN	Facility	Work Schedule	Nbr Gynecologists
VISN 09	Louisville VAMC (603)	Part-Time	1
VISN 09	Memphis VAMC (614)	Part-Time	1
VISN 09	TN Valley HCS (626)	Part-Time	2
VISN 09	TN Valley HCS Murfreesboro Campus (626 E)	Part-Time	1
VISN 10	Cincinnati VAMC (539)	Part-Time	2
VISN 10	Cleveland VAMC (541)	Fee Basis	1
VISN 10	Cleveland VAMC (541)	Full-Time	1
VISN 10	Cleveland VAMC (541)	Part-Time	1
VISN 10	Columbus OPC (757)	Part-Time	1
VISN 10	Indianapolis VAMC (583)	Full-Time	1
VISN 10	Indianapolis VAMC (583)	Part-Time	1
VISN 12	Hines VAMC (578)	Part-Time	1
VISN 12	Madison VAMC (607)	Part-Time	1
VISN 12	Milwaukee VAMC (695)	Part-Time	3
VISN 15	Eastern Kansas HCS (589 EA)	Fee Basis	2
VISN 15	Eastern Kansas HCS (589 EA)	Full-Time	1
VISN 15	Kansas City VAMC (589)	Part-Time	1
VISN 15	St. Louis HCS (657)	Part-Time	1
VISN 15	Wichita VAMC (589 WA)	Fee Basis	1
VISN 16	Central Arkansas HCS (598)	Full-Time	1
VISN 16	Gulf Coast Veterans HCS (520)	Full-Time	2
VISN 16	HCS of the Ozarks, Fayetteville, AR (564)	Full-Time	1
VISN 16	Houston VAMC (580)	Full-Time	1
VISN 16	Houston VAMC (580)	Part-Time	1
VISN 16	Jackson VAMC (586)	Full-Time	1
VISN 16	Jackson VAMC (586)	Part-Time	1
VISN 16	Shreveport VAMC (667)	Part-Time	1
VISN 16	Southeast LA HCS (629)	Fee Basis	1
VISN 16	Southeast LA HCS (629)	Part-Time	2
VISN 17	Central Texas HCS (674)	Full-Time	1
VISN 17	Central Texas HCS (674)	Part-Time	2
VISN 17	El Paso HCS (756)	Full-Time	1
VISN 17	North Texas HCS (549)	Full-Time	1
VISN 17	South Texas HCS (671)	Full-Time	1
VISN 18	Phoenix HCS (644)	Full-Time	1
VISN 18	Phoenix HCS (644)	Part-Time	3
VISN 18	Southern AZ HCS (678)	Full-Time	1
VISN 18	Southern AZ HCS (678)	Part-Time	1
VISN 19	Cheyenne VAMC (442)	Part-Time	1
VISN 19	Eastern CO HCS (554)	Full-Time	1
VISN 19	Eastern CO HCS (554)	Part-Time	1
VISN 19	Montana HCS (436)	Part-Time	1
VISN 19	Salt Lake City HCS (660)	Intermittent	2
VISN 19	Salt Lake City HCS (660)	Part-Time	1
VISN 20	Boise VAMC (531)	Full-Time	1
VISN 20	Puget Sound HCS (663)	Full-Time	3
VISN 21	Central California HCS (570)	Part-Time	1

VISN	Facility	Work Schedule	Nbr Gynecologists
VISN 21	Northern California HCS (612)	Part-Time	1
VISN 21	Northern California HCS East Bay Division (612 M)	Full-Time	1
VISN 21	Pacific Islands HCS (459)	Fee Basis	2
VISN 21	Palo Alto HCS (640)	Part-Time	1
VISN 21	San Francisco VAMC (662)	Part-Time	2
VISN 21	Sierra Nevada HCS (654)	Intermittent	1
VISN 21	Southern Nevada HCS (593)	Full-Time	1
VISN 22	Greater Los Angeles HCS (691)	Part-Time	3
VISN 22	Loma Linda HCS (605)	Part-Time	2
VISN 22	Long Beach HCS (600)	Part-Time	4
VISN 22	San Diego HCS (664)	Intermittent	1
VISN 23	Black Hills HCS (568)	Part-Time	1
VISN 23	Fargo HCS (437)	Full-Time	1
VISN 23	Iowa City HCS (636 I)	Part-Time	1
VISN 23	Minneapolis HCS (618)	Part-Time	1
VISN 23	Nebraska-Western Iowa HCS (636)	Part-Time	1
VISN 23	Sioux Falls HCS (438)	Part-Time	1

Question 4. Current law allows VA to cover care for newborns of eligible women veterans for the first seven days after birth. Please provide a break out of the average number of days VA has covered care for newborns in fiscal years 2014, 2015, and 2016, and projections for fiscal year 2017.

Response. Listed in the table below is the average number of days the VA has covered for newborn care since FY 2014. These averages are consistent with the number of days the newborn was actually hospitalized.

FY	Average Auth Days
2014	2.8
2015	3.0
2016	3.2
2017 (Projected)	3.4

Question 5. In the fiscal year 2017 budget request, the Veterans Health Administration (VHA) will create the VHA Transitional Care Program Office "to develop and manage policies, procedures and performance metrics related to VHA transitional care."

A. How many full-time equivalent employees will be dedicated to this office for fiscal years 2017 and 2018?

B. How much budgetary resources will be dedicated to this new office for fiscal years 2017 and 2018?

C. Please detail the duties of this new office, including to whom the office will report.

Response. The VHA Transitional Care Program Office is an aspirational project for the future. However, there is no specific resource or budget request for it at this time.

Question 6. The fiscal year 2017 budget request indicates that VA overestimated by $1.8 billion the obligations for fiscal year 2015 "because the obligations did not have sufficient supporting documents" and specifies VA would continue to identify the appropriations account and issue corrective actions.

A. Has VA identified the appropriations account? If so, please provide a detailed explanation of what caused the overestimate.

Response. Our financial audit identified that VA appropriations were possibly overstated by $1.8 billion in obligations due to the lack of supporting documentation. The FY 2015 financial audit required that an adjustment be made, but the audit did not indicate which specific appropriation account should be adjusted.

Most of the likely overestimate occurred due to a lack of the subsidiary system for Purchased Care not being directly interfaced/or reconciled to the main accounting system. Other overestimates occurred in other programs due to a lack of a robust review of obligation balances.

B. What corrective actions has VA taken in this matter?

Response. VA has begun implementing a new, mandatory reconciliation process for FY 2016 for Purchased Care. This new reconciliation process was outlined as part of the Care in the Community certification process in a memorandum from the Acting Deputy Under Secretary for Health Operations and Management to all Network Directors. The subsidiary accounting system will be reconciled to the main accounting system on a monthly basis, and supporting documentation will be maintained to support the reconciliation process. Documentation for obligations will also be reviewed for reasonableness and validity as part of the reconciliation process to ensure the most accurate obligation balances.

Other programs will be performing a more comprehensive review of obligations for FY 2016 to ensure adequate supporting documentation exists for all substantial obligation balances.

Question 7. Please provide an update on VA's agreement with the United States Army Corps of Engineers (USACE) to manage the seven major construction projects identified in Public Law 114–113, the Consolidated Appropriations Act of 2016, and VA's plan to ensure all future new medical facilities with a cost of $100 million or greater are managed by USACE.

Response. VA has established a master Inter-Agency Agreement (IAA) with the U.S. Army Corps of Engineers (USACE) which was signed on July 14, 2015. The scope of that IAA requires USACE to provide planning, acquisition, design, engineering, and construction management services and related work, including all levels of contracting, planning and project management support as defined by CFM for VA's "super construction projects" (projects over $100 million). IAA orders can be issued to the USACE for Exploratory, Design, and Construction requirements. To date, there are seven projects that are partnered with USACE through an IAA Task Order, or are in the process of entering the initial task order phase. To ensure that all future partnered projects are effectively managed, CFM and USACE are jointly developing an Enterprise Program Management Plan that will provide a framework and consistent approach to managing these projects. A Senior Executive Review Group consisting of CFM and USACE participants is scheduled, and this meeting will allow the participants to further define the partnership and to ensure alignment of all teams in our joint effort to ensure on time, on schedule and within budget project execution.

Question 8. The budget indicates that VA expects to fund 328 Caregiver Support Coordinators in 2016. Does the fiscal year 2017 budget request include an increase in Caregiver Support Coordinators?

Response. Yes. The budget request does include an increase in staffing for the Caregiver Support Program. VA expects to fund 400 Caregiver Support Coordinators in FY 2017, an additional 72 positions.

Question 9. Despite a projected decrease in the number of veterans to be served by the Grant and Per Diem Program, the fiscal year 2017 budget request represents an increase from fiscal year 2016. Is this solely based on the expected increase of the per diem rate, or are there other factors contributing to the increase? If so, please list the factors.

Response. The FY 2017 budget request for the Grant and Per Diem (GPD) program restores program funding at the fully authorized level. Even though the demand for GPD transitional housing beds is expected to decrease over time, the program still plays a vital role in the continuum of homeless services; providing supportive services to those Veterans who would otherwise be among the unsheltered homeless population, and ultimately transitioning to permanent housing. GPD funded providers have not had an increase in the per diem rate since December 2013; therefore, per diem costs for the program are anticipated to rise overall for operational programs as the nightly cost for per diem increases in the community.

VA and its Federal partners are promoting the use GPD to support an operational model of transitional housing as bridge housing. Bridge housing, is defined as transitional housing used as a short-term stay when a Veteran has been offered and accepted a permanent housing intervention (e.g., Supportive Services for Veteran Families (SSVF), Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH), etc.) but is not able to immediately enter the permanent housing. Veterans accessing bridge housing would otherwise be street homeless; therefore, this model is an opportunity to provide safe, secure structured environment for these Veterans while they secure permanent housing. It is anticipated that the use of this model will increase the overall utilization of GPD funded projects.

Question 10. The 2015 point-in-time count indicated a 4 percent decline in veteran homelessness from 2014, and a 36 percent decline since 2009. Despite this decline, the fiscal year 2017 budget request for programs to prevent and end veteran homelessness represents an increase between fiscal years 2015 and 2016. Please explain,

in detail, the reason for the funding increase at a time when homelessness is declining.

Response. The fiscal year (FY) 2017 budget supports VA's commitment to ending Veteran homelessness by emphasizing rescue for those who are homeless today, and prevention for those at risk of homelessness. The FY 2017 budget requests $1.6 billion for VA homeless-related programs, including case management support for HUD-VASH, GPD, and SSVF.

The requested increase in the FY 2017 VA homeless-services budget request is needed to support the $60 million in HUD-VASH vouchers that were appropriated to HUD in FY 2016. VA was not appropriated corresponding funding for case management. It is estimated that approximately 300 additional full-time equivalent employees will be required to support the Veterans who receive these vouchers. It is expected that approximately 85,000 HUD-VASH vouchers will be in use by the end of FY 2017. The increase in the GPD program budget request for FY 2017 restores the program to its fully authorized level.

The kind of progress reflected in the declining Point-in-Time estimates affirms that the strategies and systems that VA has implemented are working. Additionally, VA has made unprecedented efforts to promote the services available to Veterans who are homeless or might become homeless. As a result of the success of the effort and targeted resources, more Veterans are seeking out the VA more than ever before. Since 2010, demand for VA homeless-related services has increased by 136 percent (FY 2010: 127,070—FY 2015: 300,108 Unique Veterans accessing VHA homeless services). There has been an 8.5 percent increased demand for homeless services since this time last year (January 2015: 164,224; January 2016: 178,139). Communities that have reached the goal or are close to effectively ending homelessness rely heavily on VA targeted homeless resources. Communities that have developed a sustainment plan are dependent on those resources to remain available as they continue to tackle homelessness.

Until we have an economy that benefits everyone, Veterans will still have housing crises and some will become homelessness. The systems we have in place will make sure that the experience is measured not in months or years, but in days if sustained. Therefore, VA remains focused on ensuring adequate resources that address the needs of Veterans who may become or are at-risk of homelessness and sustains the support for Veterans who have moved into permanent housing so that they maintain housing stability and do not fall back into homelessness.

Question 11. The fiscal year 2017 budget request includes this legislative proposal:

Clarify Evidentiary Threshold at Which VA is Required to Provide a Medical Examination

This proposal seeks to amend 38 U.S.C. § 5103A(d) to clarify the evidentiary threshold for which VA, under its duty to assist obligation, is required to request a medical examination for compensation claims. This amendment would clarify section 5103A(d)(2) to require, prior to providing a medical exam, the existence of objective evidence establishing that the Veteran experienced an event, injury, or disease during military service. VA would still consider lay evidence as sufficient to show a current disability or persistent symptoms of a disability. However, except in special circumstances, objective evidence such as medical records, service records, accident reports, etc., must also be of record to trigger an exam. Benefit savings to the Compensation and Pensions account are estimated to be $120.1 million in 2017, $124.9 million in 2018, and $650.3 million over 5 years and $1.4 billion over 10 years.

A. Please provide the Senate Committee on Veterans' Affairs (Committee) with a breakdown of the savings expected from this proposal and the underlying assumptions used to calculate the expected cost savings, such as the expected reduction in the number of examinations that would be provided by VA each year and the expected impact on awards of compensation.

Response. Requiring the existence of objective evidence establishing that the Veteran experienced an event, injury, or disease during military service prior to providing a medical exam is estimated to save $120.1 million in FY 2017, $650.3 million over five years, and $1.4 billion over 10 years.

VA estimates approximately 505,478 disability exams will be conducted in FY 2017, and approximately 30 percent of these exams will result in denial of claimed conditions being associated with a Veteran's military service. VA assumes 113,732 exams (75 percent of denials) would no longer require a disability exam based on this proposal.

Cost Benefit Analysis:

Benefit Savings (Mandatory)

Fiscal Year	Caseload or Workload (as appropriate)	Savings ($000s)
2017	113,732	$120,082
2018	113,732	$124,875
2019	113,732	$129,860
2020	113,732	$135,044
2021	113,732	$140,435
5-Year Total	568,662	$650,296
2022	113,732	$146,041
2023	113,732	$151,872
2024	113,732	$157,935
2025	113,732	$164,240
2026	113,732	$170,798
10-Year Total	1,137,325	$1,441,182

GOE Costs (Discretionary)

No GOE costs are associated with this proposal

Fiscal Year	Caseload or Workload (as appropriate)	Savings ($000s)
2017	0	0
2018	0	0
2019	0	0
2020	0	0
2021	0	0
5-Year Total	0	0
2022	0	0
2023	0	0
2024	0	0
2025	0	0
2026	0	0
10-Year Total	0	$0

Methodology:

Approximately 30 percent of disability exams result in denial of claimed conditions being associated with a Veteran's military service. Compensation Service assumes 75 percent of these denials would no longer require a disability exam based on this proposal.

This proposal would not result in GOE savings. VBA would increase its administrative efficiency by redirecting resources to other critical claims processing.

Compared to the estimate provided in the FY 2016 President's Budget, savings in this updated estimate have increased as a result of Section 241 of Division I, Title II, of P.L.113–235 (enacted December 16, 2014), which proposes to expand the number of sites where contract medical exams could be funded by the C&P appropriation. The estimated cost savings in the FY 2016 Budget was based on an estimated 165,000 exams completed under this authority. This revised cost savings estimate is based on 500,000 exams completed under this authority

In addition to the change in Pub. L. 113–235 regarding the number of sites authorized to utilize contract medical exams, VBA plans to absorb all contract medical exams previously performed under VHA contracts. VHA historically used contractors to complete exams it did not have capacity to complete through its own clinicians. Moving forward, any exams VHA does not have capacity to complete will be completed by VBA's contractors. Therefore, the revised estimate of 500,000 exams completed under VBA's mandatory funding authority includes approximately 200,000 exams VHA previously planned to have contractors complete.

VHA will continue to be the primary provider of disability exams for VA, and VHA clinicians will continue performing disability exams for VA at current capacity levels. Contract exams are only utilized when VHA exam capacity is exceeded. VA will maintain current protocols to ensure distribution of exam capacity that results in use of VHA resources before contract resources are utilized. As such, only contract exams will be reduced as a result of this proposal, and VHA funding for exams performed by VHA employees on a non-contract basis will not be impacted.

Question 12. In the fiscal year 2017 budget request, VA seeks an additional 300 staff to process non-rating claims work.

A. How many staff are currently dedicated to non-rating work (other than appeals), how many additional staff does VA expect will be brought on board for that purpose during fiscal year 2016, and how many employees in total would perform that function in fiscal year 2017 if the budget request is adopted?

Response. Currently, VBA has 1,219 staff assigned to perform non-rating work, which includes management, clerical, and direct-labor employees. This figure includes approximately 260 temporary employees who are assigned to work non-rating work. VBA is grateful for the authority to hire 320 FTE for non-rating work in FY 2016, which will permit conversion of its temporary employees to permanent status and hiring of an additional 60 FTE. VBA requested an additional 300 FTE in its FY 2017 budget request, which will bring our non-rating strength to 1,579 FTE.

B. On average, how many non-rating actions (other than appeals) are completed per year by individual non-rating staff, what are the performance targets for these employees, and how many actions per employee would you expect to be completed per year if funding for the additional staff is provided?

Response. VBA does not budget FTE solely for rating or non-rating work. Production per FTE is based on all compensation and pension employees assigned to each regional office's claims processing workforce. Please see the chart below for production per FTE; in FY 2016, compensation and pension FTE are prorated for four months to determine production per FTE.

	FTE	Non-Rating Claim and Administrative Actions Completed	Non-Rating Production per FTE
FY 2014	14,307	2,699,264	188.7
FY 2015	15,121	3,112,379	205.8
FY 2016 as of Jan. 31	5,130	878,208	171.2

VBA estimates the additional 320 non-rating employees will not substantially increase the non-rating claims output because approximately 260 of these employees are already performing non-rating work. The additional 60 FTE are estimated to complete between 9,000 and 13,000 additional non-rating claims and administrative actions in FY 2016. However, the number of non-rating claims completed per FTE will initially decrease because of the hours devoted to training new employees and the lower production levels of these employees due to their inexperience. In FY 2016 and FY 2017, VBA expects non-rating claim production per FTE to decrease slightly from the FY 2015 average of 206 non-rating claims/actions per compensation and pension FTE.

Individual employees have a production element in their performance standards based on their General Schedule grade level, time in position, and type of work. Once fully trained, these employees will complete approximately 7 to 10 actions on average per day. All actions lead to the completion of a claim, but some claims will require multiple actions to fulfill legal requirements to develop for additional evidence or provide due process notice.

C. How many employees are currently dedicated to handling appeals at the Veterans Benefits Administration, how many additional appeals staff does the Veterans Benefits Administration plan to bring on board during fiscal year 2016, and how

many employees in total would perform that function in fiscal year 2017 if the budget request is adopted?

Response. In FY 2015, VBA had an average of 916 employees dedicated to appeals and has increased staffing to 1,178 employees as of January 31, 2016. VBA is grateful for funding to hire 100 appeals FTE in FY 2015 and 200 appeals FTE in FY 2016. However, additional FTE are not sufficient to address the existing or future workload for appeals. Under current law, VA appeals framework is complex, ineffective, and opaque, and Veterans wait on average five years for final resolution of an appeal. The 2017 Budget supports the development of a Simplified Appeals Process to provide Veterans with a simple, fair, and streamlined appeals procedure in which they would receive a final appeals decision within 365 days from filing of an appeal by FY 2021. The 2017 Budget also provides funding to support over 900 FTE for the Board and proposes a legislative change that will improve an outdated and inefficient process which will benefit all Veterans through expediency and accuracy. We look forward to working with Congress, Veterans, and other stakeholders to implement improvements.

D. On average, how many appeal-related actions are completed per year by individual appeals staff, what are the performance targets for these employees, and how many appeal-related actions per employee would you expect to be completed per year if funding for the additional staff is provided?

Response. The complex appeal process defined in current law involves multiple reviews of the evidence considered in the original decision as well as any new evidence received during the appeal. Please see the chart below for VBA's total completed appeal actions (such as statements of the case and appeal certifications) and appeals productivity; in FY 2016, compensation and pension FTE are prorated for four months to determine production per FTE.

	VBA FTE	Appeal Actions Completed	Appeals Productivity
FY 2015	916	198,774	217
FY 2016 as of Jan. 31	1178	69,084	176

Employees processing appeals are typically VBA's most experienced disability claims processors, which mitigates productivity losses. VBA expects a short-term decrease in appeals productivity as employees new to processing appeals become familiar with the entire process but will mitigate that loss by utilizing overtime to process appeals. As previously noted, productivity per FTE is based on all compensation and pension employees assigned to regional offices, not just FTE processing appeals.

The performance standard for Decision Review Officers is based on type of work and the number of issues addressed in each decision. At minimum, employees will complete three appeal actions per day to achieve the fully successful level of performance.

To increase efficiency, VBA is working closely with the Board of Veterans' Appeals, Veterans Service Organizations, and Congress to identify legislative solutions to simplify the appeals process and improve the timeliness of appeal decisions.

Question 13. The fiscal year 2017 budget request includes an increase of $46 million for the Board of Veterans' Appeals to fund an additional 242 employees.

A. How long is it expected to take to hire and train 242 new employees?

Response. The Board will begin the recruitment process for the 242 additional employees immediately upon enactment of the FY 2017 budget in order to support execution of the funding by the end of the Fiscal Year. In advance of the actual job announcement, the Board is working with OPM on an aggressive strategic recruitment plan, to ensure successful execution. The 242 additional employees will primarily consist of staff attorneys to draft appeals decisions, with an appropriate complement of administrative support staff and some additional judges. For new attorney staff, the Board has a 6-month training curriculum to ensure thorough training on veterans benefits law. New judges will undergo rigorous initial training with follow-up mentoring and continuing education for both legal training and leadership training. Administrative staff will also undergo new employee training specific to their business line.

B. What positions would be filled by those new employees?

Response. Most of the 242 employees would be staff attorneys. Specifically, the goal is for 145 attorneys, 24 judges, and 73 support staff.

C. What challenges would the Board of Veterans' Appeals face in expanding rapidly if funding for this increase in staff is approved and how would those challenges be handled?

Response. Taking lessons learned from the 2013 hiring surge of 100 attorneys in a four month timeframe, the challenges faced would include human resources support, information technology (IT) support, training support, and office space. These challenges would be handled by having a strong recruitment plan in place this year, in advance of the budget enactment, with a tiger team of dedicated personnel to handle the recruitment and on-boarding. The IT needs would also be identified in advance, with a streamlined plan to have the necessary equipment in place in a timely fashion as new hires were on-boarded. The training needs would be handled by having a strong training plan in place, using lessons learned from the large training in 2013, and subsequent trainings. Finally, the office space training would be handled by a combination of repurposing existing space for storing paper claims files, and increasing telework for eligible employees.

D. Would the Board of Veterans' Appeals expect any short-term decrease in productivity if there is a large influx of new employees during fiscal year 2017?

Response. Eighty-five percent of the Board's budget is allocated to personnel costs; therefore, a large portion of any increase in funding will be applied to hiring to address the Board's pending inventory of appeals. A direct and proportional correlation exists between the number of Board employees and decision output. It is likely that the Board will experience a decrease in productivity during the on-boarding and initial training period, as existing Board staff will be needed to focus on training the new employees as expediently as possible. While the Board may experience a slight dip in productivity during the initial new attorney training period, the Board anticipates that any decline will be made up once the new employees are in place and are fully trained. In this regard, following the FY 2013 and FY 2014 hiring surges during which the Board recruited and onboarded approximately 170 additional FTE, the Board saw a short term productivity dip during the training period, but a subsequent overall productivity increase, resulting in 55,532 dispositions in FY 2014 and 55,713 dispositions in FY 2015.

In 2015, each Board FTE produced approximately 86 appellate decisions. The Board anticipates that the number of appellate decisions per FTE may increase slightly with technological enhancements as the appeals process is modernized provided that resources and enterprise support are intact. However, a competing force against that increase is the ever changing and complex legal landscape, along with increased evidence-gathering and readjudication at every stage in the multi-stage appeals process.

E. Please provide a break out of the non-personnel costs that would be incurred to bring on board those employees, such as rearranging office space, equipment, office supplies, or training materials.

Response. As noted above, 85 percent of the Board's budget is allocated to personnel costs. The balance of funds will allow the Board to pay for operating costs such as rent, security, and other administrative requirements. See chart below for further details.

Board of Veterans' Appeals
Summary of Employment and Obligations
(dollars in thousands)

	2015 Actual	2016 Budget Request	2016 Current Estimate	2017 Request	Increase (+)/ Decrease (–)
Average Employment	646	669	680	922	+242
Obligations:					
Personal Services	88,757	92,522	96,317	133,379	+37,062
Travel	319	415	413	422	+9
Transportation of Things	0	80	94	129	+35
Rents, Communications & Utilities	8,704	8,960	9,993	13,539	+3,546
Printing & Reproduction	40	90	94	135	+41
Other Services	5,016	5,022	5,167	7,442	+2,275
Supplies & Materials	257	325	468	511	+43
Equipment	35	120	100	189	+89
Insurance & Indemnities	3	350	292	350	+58
Total Obligations	$103,131	$107,884	$112,938	$156,096	$43,158

Board of Veterans' Appeals
Summary of Employment and Obligations—Continued
(dollars in thousands)

	2015 Actual	2016 Budget Request	2016 Current Estimate	2017 Request	Increase (+)/ Decrease (–)
Reimbursements	0	0	0	0	0
SOY Unobligated Balance (–)	(7,300)	0	(3,156)	0	+3,156
EOY Unobligated Balance (+)	3,349	0	0	0	0
Transfer from Unobligated Balance (–)	0	0	102	0	–102
Budget Authority	$99,180	$107,884	$109,884	$156,096	$46,212

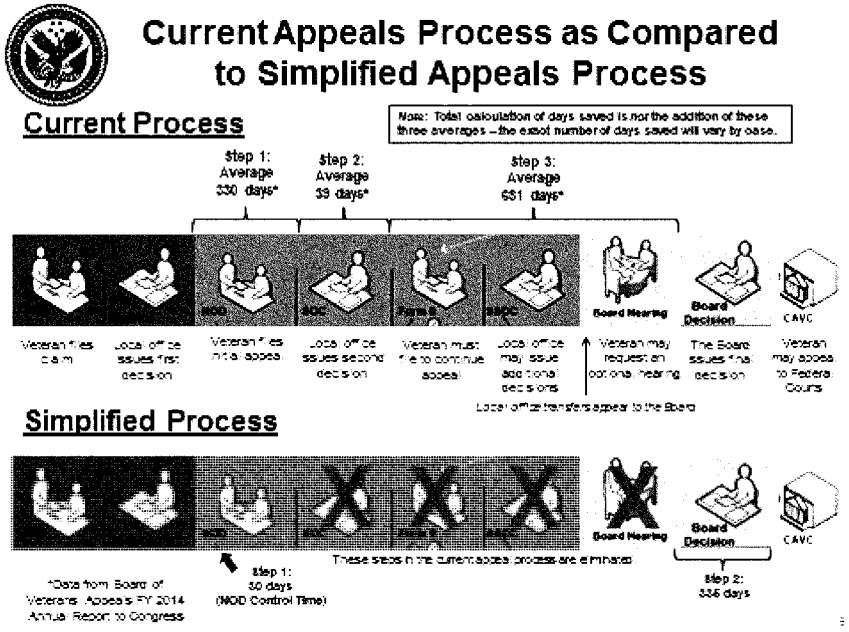
Question 14. According to VA, the appeals process takes on average 5 years between filing the appeal and receiving a decision by the Board of Veterans' Appeals.

A. Of that 5-year timeframe, please provide a break out of how many days/months on average an appeal would be waiting for the Veterans Benefits Administration or the Board of Veterans' Appeals to take a required action on it.

B. Of that 5-year timeframe, please provide a break out of how many days/months on average the Veterans Benefits Administration or the Board of Veterans' Appeals would be waiting for the appellant or his/her representative to take a required action regarding an appeal.

Response. In FY 2015, the average appeals processing time from the date of filing a Notice of Disagreement (NOD) to a Board adjudication (including grants, denials, and remands for further development) was approximately 5 years (1,771 days). The attached SVAC Pre-Hearing Presentation captures the average processing time in days for each step of the multi-step appeals process, including a breakdown of VSO and Board time for cases completed by the Board from FY 2005 to FY 2015. The data include only appeals decided by the Board, not those resolved at earlier stages of the appeals process.

The chart below shows what a simplified appeals process would look like, as well as the corresponding VBA and Board processing times by 2021, with implementation of the legislative proposals and resources requested in the 2017 President's Budget for 2017 and beyond.



Question 15. In response to questions about the fiscal year 2016 budget request, VA indicated that, during fiscal years 2014 and 2015, the Veterans Benefits Administration processed compensation and pension claims during overtime hours but did not process appeals during overtime hours. VA estimates that approximately 11 to 12 percent of individuals receiving a decision on their claims by the regional offices will appeal.

A. What percent of claims processed during overtime did the Veterans Benefits Administration project would generate appeals?

Response. VBA does not separately track claims processed on overtime and anticipates the overall ratio of appeals received divided by claims completed in a year will continue to be approximately 11 to 12 percent, which includes claims completed during overtime. The appeals process established by current law allows Veterans to file appeals up to one year following VA's notice of a final decision. As such, many decisions rendered during FY 2015 are still within their appeal period.

B. By opting to use overtime to process claims but not a commensurate proportion of appeals, did the Veterans Benefits Administration project that the appeals inventory at the Veterans Benefits Administration would increase during that time? If so, please share those projections with the Committee.

Response. VBA did project its appeals inventory would increase in FY 2015 by approximately 30 percent. This projection was based on a historic level of 1.4 million disability rating claims completed and 3.1 million non-rating claims and other administrative actions completed. VBA implemented new performance metrics for appeals output and increased staffing and to address the increase in appeals inventory.

However, without legislative change or significant increases in staffing, VA will face a soaring appeals inventory, and Veterans will wait even longer for a decision on their appeal. If Congress fails to enact VA's proposed legislation to simplify the appeals process, Congress would need to provide resources for VA to sustain more than double its appeals FTE, with approximately 5,100 appeals FTE onboard. The prospect of such a dramatic increase, while ignoring the need for structural reform, is not a good result for Veterans or taxpayers.

Question 16. On January 21, our Committee held a hearing on the *MyVA* transformation. This initiative detailed priorities and strategies for transforming how VA interacts with veterans. The budget is largely silent on specifics related to spending and the *MyVA* initiative. Please provide a breakdown of the following:

A. How much VA has spent and plans to spend on implementation of the *MyVA* initiative.

	Actual FY 2015
Veteran Experience Stand-Up	
Veteran Experience Stand-Up Total	$10,236,182.62
Support Services	
Support Services Total	$4,667,037.34
Performance Improvement	
Performance Improvement Total	$9,054,806.85
Strategic Partnerships (Not funded with reimbursable funds)	
Strategic Partnerships	$137,243.16
MyVA Task Force PSO (Not funded with reimbursable funds)	
My VA Task Force PSO Total	$10,005,171.00
MyVA Total	
MyVA Total	$34,100,440.97

These costs reflect direct costs incurred by the MY VA Task Force. Costs associated to the 12 Breakthrough Priorities are spread throughout the entire department.

B. A specific breakdown of funding sources and any areas you have had to divert from other resources.

MyVA Funding by Account

Pro Rata Share of Reimbursements	FY 15	FY 16
VHA	$31,297,500	$68,692,500
VBA	2,434,250	5,342,750
OIT	869,375	1,908,125

MyVA Funding by Account—Continued

Pro Rata Share of Reimbursements	FY 15	FY 16
NCA	173,875	381,625
Total	$34,775,000	$76,325,000

C. How many full-time equivalents are currently being utilized in the transformation and how many VA projects will be needed.

		Initial Priorities						Cumulative			
		Veterans Experience	Employee Experience [1]	Support Services [2]	Performance Improvement [3]	Strategic Partnership [4]	MyVA PSO (Taskforce) [5]	Shaded Blue = Reimbursable Authority	Shaded Green = Budget Authority	Total MyVA	
FY15	FTE	5	0	0	10	1	8	15	9	24	FTE
	Details [6]	10	0	4	4	3	10	18	13	31	Details [6]
	Total FTE	15	0	4	14	4	18	33	22	55	Total FTE
	TOTAL $	$ 10,236,183	$ -	$ 4,667,037	$ 9,054,807	$ 137,243	$ 10,005,171	$ 23,958,027	$ 10,142,414	$ 34,100,441	TOTAL $
	Pay	$ 306,251	$ -	$ 84,195	$ -	$ 113,233	$ 598,744	$ 390,445	$ 711,977	$ 1,102,422	Pay
	Operations [7]	$ 9,929,932	$ -	$ 4,582,843	$ 9,054,807	$ 24,010	$ 9,406,427	$ 23,567,582	$ 9,430,437	$ 32,998,019	Operations [7]

[1] Employee Experience efforts are funded through the Office of HR&A.
[2] Support Services efforts in FY17 will be funded through franchise funds.
[3] Staffing for Performance Improvement is funded through Office of Policy & Planning (OPP) in FY15 and FY16. OPP becomes the Office of Enterprise Integratio
[4] Strategic Partnerships moves to the Office of the Secretary in FY17.
[5] MyVA PSO (Taskforce) becomes part of the Office of Enterprise Integration in FY17.
[6] Details represent the number of temporary positions, developmental in nature, used to meet program objectives.
[7] Operations includes contracts, travel, training, supplies, and other expenses.

Question 17. The budget requests almost $4.3 billion in information technology. One of the breakthrough priorities for the Secretary is that VA will complete 50 percent of information technology projects on time and on budget.

What percentage of information technology projects are completed on time and on budget now?

Response. The Veteran-Focused Integration Process (VIP) replaces the Project Management Accountability System (PMAS) for enterprise IT management of products and services, which VA has used since 2009 to oversee its IT project delivery. The move from PMAS to VIP takes a generational leap forward in VA's commitment to serve our Nation's Veterans. Using PMAS criteria (which measures work product delivery); VA currently has a 78% on time rate for delivering increments of work within IT projects.

However, the evolution to VIP greatly expands the scope and span of what VA will be measuring, while reducing the paperwork requirements by 88 percent. Under VIP, VA is re-organizing to a portfolio management construct focused on measuring end product delivery rather than work product delivery. The near-term (6–18 month) goal for VIP is targeting 50 percent on-time and on-budget delivery, higher than the industry standard of 45 percent.

Question 18. The budget requests an additional 703 full-time equivalents for information technology. 599 of these employees will be staffing "enterprise operations." Can you please provide further details on these projects and the specific program offices where the full-time equivalents will be needed?

Response. Enterprise Operations (EO) is a computer operations and hosting function currently funded within the VA Franchise Fund. EO has been organizationally aligned within OI&T Service Delivery and Engineering (SDE) for several years. This realignment will not change OI&T budget requirements; funds that would have been transferred to the Franchise Fund will be directly obligated by OI&T instead.

EO operates or contracts for the computing infrastructure for many of VA's software applications that directly serve Veterans, VA business lines that provide direct Veteran service, or internal administrative services. EO provides a full complement of technical solutions including service planning architecture, security services, service management, hosting, monitoring, business continuity and recovery, application management, and managed hosting. Most of the EO FTE that are organizationally aligned to SDE will be transferred to SDE for funding purposes. Operational management and functions will not be impacted. This is primarily a change from a Franchise Fund to the appropriated OI&T fund without a change in cost.

The budget reflects a decision to migrate Enterprise Operations staff and data centers from the Franchise Fund to the IT appropriation (Net $0/0 FTE change). OI&T anticipates a transfer of 599 Enterprise Operations (EO) FTE from VA's Fran-

chise Fund. This transfer was directed by VA Executive Leadership to improve efficiency and responsiveness of this critical infrastructure component. Sustainment was reduced by $151 million due to the transfer and moved into the staffing and support services account resulting in the 14% increase.

Chairman ISAKSON. Well, thank you very much, Mr. Secretary. We are delighted to have you here today and appreciate your opening remarks. I will start the questioning, then we will go Republican to Democrat, after we go to the Ranking Member, all the way through.

Your proposal has a unique system for senior executive employment within the Veterans Administration which would create a unique pay schedule and disciplinary system under Title 38. As I said in my opening remarks, accountability is the single most important thing we must accomplish, in my judgment, on this Committee and within the VA itself.

Can you detail for the Committee the justification for the proposal and how you believe this solves the accountability problem at VA?

Secretary MCDONALD. Yes, Mr. Chairman. As you know, we run a health care business. We run an organization that, if it were a company, would be Fortune 6 on the Fortune 500. We compete with health care professionals from the best health care systems in the country, whether they be medical centers that we are affiliated with like Duke Medical Center, or whether they be large health care companies like Mayo or Cleveland.

We believe the best way to treat VA employees is as the health care professionals that they are, and the Title 38 provision would give us that ability. We could pay them more competitively. Right now, our average medical center director is paid, at best, half what they can earn in the private sector, and we have lost several recently. We are paying them the best we can with the SES system.

Separately, we can also recruit and appoint people more quickly because Title 38 would give us direct hiring authority. We believe that moving to Title 38 for all SES employees in VA would be a big step forward and make us competitive with the private sector and would improve care for veterans.

Chairman ISAKSON. In the case of disciplinary action, how does Title 38 differ from what is now there?

Secretary MCDONALD. The Title 38 in the case of disciplinary action would make me the appeal authority, so people would appeal to me. So, it would put appellate authority within the Department rather than in some external organization that looks across Government.

Chairman ISAKSON. In a hypothetical example that is really not so hypothetical—in the Pennsylvania case that has just been adjudicated on appeal, that would have been appealed to you and not to MSPB?

Secretary MCDONALD. That is correct, sir.

Chairman ISAKSON. Next, we talked about the 440,000 pending appeals at the Veterans Administration. You made a statement in a House Committee meeting the other day that the proposals in here are really a straw man for something like that. Do you have specific proposals in terms of that in this budget proposal that you are offering?

Secretary MCDONALD. Yes, sir. We have offered a specific proposal, but also, as we are talking right now, we have been meeting with veterans service organizations, Members of the Committee and other members of Congress, and are making progress in getting alignment as to what that proposal should look like. I suspect while the proposal we have submitted is a good one, we can make even further enhancements to it which could create a greater consensus moving forward. As we have discussed, we expect to have all that done by the end of March so we can get something done with this.

Chairman ISAKSON. Are you moving away from the fully developed claim process?

Secretary MCDONALD. No, sir. We think the fully developed claim is a good step on the way to a totally new appeals process. But, it does not fundamentally change the process to the degree that we think it needs change.

Chairman ISAKSON. Using the word of the day, which is "accountability," I think it is important for our veterans to have accountability in the system to make sure if they have an appeal, that it is justified and is heard, but make sure also that one veteran or two veterans or a handful of veterans' appeals do not cause other veterans to get a slow response on an appeal that otherwise would not be an appeal to begin with. One of the things I have seen from talking with Dr. Shulkin and some of the others at the VA, there are a handful—and I use "handful" as a reference—of appeals that over and over and over again, over a series of years, have still been active and in process. Every time one of those takes place, it takes time away from a claim that is recently filed by a veteran who deserves meritorious treatment in a hasty way.

I personally am very supportive of us finding a way to give the tools necessary to ensure the veteran gets accountability, but also have some ability to cut that off so it is not an ongoing process.

Secretary MCDONALD. Yes, sir, you are right. As you know, 10 to 11 percent of veterans appeal the decisions. Of those 10 to 11 percent, it is about 2 percentage points, 2 percent of all veterans that, when they appeal, drive multiple appeals, and their appeals comprise about 45 percent of all appeals. So, you are right. About 20 percent of veterans are creating about half of the work. That is an unacceptable situation and one that we should resolve to the benefit of all veterans. As we have committed in our 2016 end-of-year outcomes, we would like by the end of this year to be able to have a process in place that eventually would lead to 1 year for a veteran appeal.

Chairman ISAKSON. Just one last comment. In your prepared remarks, you said that 10 of the 16 top leaders in the VA are new hires that you have brought in, people from hospitals, people from the private sector. Dr. Shulkin and Ms. Council, are they two of those ten?

Secretary MCDONALD. Yes, sir, they are.

Chairman ISAKSON. Well, let me make a comment. If the other eight of those ten are doing as good a job as those two are, we are going to be in much better shape at the VA, because publicly I want to acknowledge Dr. Shulkin's help in the meetings we have been having at the VA to deal with the accountability issue and

some of the other things going on. They are doing a great job, and I appreciate the fact that they have been very responsive to us, as Ms. Council has done on the IT situation as well. So, thank you very much.

Secretary MCDONALD. Mr. Chairman, as you know, we have an IG nominee who we all think very highly of, I think the Committee thinks very highly of. We would love that to get passed on the Senate floor.

Chairman ISAKSON. For the record, I am meeting individually with people that I think need to be met with to try and see if we can't get that to a vote on the floor. We are not there yet, but we are making progress.

Senator Blumenthal?

Senator BLUMENTHAL. Thanks, Mr. Chairman.

I want to first just mention the elephant in the room, which is the potential hurdles and obstacles to approval of this budget in the potential gridlock and paralysis in the budget process overall. The VA illustrates to me the urgency of putting aside partisan differences, putting aside extraneous issues, and proceeding to a budget regardless of what our colleagues in the House of Representatives may think about the budgeting process and regardless of other issues relating to the Supreme Court or any other kinds of challenges that we face here. I think that you have come here in good faith to argue for some really urgent priorities that must be met, and they are commendably a part of this budget.

Earlier this year, the Hartford VARO reached out to me because they were informed that there were no additional hearing dates, travel board or teleconference dates for Hartford in the remainder of the fiscal year in terms of the appeals process. After my inquiry, the BVA additional teleconference date has been added, which I appreciate. But, I think that that experience illustrates the importance of reforming the appeals process. The VSOs have focused on it, and I assume you agree it should be a priority.

Secretary MCDONALD. Yes, sir, absolutely. I also agree on the budget. I would tell you that this is my second budget at the VA, but I feel better this year than I have ever before about connecting our strategies with the budget, with resources, with the legislation required, and with the 12 priorities that we have listed for 2016.

This is more than just a budget. This is the delivering of outcome for veterans. We need this budget in order to do that, but we also need the legislation and the other things that we have talked about as a group.

Senator BLUMENTHAL. Focusing for the moment on delivery of services to women veterans, there is a request for $515.4 million for gender-specific health care for women and nearly $5.3 million in total care for women, which recognizes the need to consider the growing female veteran population in our country and provide care that is both welcoming, efficient, and proficient to meet their needs.

I am still concerned that the culture of the VA and the ability to welcome female veterans and provide health care services to them in a sensitive and tailored manner may not be keeping pace with the number and the needs of those veterans.

Could you please tell us how you intend to use the requested funding for women's health care to address, frankly, the pervasive

feeling of many female veterans that the VA remains a male-focused culture and organization?

Secretary MCDONALD. I am really glad you raise this, Senator Blumenthal. This is such an important topic to us. I really think this will be one of the seminal issues of transformation that we will be held responsible for as people look back years from now.

As you know, since 2000, the number of women veterans seeking VA health care services has doubled, from 160,000 to over 447,000 in fiscal year 2015. This is a major focus for us.

We have enhanced care for women. We have designated women's health providers at every site where women access VA health care. Currently, 100 percent of our medical centers and 94 percent of our community-based outpatient clinics have at least one designated women's health provider. We need to get that to 100 percent.

We have trained over 2,400 providers in women's health to ensure that every woman veteran has the opportunity to receive her primary care from a women's health provider. We have women veteran program managers, maternity care coordinators at every health care facility. We provide gynecological care, including maternity care and 7 days of newborn care, to all women veterans either on-site—that is through 130 health care systems—or through care in the community.

This is really a very important point to us, and we have to continue to make this transition over time, because as you have said, it is going to continue.

Senator BLUMENTHAL. Thank you very much. My time has expired. I have other questions that I may submit for the record, but thank you to you and your team for being here today.

Thank you, Mr. Chairman.

Chairman ISAKSON. Senator Rounds.

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

Senator ROUNDS. Thank you, Mr. Chairman, and let me just begin by saying that I have appreciated the bipartisan approach by both the Chairman and Ranking Member Blumenthal as we move through the different and challenging issues before us, including the budget itself. I am optimistic that this Committee will work very favorably in moving forward in this particular budget process. I have only been here a year, but I have been encouraged by the way this group here has worked on these issues.

One of the major challenges that has hampered the Choice Program has been the VA's shift of cost for care to the veterans who have been utilizing the Choice Program. Veterans are paying far more for their care under Choice than they traditionally paid under normal VA facility care or non-VA care, typically as a result of deductible and co-pay calculations that are different when they are seen in the private sector.

As you consolidate the care in the community programs, do you envision veterans continuing to pay more out-of-pocket to be seen in the private sector?

Secretary MCDONALD. Senator Rounds, it is a great point. We would like, when we consolidate care, to go to one payment system, one reimbursement system, so that we eliminate the complexity. You are right that when the Choice Act was created, veterans were

forced to pay higher co-pays to use the Choice actual service in order to keep the costs down of the total Choice Act. If they use a VA service, there is no co-pay. If they use a Choice Act, there is a co-pay. So, we do think that change needs to be made.

David?

Dr. SHULKIN. Yes, Senator, the primary difference is that the way the Choice legislation was written is that in Choice VA is the secondary payer. So, a veteran has to use their primary insurance, and they have to use their co-pays.

What we have suggested in our legislative proposals is to make VA the primary payer and to consolidate all the care in the community. That would eliminate this disparity that veterans see today.

Senator ROUNDS. In South Dakota, we continue to hear that timely provider payment under the Choice Program is a continuing issue. Recently, I heard from a private sector provider that has over $3.3 million in payments that have been outstanding for more than 90 days. What specific initiatives are you putting in place to accomplish your 2016 breakthrough priority of getting 85 percent of claims paid within 30 days? It looks to me like you have got quite a hill to climb.

Secretary MCDONALD. First of all, please give us the name of that provider. We will go back and make sure they get paid.

Second, the systemic change we need is to follow the best practices in the private sector, which is to pay the provider based on them providing the service, not waiting for the paper documents, which has been our past practice. Dr. Shulkin has put that change in place. We have another week or so until we actually activate it. But, that means providers will get payments virtually as soon as they provide the service.

David?

Dr. SHULKIN. Yesterday we delivered to the two TPAs a proposal for them to sign that would decouple documentation from payment so we can make faster payments to providers.

Senator ROUNDS. I have heard that in my State VHA has made the conscious decision to shift certain health care services over to the Choice Program and away from VHA facilities. Yesterday, we saw a similar story out of Cincinnati that contained allegations of services being switched to Choice in the community in order to make hospital finances look better.

Whether that is the case or not, how do you reconcile shifting services over to the Choice Program and in the process eliminating capability to perform those services when Choice is clearly a temporary program designed to supplement VA care and its authorization expires next year?

Secretary MCDONALD. The most important thing in making any of these decisions is what is best for the veteran. Nothing else should be a consideration. Unfortunately—and I am not saying this is happening because we have to investigate the allegation you described. Unfortunately, because of the fact that we have got 70 line items of budget where we cannot move money from one to the other, you may recall last year I had to come to this Committee and ask for the ability to move money from the Choice budget that was for care in the community to the VA budget that was for care

in the community. Same purpose, but we had to ask your permission to move that money.

What we have put in our 2017 budget proposal is a proposal to give us flexibility on only 2 percent of our funding so that we can move money between accounts—again, with the idea that we have got to get the best care for the veteran.

Senator ROUNDS. Thank you. My time has expired. Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Rounds.

Senator Tester?

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

Senator TESTER. Thank you, Mr. Chairman.

I want to go back to Title 38. Could you tell me, Mr. Secretary, how many medical center directors were either acting or without a position or director?

Dr. SHULKIN. I would be glad to. Today, Senator, we have 34 medical centers without a permanent medical center director. I will tell you, being responsible for the health care organization, there is no way I can assure that we are doing the best for veterans with 34 open positions.

Senator TESTER. How many are acting? Or does that include acting?

Dr. SHULKIN. That includes acting. Those are ones that we need to fill.

Senator TESTER. Can you tell me how long it takes you to recruit and appoint an M.D., or a P.A. or a nurse right now?

Dr. SHULKIN. Approximately—they differ a little bit, but I am going to say, on average, 6 months?

Senator TESTER. Six months? OK. Now, if we make the changes that you have recommended, how long would it take you to recruit and appoint?

Dr. SHULKIN. Well, I think the change to Title 38 is going to help us get more candidates and better candidates. We have many medical centers that, frankly, have had openings for years and years because we do not have candidates. So, I think it is going to increase the pool. We have to—one of the Secretary's 12 priorities is to streamline the hiring process, because we have to get to where the private sector is. We have to be able to match or beat where the private sector is to get the best candidates.

Secretary MCDONALD. But, the Title 38 recruiting and hiring process is more streamlined than the SES process.

Dr. SHULKIN. Yes.

Senator TESTER. So, your hope is to get it down to what kind of a timeline?

Secretary MCDONALD. I would like to break it in half.

Senator TESTER. OK.

Secretary MCDONALD. I think we can do it.

Senator TESTER. OK. You put a number of legislative requests forward. Is it accurate to say that veterans' access to care has been impeded by the legal vulnerability associated with referring veterans to traditional fee care outside the Federal Acquisition Regulations?

Dr. SHULKIN. When you say "legal," the complexity of the system, absolutely, that is correct.

Senator TESTER. OK. I believe we have a bill—maybe not totally what you want, but a bill to get that done I think has come out of this Committee. Is it accurate to say that the VA's efforts to improve the quality and delivery of care have been impeded by the number of director vacancies?

Dr. SHULKIN. Yes.

Secretary MCDONALD. For sure, absolutely.

Senator TESTER. Is it also fair to say that from a medical personnel standpoint the appeals process has not been working like it should?

Secretary MCDONALD. We would agree with that.

Senator TESTER. OK. Is it also more important to say that you need flexibility in your budget?

Secretary MCDONALD. Yes, sir, we do.

Senator TESTER. To move money around.

In July 2014, Mr. Secretary, you were confirmed by a 97–0 nothing. Nobody in the Senate opposed you.

Secretary MCDONALD. I am still looking for those three that did not vote.

Senator TESTER. They were probably out campaigning for President. But, at any rate——

[Laughter.]

Senator TESTER. I would just say this: as a Committee—and I would be happy to work with the Chairman so it is on a bipartisan basis—we need to push the leadership to get these bills to the floor to hold this man accountable. We cannot hold him accountable if his hands are tied; I really think that it is important—I mean, he came from the private sector. Ten of his 16 folks have come from the private sector. If we want the VA to work, we have got to put our trust there. If he screws up, he is gone. But, the fact is I trust the Secretary; I believe that he can get this done. I think we need to give him the tools to get that done. It is going to require some floor action on these bills with a very limited amount of time for floor action.

If it would take a letter, if it would take phone calls, if it would take a group meeting with Senator McConnell, I would be more than happy to join you in that.

The only thing I would say—and this may be parochial in nature, but there is an issue with travel pay right now, where the veteran used to get travel pay immediately when they came. Now, because of people thinking they were going to try to game the system, they go to a kiosk. Now it is a month or longer to get their travel pay. I am hearing a lot about this. I am not sure that it solves any of the problems with pay going to a kiosk because if a guy wants to be a crook, he will be a crook on a kiosk just as well. What it is doing is it is stopping some of our veterans from being able to get the care timely. It may be hard to believe, but a lot of these guys need that travel pay and they need it quick. So, if we can do something on that, I would appreciate it.

Dr. SHULKIN. Senator, we will look into that. That is not an intentional delay, so we need to fix that.

Senator TESTER. The last thing I would say is—and I attribute this mostly to the third-party providers and not to the VA, which we have got to get this fixed. My staff just gave me a chart, and you can take a look at it: 53 percent of the work that we do is veterans work. It used to be a third. It is 53 percent now. That is not happening because things are going smoothly. I think you guys know that. We need to get it fixed. I think this Committee needs to do its job to help you fix it, and then we need to hold you accountable for that.

Thank you, Mr. Chairman.

Chairman ISAKSON. In reference to your comment in the beginning about meeting with Leader McConnell, for your edification and information, I appreciate your raising the visibility of those bills that we have passed out which have not gotten through the Congress yet. We are working on, if you will, an omnibus proposal that we hope to, by the end of March, have finished and acted upon in the House and the Senate. That is an aggressive game plan, but we are trying to get all that done. Sen. Tester, I will take you as a volunteer to be on my team, we will make sure we use you to help us do that—in a bipartisan way, too.

Senator TESTER. I would be more than happy. I think that it is important for us to hold the agency accountable. I think it is also important for us to listen to the people that are at the head of it and make sure we give them the tools that they need to be successful and then hold them accountable.

Thank you.

Chairman ISAKSON. We have got to hold ourselves accountable.

Senator TESTER. That is correct.

Chairman ISAKSON. That may be the biggest problem of all. We have got to correct that.

Senator Moran?

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

Senator MORAN. Mr. Chairman, thank you very much. Mr. Secretary, welcome. Thank you for the telephone conversation that we had recently.

I was interested in what Senator Tester had to say about case work. As you and I have talked, that has been a significant fact in our life, more veterans with more questions, I guess, and concerns. I appreciate Senator Tester raising that issue.

Let me talk about a couple of items that are Kansas related. The Choice Act provided for a new CBOC in Johnson County, KS. Johnson County is the Kansas side of the Missouri-Kansas line in Kansas City, our fastest-growing part of our State. The requirement, as I understand it, is for those proposed medical facility leases to be submitted to GSA. Then, the timeframe is seemingly extraordinarily long, like 5 years once the decision is made to begin that lease process.

Is there something that we can do to help speed up this process? We have the same issue in Junction City. Junction City is a bedroom community of Fort Riley with lots and lots of veterans. The CBOC there is needing to move out of its current facility, and they are looking for space, which, to my knowledge, they have not found.

Could you bring me up to date on both of those. The broader question is: is there something we can do to help speed up the process?

Secretary MCDONALD. The process does take too long. We have, I think—is it 16 or 18 leases right now? We are waiting—16. We are waiting for authorization from you all to move forward on.

Mr. MURRAY. Eighteen.

Secretary MCDONALD. Eighteen. So, you know, if you could authorize those, we would really appreciate it.

Senator MORAN. In the case of at least Johnson County that I am talking about, it is authorized.

Secretary MCDONALD. OK.

Senator MORAN. Then, having been authorized, I am told it is at least 5 years before——

Secretary MCDONALD. No—well, it should not be. We have worked with GSA to streamline that process, but I am happy to—we will come over and sit down with your staff and go through a streamlined timeline of how long it will take. It should not take 5 years.

Senator MORAN. OK. Well, there are two, if we could talk about the one in Junction City and the one in Johnson County.

Mr. Secretary, let me raise a topic of construction of a new hospital in Leavenworth, again, a military community. The strategic capital investment plan lists Leavenworth inpatient facility as number 13 of the VA's priority list, but there were no funds requested in fiscal year 2017. What does that mean? What is the value of that 13th ranking and no funding?

Secretary MCDONALD. Well, I think what it demonstrates, Senator, is we need more money in construction. Most of our priority projects are seismic projects or projects that deal with human safety. As I showed in my written testimony, we have had catastrophes happen because we have not been seismically ready.

Sixty percent of our buildings are over 50 years old. We would love to get down through the total list, but that is going to require a disproportionate amount of capital to do that.

Senator MORAN. In that circumstance, is the VA open to public-private partnerships, a local entity that would build the facility and then lease it back? Does that speed up the process and help the budgetary constraints?

Secretary MCDONALD. We are. There are actually two different processes, both of which we are looking at. One is something we already have experience with called "extended use leasing." This is a process where, for example, there is a company called Core that built a building on our campus in Menlo Park that we are able to rent from them to house homeless veterans. That is the bill I need passed for Los Angeles, because I cannot do that in Los Angeles right now, and that is where we have the majority of homeless veterans.

There is another process called "public-private partnership," or "P3," which we are currently exploring to move our San Francisco campus, which is landlocked and isolated. What we do not know yet is how CBO and OMB will score that and whether or not, because it is an extended use program, they will score it as if it were a capital project. We are looking into that. We should have an an-

swer in March, and we will be back to you, because if we can do P3s, it will unlock a lot of capability for VA.

Senator MORAN. Maybe we can have that conversation where we talk about the CBOCs as well, because I think there is an opportunity for this kind of thing to occur in Kansas.

My final question is: how does the CBOC issue affect the consolidation, Choice, community care plan? Are CBOCs any less valuable? Is there less emphasis as a result of Choice and consolidation, your program? Or——

Secretary MCDONALD. No, I do not think so, but I think what it does is it speaks to something you and I have talked about before, which is when we improved access last year, we did 7.5 million more completed health care appointments, that was in large part because we added over 2 million square feet of new space. So, every time you put a building out there, it creates access, advantages that you did not have before. But, what we have to do is we have to be more choice-ful—I do not mean a pun in that word, but we have to be more choice-ful about where we put them so we make sure we are taking advantage of all of our affiliates, like Indian Health Service, medical school affiliates, and others, and we are putting those only where they are required, being good stewards of taxpayer money.

Senator MORAN. I appreciate this conversation and look forward to having a future one.

Secretary MCDONALD. Me, too, sir.

Chairman ISAKSON. Senator Brown.

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

Senator BROWN. Thank you, Mr. Chairman. Welcome, Mr. Secretary and all of you. Thanks for your public service to our veterans and to our country, all of you.

I want to address the very serious allegations Senator Rounds mentioned about Cincinnati of mismanagement of the VA medical center and leadership of VISN 10. You and I have talked, Mr. Secretary, a number of times for months and months about some of these allegations and issues—nepotism, lack of cleanliness, mismanagement, staffing shortages, and fear of whistleblower retaliation.

First, it is about quality of care, as you have assured us, and I know how much you care when you took this job about that. I need your assurances first that while this investigation is going on and the issues and problems are being fixed, you will ensure that veterans receive better quality and good quality care throughout. I know you believe that. I just want your assurances, at the same time restoring faith in Cincinnati that veterans and their families feel compromised. I am glad that you have agreed to visit that VA as soon as our schedules permit both of us to go together. Thank you for that.

I want to talk about whistleblower issues for a moment. For more than a year, a number of whistleblowers have talked to my Cincinnati office, talked to me personally, talked to a number of people in my office and others. The atmosphere is, some workers will say, "toxic" where workers fear they will be punished for doing their jobs well. When VA employees come forward to voice concerns

regarding improper medical care or other issues, I am concerned that in too many cases VA management has retaliated against them.

So, I want your commitment for a couple of things, Mr. Secretary: one, that no employee in Cincinnati VA who did the right thing and advocated for our veterans will be retaliated against for their actions; and I want your commitment that if any VA employee is retaliated against for speaking up on behalf of veterans and patients, that you will hold those people accountable.

Secretary MCDONALD. First of all, relative to Cincinnati, as you noted, Senator, the investigation is ongoing. The Cincinnati facility has been a five-star facility historically in VA, one of our very best. I have visited it a couple of times myself over the last 2 years. It is an important facility. It has been historically a good facility. We need to dig into this and find out whether or not these allegations are supported and then take action as quickly as possible to remediate them if they are.

Relative to whistleblowing, you know, we were the first Department certified by the Office of Special Counsel to have done the training on whistleblowing. We take it very seriously. In fact, we ask all of our employees to give us negative feedback as well as positive feedback so we can change. That is why we are training them in things like Lean Six Sigma so they can create change themselves.

We do not tolerate retaliation and will deal with it if we see it. We just do not tolerate it, and we work very closely with the Office of Special Counsel to make sure whistleblowers are protected, that they are given good jobs moving forward, and that people who retaliate are held accountable.

Senator BROWN. That is what you say, and I believe you, but that——

Secretary MCDONALD. That is what I say; that is what I do.

Senator BROWN [continuing]. Is not what some people—apparently some people in Cincinnati that work at the VA have done. So, I do want the commitment that, if proven, people who have retaliated against whistleblowers will be held accountable.

Secretary MCDONALD. They will. Anybody who retaliates against a whistleblower will be held accountable. But, again, what we are describing here are allegations.

Senator BROWN. I understand.

Secretary MCDONALD. Let us do the investigation before we permit people——

Senator BROWN. That is why I said—I do not want to convict anybody. I did not mention names. I just said, if proven, I just wanted the commitment that you just gave me that——

Secretary MCDONALD. Yes, just know that we get a lot of whistleblower——

Senator BROWN. I understand. I see that. When I was a Member of the House, I heard it in Brecksville. I heard it in Wade Park. Sometimes it was accurate, sometime it was not. Thank you for that.

Let me talk briefly on—one, I want to echo Secretary McDonald's and Chairman Isakson's remarks about confirming Mike Missal at the IG. That is really important. When Cincinnati—I wrote to the

VA about Cincinnati. Unfortunately, the letter went to Linda Halliday, the Deputy Inspector General, instead of the Inspector General. I appreciate all your comments on making that happen.

Let me just close with a bit about staffing directly connected to Senator Rounds' comments. The report recommended the veterans—the required Section 301 report on staffing recommended 61 full-time equivalents be hired for the Cincinnati VA to properly meet the needs of veterans. There are reports that leadership at the Cincinnati VA may actually be abusing it by using it as an excuse to cut staff.

Can you tell me about any of that specifically now at this point? Or is that something you need to share later once you know more?

Secretary MCDONALD. We immediately sent the Office of Medical Inspection to Cincinnati. We do have a preliminary report from them, so we can—I am fine with updating you on that now.

Senator BROWN. OK.

Dr. SHULKIN. The other thing, Senator, that we did immediately was we removed the management authority from the VISN Director away from the Cincinnati VA to make sure that there was no ability to influence or to keep people from raising issues. So, we want this to be very transparent, and we will be glad, as soon as we get this final report, to review that with you.

Senator BROWN. How long will it take for these—whatever the number, up to and including the number 61, if there are 40 or 60 or 20—how long will it take to bring in and train new providers?

Dr. SHULKIN. Well, it will depend on the type of providers that are there. Obviously, physicians and nurses take longer because of their orientation and credentialing period, then staff, front-line staff. So, there will be a spectrum along that line. But, the VISN and the medical center have been given their budget and do have the ability to hire the most critical positions that they need to hire right now.

Senator BROWN. All right. Thank you.

Chairman ISAKSON. Senator Brown, just so it is clear on the record, I consider accountability to apply two ways: employee to supervisor, but supervisor to employee as well. We have got to have accountability on both sides, and that is what we are pushing so hard for. I appreciate your comment on that.

Senator Tillis?

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

Senator TILLIS. Thank you, Mr. Chair. Thank you all for being here. To Secretary McDonald and the folks on the panel, thank you so much for the time you have invested coming to my office and working with me.

I just want to emphasize what you have said that is critically important, that of the breakthrough priorities, there is very clearly instances where Congress sits in the critical path. If we do not take action to move forward on these legislative priorities, then it will either impede or prevent completely your ability to achieve the goals you have set out. I will continue to mention that and stand up for it.

Ms. Council, I want to talk to you for a minute about IT. It is fantastic to have somebody with your professional experience in the

role that you are in, and I am glad to have you there. Can you give me an idea of what your instincts are telling you as you look at this enormous IT base? You and I have talked about application portfolio, which we can talk in acronyms and most people would think it was a second language. Can you tell me what your gut tells you the IT platform looks like 5 years from now versus today in terms of off-the-shelf solutions, integrated platforms, those sorts of things that I think are, at least according to the Secretary and others, huge enablers to what you all are trying to accomplish?

Ms. COUNCIL. Senator Tillis, it is great to talk to you as well. I will not use any acronyms this time.

As we sort of look out into the future, one of the things that has become very clear, not just on intuition but on fact, is that we have a very complex architecture and a variety of different things in our midst. So, figuring out how to manage those today and move off of them toward the future is critical.

One of the critical areas that I think that will look very different in the future is how we manage and use data and how we leverage that data in support of the veteran. I believe we have a prime opportunity with putting in a data management function, but putting in something that is very different than anyone has seen at this point that will move us forward to have much more agility related to our operations, related to what the veteran will need, increasing our ability to be much more mobile, have mobility being used by the veteran and our access to information as well as our ability to speak and engage with them.

I think also when we look at our infrastructure, having a much more solid supply chain capability, a financial system that will enable much more visibility into an environment, but also ensuring that we have some best of breed capabilities wrapped around our health care as well as in our benefits areas.

Senator TILLIS. Well, one thing—and I want to try and get a lot in in the last couple of minutes, but one thing I would really like to see from you all over time that makes sense, not out of order for all the things you need to do to transform the IT operation, is something that would give me some sense that these duplicative or redundant platforms that are used out in the VISNs are consolidated when they make sense. There are very clear patterns that I can view when I take a look at these transition plans, and I would like to see that so I know we are making the organizational changes and the systems changes to make a lot of these things that are falling through the cracks and probably the root cause of a lot of the problems that we have. I appreciate the opportunity to maybe get briefed with you once you have gotten your legs there. I appreciate it.

I want to go into a lightning round real quick because I want to try to stick to my time allotment.

First, I just want to echo the sentiments here that we need to confirm the IG and do everything that I can to get the Inspector General there. It is a very vital role. We need somebody in a permanent position.

Mr. McDonald, this organization chart seems to me to be an optimized state. I mean, it is a pyramid. It looks like you have got the right distribution, but today it seems to me like it is an obelisk.

One thing that we really have not talked about here is the organizational change, and over time, unless you have data here, I would like to find out what we are doing in the middle to reorganize and either eliminate those resources or free up the resources to provide care out in the communities.

Can you give me some idea—we have not talked much about that track. Can you give me some idea of what that looks like?

Secretary MCDONALD. Well, the middle is the most important part, as you well know, of any organization. Number 1, training. We are training the leadership team. That training is now cascading through the organization. Twelve thousand senior leaders will have been trained. We are training leadership. We are training process mapping. We are training Lean Six Sigma, values, mission, all the important things. Three days of training.

Number 2 is structure, spans and layers. We have to reduce the number of spans and reduce the number of layers.

Senator TILLIS. OK.

Secretary MCDONALD. We talked about moving from 21 VISNs to 18. That has already shown savings. That was in my oral testimony. But, the fact that we have so many open positions is an opportunity to reduce even more.

So, with every open position, we really question, David and I question, and Sloan, whether or not we should fill it. We want to reduce spans, we want to reduce layers, and we can share that plan with you next time we——

Senator TILLIS. Thank you. I would like that. It is just because my time is short that I am cutting you off.

Secretary MCDONALD. Yes, I see.

Senator TILLIS. I think seeing a measurable—instinctively, this organization looks like it is heavy in the middle, and with that comes cost and complexity and breakdowns and handoffs. I would like to see what that transformation looks like over time, both in terms of its structure and in terms of the people. To your point, many of them may be open, so it just means you no longer have a need for that position. I think that would be helpful so that people understand there is an organizational transformation that is going on.

My last thing, just to follow up. When a veteran calls for help—let us say it is a distress call for a veteran who may be worried that they are thinking about suicide. How are these calls tracked? In other words, if I get reports, as I have in North Carolina recently, that a veteran called and was told to call back, how can I track that down; either make sure that person has been trained and has not done their job, therefore they should be fired, or that their supervisor has not gotten them the appropriate training to make sure that that is never an appropriate disposition, if, in fact, it is happening? What I want to do is at least go in and be proactive and say maybe I do not have the facts straight based on what has been reported on the ground. But, if those facts are right, then I want to go after that person for doing the wrong thing for a vet. I would like your advice on that, either in the Committee or afterwards.

Secretary MCDONALD. Well, it is a very complex issue, so let me give you a headline, and then we will come over and talk about our Veterans Crisis Line.

As you know, one of our priorities for this year is to fix the outreach to veterans and the Veterans Crisis Line. When all of us came, new people, to this organization, what we discovered was the Veterans Crisis Line, a recent IG report which was written starting on an investigation in May 2014, so before I was confirmed, found that we had a third party that we had contracted with that was using voicemail. Well, you do not use voicemail for a crisis line.

We have put new leaders in place. We hired a person with experience on Philadelphia 311. They have come in. We have got new technology in place, new training in place. But, we have got to get out of the potential for a veteran being put on hold, having to call a different number.

We still have some medical centers—and we are trying to discover which those are and then eradicate them—where if they call the medical center and there is an emergency, it says, "Please call this number," rather than immediately shifting that call. We are trying to identify where those are and then shift the call automatically rather than having them call back.

So, this is a work in progress. We are happy to brief you on it. It is taking us longer than we would like. Yet, it is one of our goals for this year, and we do need the budget to do it.

Chairman ISAKSON. Thank you, Senator Tillis.

Senator Sullivan?

HON. DAN SULLIVAN, U.S. SENATOR FROM ALASKA

Senator SULLIVAN. Thank you, Mr. Chairman. I appreciate the witnesses' focus on these very important issue. Mr. Secretary, good to see you again.

Dr. Shulkin, I wanted to follow up on a couple things. Dr. Shulkin, I sent you a letter dated January 4, 2016. This is on the ongoing issue. It is a bit of a minor issue in some ways, but it is a huge issue also. I think you and I have seen this—we have been talking about it for a while now, about veterans who are hounded by collection agencies for unpaid bills where the services were approved by the VA and now somehow our veterans are getting saddled with that. The letter had a number of—actually, pages of cases that last time we spoke—last time you testified, you mentioned to me to get you those specific examples. I did. Can you give me an update on where we are on that? This is something that I think we should just nip in the bud, kill. I mean, it is outrageous that we have vets going through that kind of stress.

Dr. SHULKIN. I absolutely agree, and I heard this directly from you and from veterans when we were together in Alaska as well. So, this is a short-term problem and a little bit longer-term problem. Fortunately, I think we have solutions for both.

The short-term issue, we do not want veterans put in the middle, and so we have established a toll-free number—I wish I had the number memorized, but I will get it to your office—where if a veteran lets us know about that situation, we will intervene immediately. We have done over 400 interventions in the last 3 weeks since we put that number up.

Senator SULLIVAN. Great. Thank you.

Dr. SHULKIN. We want to know from all your offices because we want to help, and——

Senator SULLIVAN. Is there something legislatively we need to do to fix this at all?

Dr. SHULKIN. No.

Senator SULLIVAN. Just let them know that if that is an issue, they should call you guys, and you will take care of it.

Dr. SHULKIN. What has happened is because we have had a problem in paying on time, the veteran has been put in the middle, and those are the ones that we want to stop. Right before you came in, we talked about we now actually have delivered to the TPAs yesterday the contract for them to sign that will decouple medical documentation from payment so we can get much better at making payments and keep these situations from happening.

Senator SULLIVAN. OK. If you can follow up on the specific ones I have in that letter——

Dr. SHULKIN. Absolutely.

Senator SULLIVAN [continuing]. That would be very useful.

Dr. SHULKIN. Yes.

Senator SULLIVAN. I wanted to next go to the issue with regard to the appeals process. Mr. Secretary, I noted that the budget certainly focuses on this. It is an issue that—I know, you know the numbers, but 400,000 veterans have appeals pending as of January 2016; 80,000 of those are older than 5 years old; 5,000 of those are older than 10 years old. I put forward a bill, S. 2473, with very strong bipartisan support on this Committee. I will not go through all the elements of it, but we certainly want to work with you. I think my staff has been working with your staff. I think you are supportive of the bill.

Could you talk a little bit about how we get our arms around this appeals issue? Because it does relate, of course, to the backlog issue, and what we do not want to have happen is alleviate the backlog, then have the appeals become the problem. We think there are some good things in the bill that a number of us have cosponsored, but I would like your view on that, particularly because you do seem to be focused on it in the budget.

Secretary MCDONALD. We do think moving forward with the fully developed appeals process makes sense. We are supportive of that. But, we do not think it goes far enough to get to what we think is a breakthrough—one of our 12 breakthrough objectives, which is to be able to decide an appeal in a year.

Senator SULLIVAN. Yes.

Secretary MCDONALD. To do that, what we put together here in this budget is a plan where we add more people now in the short term in order to knock the backlog down as much as we can, but at the same time we redesign the appeal law, which is over 80 years old, so that we can get to that point later where we deal with each appeal within a year. That will actually save us money. That will save the Government money and save taxpayers money.

To do that, we are going to have to deal with the fact, as I said earlier, that there is only a small group of veterans that are gumming up the system for everyone else. Ten to 11 percent of veterans appeal; 2 percent of veterans created about 45 percent of the ap-

peals. Some have appealed 25 times, 50 times. The majority of those appealing, the majority, are already receiving some form of compensation—maybe the wrong amount, but they are already receiving some form of disability compensation. Many of them who are appealing are already rated 100 percent disabled.

So, you know, you want to get to the point where you can freeze the Form 9, as we call it, and cause the person to have to resubmit rather than having the same person appeal over and over and over again, recognizing that there is no recourse that we have to stop them from doing that.

Senator SULLIVAN. OK. We would like to work with you. I appreciate that update and how you are laying that out more strategically. We will continue to work with your staff on S. 2473, which we think is—it is a pilot program. You may have seen the legislation. We think that it offers a good opportunity, similar to the pilot program that the VA is instituting in Alaska.

Mr. Chairman, I will just ask, via posthearing questions for the record, an update on where we are on the Alaska pilot program as well.

Senator SULLIVAN. Thank you, Mr. Chairman.

Chairman ISAKSON. Senator Cassidy.

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

Senator CASSIDY. Thank you. Mr. Secretary, thank you for being here. I have kind of a smattering of questions all over the place.

What is the VA currently paying for the cost of hepatitis C treatment, for a regimen of hepatitis C treatment?

Dr. SHULKIN. Less than we were.

Senator CASSIDY. I got that.

Dr. SHULKIN. Our drug pricing is proprietary, so, unfortunately, I cannot say exactly what it is. I will tell you that it is by far the best on the market. That is why it is proprietary.

Secretary MCDONALD. We would be happy to tell you privately.

Senator CASSIDY. OK. I was just thinking about it. If $54,000 is what the latest regimen costs list and you are averaging 25 to 30 percent less, it seems like we should be able to treat more veterans for the $1.5 billion that we are giving if, ballpark, you are paying $30,000 per. It seems like we should be treating 50,000 veterans as opposed to 30,000 just to——

Secretary MCDONALD. That is exactly the idea. We had a 5-year plan, and we are now looking at, with lower costs, how do we compress that plan forward and get everyone treated.

Senator CASSIDY. So, the $1.5 billion you mentioned, and I think 35,000 plan to be treated, actually you hope that is elastic on the up side.

Dr. SHULKIN. There is no doubt that is the case. Thirty-five thousand was what we submitted in the budget. We believe we can treat many more now.

Senator CASSIDY. I see. Thank you.

Second, in this new regimen of folks, you know, having a new pay scale, government benefits are typically more generous than private sector benefits. So, if you increase—and I do not know if that is true for executive compensation.

Dr. SHULKIN. It is not.

Secretary MCDONALD. I would argue that.

Senator CASSIDY. No, no. I am talking about retirement benefits. I am not talking about—so the retirement benefits would be roughly equivalent as well.

Dr. SHULKIN. Yes, sir.

Senator CASSIDY. OK. So, there is not a tail on this that is going to come back and bite us that would be greater than we would otherwise anticipate.

Dr. SHULKIN. No, sir.

Secretary MCDONALD. No, sir.

Senator CASSIDY. OK. By the way, just to be sure, clearly when industry decides to downsize, a lot of middle management and top management also goes. But, obviously, our current civil service restricts the ability to release folks even when they are no longer needed. It is great for the individual. It is terrible for the taxpayer and, arguably, bad for the veteran. Under this new authority, if you downsize, if we no longer need this facility, for example, can you immediately release the person without having to go through a complicated process?

Secretary MCDONALD. Title 38 gives us much more flexibility to do that.

Senator CASSIDY. Much more flexibility. Would it be as flexible as the private sector or——

Secretary MCDONALD. Virtually as flexible as the private sector. I am trying to think. David?

Dr. SHULKIN. The private sector differs. Some people have extended contracts. Other are at will. Title 38 is going to be somewhere in between.

Senator CASSIDY. I get it. OK.

Now, you mentioned in your testimony regarding closing unsustainable facilities, and we are actually interested in this, and we sent a poorly worded request and now we have a better worded request trying to figure out, you know, where these facilities are. You attempted to close one in Massachusetts, as you mentioned, but you ran into environmental issues. I think I have heard you say it before, but just for the record, tell me, if you have all these vacant and underutilized facilities, what are the three top obstacles in closing them, may I ask?

Secretary MCDONALD. Number 1 would be congressional opposition, and congressional opposition born by perhaps veteran opposition. I mean, if you are a veteran and the hospital where you go is in a remote area and that hospital only serves five patients a day, it obviously is very expensive to run a hospital serving five patients a day. But, if you are one of the patients being served, you obviously want it to stay open.

Senator CASSIDY. You mentioned, though, that you have 370 facilities which are either fully vacant or less than 50 percent occupied, which presumably would not have to be completely shut down but, rather, could be, OK, this wing we are no longer using sort of thing. Of those that are fully vacant, what is the obstacle to closing those?

Secretary MCDONALD. Again, congressional opposition——

Senator CASSIDY. Even for something fully vacant?

Secretary MCDONALD. Yes, sir. Veteran opposition. Some are on the historic register of buildings because, remember, 60 percent of our buildings are over 50 years old, so we have to come up with an alternate use for those historic structures unless there is some way to obviate that law or——

Senator CASSIDY. Now, let me ask, that could include just boarding up and putting a fence around it, I presume?

Secretary MCDONALD. Yes, sir.

Senator CASSIDY. I am just saying that for the taxpayer, I mean, we are running this incredible deficit. We have got $26 million that is not being used for patient care, but which is basically being used to not mothball buildings which should be mothballed.

Secretary MCDONALD. Yes.

Senator CASSIDY. I would be an advocate for just putting the fence around it until, you know, something could be done, it could be sold or developed or something.

Any other reasons? I am sorry I interrupted you.

Secretary MCDONALD. No. Those are the primary reasons.

Senator CASSIDY. OK. Downsizing from 50 percent use to, you know, closing off a wing. What is the obstacle there?

Secretary MCDONALD. Again, it depends on the historic structure of the building and what it is used for.

Dr. SHULKIN. Yes, we do close off wings in bigger buildings, but they still are very expensive for us to maintain. You still have to maintain the pipes and the heating and other types of things. So, what we normally refer to is the 10 or 11 million square feet that costs us the $25 or $26 million a year.

I think in some cases we are being shortsighted in not putting in the capital investments to make the upgrades. When 50 percent of our buildings—or 60 percent of our buildings are more than 50 years old, you know that we are maintaining systems that are very, very expensive to maintain that, using today's technology, we would be able to do a much better job by investing some money right now.

Senator CASSIDY. Well, typically, when they rebuild a new hospital, they tear it down because the code is so—you get grandfathered in until you break a wall, and then you have got to institute the whole code. I could see it would also be more cost-effective just to cut your losses.

I yield back. Thank you.

Chairman ISAKSON. Thank you, Senator Cassidy.

Senator Boozman?

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

Senator BOOZMAN. Thank you, Mr. Chairman. Thank you all for being here, and we do appreciate your hard work. Also, I very much appreciate the ability to get in touch with you and you all being very accessible.

You mentioned several accomplishments that you all have made, rightfully so, and I think that is one of those that people do not think about, but the accessibility really is important to Members of Congress.

In going along with that, you also said that the systemic problems could not be fixed overnight. Can you talk a little bit about

some of the biggest obstacles that you face in that regard? Is there need for additional legislation to help you in that regard?

Secretary MCDONALD. Senator Boozman, thank you so much for the question, and thank you for the time we spent together. To me, job one of any leader is to get the right leadership team in place. Frankly, it has taken me too long to get 10 of the 16 leaders in place since I came on board. I wish the nomination and confirmation process were more quick, which we have talked about the IG as an example of that.

I will tell you also, within the organization, getting new leaders in place is job one, and that is why we have recommended taking the SESs from Title 5 to Title 38. We are in the process of revamping the recruiting process as well. But, for me, that is job one. We have got to get the right leaders in place.

Senator BOOZMAN. The latest decision by the Merit Systems Protection Board overturned disciplinary action. I think we have a situation now where they have overturned more than they have upheld.

Secretary MCDONALD. They are batting a thousand. They have overturned every one.

Senator BOOZMAN. Which, you know, is sad. You were blessed and worked hard and got in a situation where you headed one of the biggest, most respected corporations in America. When we visited, I think you pointed out that if the VA were a business, it would be the sixth largest in the country.

Secretary MCDONALD. Yes, sir, that is correct.

Senator BOOZMAN. Can you talk a little bit about how impossible it is to run an efficient entity where you simply do not have the ability to discipline people when they need to be disciplined? With that size, the reality is that there are going to be situations where people need to be disciplined, need to be held accountable. So, please talk to us a little bit about how we can help you in that regard to see if we can get this straight.

Secretary MCDONALD. I will start with the last question first. We think the right approach is this proposal that we are all working on together, the White House and Congress——

Senator BOOZMAN. As far as legislation.

Secretary MCDONALD [continuing]. On going from Title 5 to Title 38 for the SES employees. As I was sharing with the Chairman—I think we talked about this when we were together—we have worked hard to connect performance with outcome. I talked in my testimony about how bonuses and rewards are down in the VA. We have a ranking of our——

Senator BOOZMAN. So, the old days of just handing out a check are over.

Secretary MCDONALD. Over.

Senator BOOZMAN. Good.

Secretary MCDONALD. The ranking of our performance by performance level is, I would argue, best-in-Government and fully equal to best in the private sector. So, for example, the top ranking, one, which would be considered the most outstanding, in 2012 over 25 percent of the people were rated that way. Today, it is around 10 percent. The steps that we are taking are giving people a good knowledge of what they have to accomplish, holding them respon-

sible for doing that, then making the reward match that. That is part of the training that we are doing. This Leaders Developing Leaders training is all about that, accountability and responsibility. But, we think, again, changing the SESs from Title 5 to Title 38 would be a big help.

Senator BOOZMAN. Right. That is so important.

You mentioned the VetLink program. I think about 3 percent were dissatisfied, which, again, that is a low number. What do we do about the 3 percent? How do we follow up on that?

Secretary MCDONALD. Just in general, we are putting in place a standard veteran satisfaction measure across the enterprise, and this will be the first time ever that VA has had this, believe it or not. We will follow up with all the veterans who demonstrate some level of dissatisfaction by getting the verbatim comments and then acting to remediate what their verbatim comments are. That is what we are trying to do with VetLink, is to make sure we take those comments in. Then, the medical center director has got to react to them and make changes right on the spot.

Senator BOOZMAN. Very good. Well, again, thank you for being here.

Secretary MCDONALD. Thank you.

Senator BOOZMAN. I appreciate your service.

Thank you, Mr. Chairman.

Chairman ISAKSON. Well, thank you, Senator Boozman, and thank you for bringing up the part about the accountability. Earlier in the hearing, the Secretary in his testimony addressed that subject and a number of Members have as well. I think the fact that you, Secretary McDonald, independently brought that up as your first comment—we are in a situation where you have got a toolbox that does not have all the tools you need in it to really run the agency the way you would like to and the way it should be. I commend you on the things that you have done, but let us stick to our goal of by the end of March getting a new toolbox and giving you the tools that you need to have accountability as a mechanism that works in the VA.

Thank you, Senator Boozman. Thank you, Mr. Secretary.

[The posthearing questions to Secretary McDonald follows:]

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOHNNY ISAKSON TO U.S. DEPARTMENT OF VETERANS AFFAIRS

VETERANS HEALTH ADMINISTRATION

Question 1. The Secretary testified that the Veterans Health Administration (VHA) is looking to expand capacity by "focusing on staffing, space, productivity, and VA Community Care." Specifically, he noted the Access Stand Down VHA held last fall to review and schedule consults that were open more than 30 days, hired more than 41,000 health staff, the activation of more than 2.2 million square feet of space, a nine percent increase in physicians' Relative Value Units, and 2.4 million appointments in the community.

A. What other improvements has VA reviewed that would increase access, such as night and weekend hours for certain clinics; extending the hours of the operating rooms to match the private sector; or increasing a physician's panel size to also match the private sector?

Response. The Department of Veterans Affairs (VA) is committed to providing timely access to Veterans as determined by their clinical needs. We strive for all Veterans to have safe, high-quality, personalized, and timely care wherever they receive their health services. VA has made progress in improving appointment availability. VA is currently completing more than one in five of its patients' appoint-

ment requests on a same-day basis. Additionally, we are making strides to reduce the number of Veterans waiting longer than 30 days by ensuring that all clinic management teams have the processes, structure, and resources to make real-time adjustments to address the needs of their specific population.

As part of a large-scale and immediate effort to assess the urgent health care needs of Veterans, VA conducted a second "Access Stand Down" on February 27, 2016. The nationwide, one-day event resulted in VA reviewing the records of more than 80,000 Veterans to get those waiting for urgent care off wait lists. Newly released results of the Access Stand Down show that 93 percent of Veterans waiting for urgent care have been contacted, with many receiving earlier appointments. VA's ability to meet the primary and urgent health care needs of our Veterans is a priority for us, and is why we established *MyVA*, which focuses all that we do around our Veterans.

Nationally, VA completed more than 57.36 million appointments from March 1, 2015, through February 29, 2016. This represents an increase of 1.6 million more appointments than were completed during the same time period in 2014/2015. VA completed 96.46 percent of appointments in February 2016 within 30 days of clinically indicated or Veteran's preferred date. VA increased its total clinical work (direct patient care) by 10 percent over the last 2 years as measured by private sector standards (relative value units). This increase translates to roughly 20 million additional provider hours of care for our Veterans. VA is also working to increase clinical staff, add space, and locations in areas where demand is increasing and extending clinic hours into nights and weekends, all of which have helped increase access to care even as demand for services increases.

Additionally, VHA's new initiative, *MyVA* Access, represents a major shift for VA by putting Veterans more in control of how they receive their health care. *MyVA* Access is a declaration from VHA employees to the Veterans they care for; it is a call to action and the reaffirmation of the core mission to provide quality care to Veterans, and to offer that care as soon as possible to Veterans how and where they desire to receive that care. *MyVA* Access ensures that the entire VA health care system is engaged in the transformation of VA into a Veteran-centered service organization, incorporating aspirational goals such as same-day access to mental health and primary care services for Veterans when it is medically necessary.

B. Of the more than 41,000 employees VA hired, how many of those positions are funded through section 801 of the Veterans Access, Choice, and Accountability Act of 2014?

Response. As of March 31, 2016, VHA had approximately 10,850 new full-time employees (FTEs) on board that are funded by Section 801 of VACAA hires, exceeding the hiring goal of 10,682 FTE. VHA continues to track VACAA onboards for financial reporting, but new hires for VACAA ceased at the end of pay period 26 on January 9, 2016.

Question 2. When VA submits the President's request for medical care accounts, VA frequently revises the amount for the current fiscal year request that was appropriated in advance. The process has been referred to as VA's "second bite of the apple." According to testimony at the Committee's budget hearing, the Paralyzed Veterans of America (PVA) indicated they questioned VA whether the requested level for fiscal year (FY) 2018 would be sufficient to meet their needs. According to PVA, in response, VA "half-heartedly admitted that they do not believe it is going to be sufficient either." PVA indicated that, since Congress has only revised the advanced appropriation amount twice, "the track record does not lend itself to underestimating now to get it corrected later."

A. What is VA doing to ensure the advanced appropriation request VA submits to Congress reflects a more accurate amount going forward?

Response. The Advance Appropriation allows VA health care to avoid the financial limitations of a Continuing Resolution or a lapse in funds that could lead to a shutdown of VA health care operations. Funding of the Advance Appropriation establishes an initial VA health care budget to continue operations until the full appropriation amount is enacted. The updated President's Budget request for adjustments to the Advance Appropriation (the "second bite") is intended for the administration to fully evaluate the resource requirements of the VA in context of the entire Federal budget. Estimates can also vary significantly in the year between requests based on updates to the Enrollee Health Care Projection Model, newly authorized benefits, emerging requirements such as Hepatitis C drugs, recommendations for changes generated by the Commission on Care, and sequestration limits.

B. In the budget justification, VA indicated that the increases from FY 2017 to FY 2018 are "offset by partial decreases from the 2017 levels for other programs."

Please list all programs that will offset the increase for FY 2018 and detail the reasons for the decreases in those programs.

Response. The $1.386 billion dollar 2018 Advance Appropriation increase over the 2017 appropriation request is due to the following factors:

- Increases in the initial 2018 estimate are offset by partial decreases from the 2017 levels for other programs, including health care infrastructure enhancements, Hepatitis C treatment, and programs to end Veterans Homelessness (see below "Programmatic Decreases, 2017 Revised Request vs. 2018 Advance Appropriation").
- Care in the Community is maintained equally to the 2016 Medical Services operating budget level.
- The 2017 level of core Medical Services FTE is sustained into 2018. The 2018 President's Budget will revisit the continuing costs of sustaining the new VACAA hires.
- Long-Term Services and Supports increase by $607 million, driven largely by cost estimates provided by the Enrollee Health Care Projection Model and projected State Nursing Home growth.
- CHAMPVA, Caregivers and other health care programs increase by $259 million to fund annual increases in workload.

PROGRAMMATIC DECREASES
2017 REVISED REQUEST VS. 2018 ADVANCE APPROPRIATION

(Dollars in Thousands)

Description	2017 Revised Request	2018 Advance Approp.	Decrease 2017-2018
Health Care Services			
Ambulatory Care	$36,135,657	$30,935,829	($5,199,828)
Prosthetics	$3,645,677	$3,376,159	($269,518)
Dental Care	$1,433,385	$1,277,378	($156,007)
Non-Add Included Above:			
Activations	*$836,293*	*$497,808*	*($338,485)*
Ending Veterans Homelessness	*$1,591,365*	*$1,122,398*	*($468,967)*
Equipment	*$1,144,512*	*$600,000*	*($544,512)*
New Hepatitis C Treatment	*$1,500,000*	*$600,000*	*($900,000)*
Pharmacy	*$8,352,950*	*$7,456,705*	*($896,245)*
Non-Recurring Maintenance	*$1,072,985*	*$600,000*	*($472,985)*
VistA Evolution	*$40,000*	*$0*	*($40,000)*
Other Health Care Programs			
Camp Lejeune (Family)	$9,840	$8,050	($1,790)

Many of the reductions were the result of the funding level available under the budget agreement, with affordability across all programs being a key driver. For example, the reduction of Hepatitis C funding from fiscal year (FY) 2017 to FY 2018 is not based on reduced demand but on affordability within VA's Advance Appropriation request "top line" funding level. Estimates for these programs will be re-evaluated during the 2018 budget cycle.

Question 3. The budget justification indicates a future goal of VHA's is to create a Transitional Care Program Office within VHA to concentrate management of transition care programs.

A. Please describe in detail the duties of this office and provide an organizational chart of the office and where it would be placed in VHA's organizational chart.

Response. Care Management and Social Work Services (CM/SWS) proposes realigning the Federal Recovery Coordination Program (FRCP) back under the Transition and Care Management (TCM), CM/SWS, to integrate care coordination services under one leadership and create a synergy to further enhance care coordination services for Servicemembers and Veterans (SM/V) and their families. The Program Office will not only centralize care coordination services, but also support an interprofessional model of transitional care, which includes, but is not limited to, nurses, physicians, pharmacists, mental health clinicians, and social workers.

VA operates a number of case management and care coordination programs that provide assistance to transitioning SM/V, including Transition and Care Management Services and the FRCP. These two programs assist wounded SM/V to navigate the recovery care continuum.

Transition and Care Management Services leads two national programs:

1) The VA Liaison Program consists of 43 VA Liaisons for Health Care at 21 Military Treatment Facilities (MTF) to facilitate ongoing VA health care for ill and injured Servicemembers transitioning from Department of Defense (DOD) to VA. Since the inception of the program, VA Liaisons for Healthcare have coordinated over 70,000 transitions. In FY 2015, VA Liaisons for Healthcare coordinated 11,221 transitions; provided 22,108 professional consultations and 2,543 briefings; and ensured that Servicemembers transitioning from DOD to VA received timely access to care by ensuring that 100 percent of Servicemembers who wanted VA health care had an initial VA appointment scheduled at the VA health care facility of their choice; and ensured that 89 percent had appointments scheduled prior to leaving the MTF.

2) The TCM Program consists of a TCM team at each VA Medical Center to provide comprehensive and specialized transition assistance and ongoing case management services to Post-9/11 Veterans as they reintegrate into their home communities and into VA health care. VA has approximately 400 TCM case managers nationwide providing case management services to almost 35,000 Veterans. In FY 2015, 90 percent of these Veterans were contacted regarding their individualized care management plan, resulting in over 367,000 contacts.

The FRCP was developed as a joint program by VA and DOD, in January 2008, to provide care coordination services to SM/V who were severely wounded, ill, or injured after September 11, 2001. The program utilizes Federal Recovery Coordinators (FRCs), either social workers or nurses funded by VA Central Office, to monitor and coordinate clinical services, including facilitating and coordinating medical appointments; and non-clinical services, such as providing assistance in obtaining financial benefits or special accommodations needed by program enrollees and their families. FRCs currently serve approximately 400 SM/Vs, of which 27 percent also have a VA Lead Coordinator (i.e., TCM Case Manager).

Aligning the two entities providing care coordination services under one leadership would integrate the two programs and create a synergy to further enhance care coordination services for SM/V and their families.

B. Please provide the Committee with the expected funding level for the office, the number of full-time equivalent employees (FTE) to include a break out of number of title 5 employees and number of title 38 employees.

Response. The VHA Transitional Care Program Office is an aspirational project for the future, with most (if not all) of its funding needs derived from current resources. However, there is no specific resource or budget request for it at this time.

Question 4. The number of unique patients VHA estimates will receive mental health care from a non-VA provider increased by 17 percent above the FY 2016 current estimated level and by 50 percent above the FY 2017 advanced appropriations. However, the number of unique patients is expected to decrease by 9 percent in FY 2018. In addition, the number of unique mental health patients receiving care in the community shows significant increases between the FY 2017 budget's estimated level and the FY 2018 advanced appropriations estimate.

A. Please explain, in detail, the reason for the significant changes in the estimated number of unique patients accessing care in the community.

Response. In projecting future Veteran demand for VA health care, VA uses the Enrollee Health Care Projection Model to account for the unique characteristics of the Veteran population, VA health care system, environmental factors impacting Veteran enrollment, and use of VA health care services. Growth in expenditure requirements to provide care to enrolled Veterans has been primarily driven by health care trends, the most significant of which is medical inflation. Health care trends are key drivers of annual cost increases for all health care providers—Medicare, Medicaid, commercial providers, and the VA health care system.

In 2015, the VACAA significantly expanded access to VA health care for enrolled Veterans. VACAA increased VA's in-house capacity by funding medical FTE growth in VA facilities, expanded eligibility for care in the community for enrollees residing more than 40 miles from a VA facility, and assured access to care within 30 days. This additional capacity facilitated an increase in current enrollees' reliance on VA health care over the level expected in 2015. At the end of FY 2015, the VA Budget and Choice Improvement Act further expanded eligibility for care in the community paid for by VA. As a result, enrollee reliance is expected to continue to increase beyond what would have been expected in the pre-VACAA environment. This expected increase in enrollee reliance significantly increased the projected resources required to provide care to enrolled Veterans in 2017 over the 2017 Advanced Appropriation level.

Additionally, the number of Veterans who received mental health care from VA has grown significantly since 2005. This rate of increase is more than 3 times great-

er than what is seen in the overall number of VA users and the number of mental health encounters or treatment visits, from 10.5 million in 2005 to 19.6 million in 2014, has been even more dramatic—at 87 percent. As a consequence of these trends, the proportion of Veterans served by VA who receive mental health services has shifted substantially. In 2005, 19 percent of VA users received mental health services, and in 2013, the figure was 27 percent. We anticipate VA's requirement for providing mental health care will continue to grow. The FY 2017 budget request ensures the availability of a range of mental health services, from treatment of common mental health conditions in primary care, to more intensive interventions in specialty mental health programs for more severe and persisting mental health conditions. We will continue to focus on expanding and transforming mental health services for Veterans to ensure accessible and patient-centered care, whether within a VA facility or in the community.

B. Please provide the Committee the types of care provided, the non-VA care programs (i.e., Patient Centered Community Care, Veterans Choice Program, fee basis, etc.) utilized to provide care in the community, and the amount spent under each program.

Response. See table below.[1]

Description	2015 Actual	2016 Estimate	2017 Estimate	2018 Estimate
Health Care Services:				
Ambulatory	$3,320,039	$3,317,655	$3,782,178	$2,097,257
Inpatient Care	$2,480,735	$2,329,672	$2,655,862	$1,472,703
Mental Health*	$171,577	$165,216	$194,781	$108,008
Dental Care	$177,268	$171,013	$201,616	$111,798
Health Care Services [Total]	$6,149,619	$5,983,556	$6,834,437	$3,789,766
**VMS doesn't allow for granularity relating to this program*				
Long Term Services & Supports:				
Community Nursing Home	$861,464	$969,603	$1,012,378	$1,064,090
Community Non-Institutional Care				
Community Adult Day Health Care	$119,692	$123,711	$132,625	$135,496
Home Respite Care	$35,399	$37,457	$40,062	$43,392
Purchased Skilled Home Care	$319,249	$333,502	$348,986	$365,392
Hospice Care	$90,817	$93,464	$96,329	$99,223
Homemaker/Hm. Hlth. Aide Prgs	$721,119	$778,602	$817,723	$864,082
Subtotal	$1,286,276	$1,366,736	$1,435,725	$1,507,295
State Nursing Home	$1,049,756	$1,166,253	$1,268,888	$1,388,354
State Home Domiciliary	$58,298	$62,855	$66,361	$70,583
State Adult Day Care	$1,031	$892	$1,029	$1,195
Subtotal	$3,256,825	$3,566,339	$3,784,381	$4,031,517
Other VA Programs Care:				
CHAMPVA	$1,061,597	$1,212,266	$1,530,368	$1,671,700
Spina Bifida	$32,352	$53,002	$58,026	$57,691
FMP	$27,051	$64,634	$31,286	$34,151
CWVV	$0	$200	$200	$200
Caregivers (CIC portion)	$17,398	$21,483	$28,059	$24,981
Indian Health Services	$14,999	$15,000	$28,062	$29,358
Camp Lejeune - Veteran Purchased Care	$6,377	$13,619	$11,347	$11,794
Camp Lejeune Family	$506	$10,273	$9,840	$8,050
Subtotal	$1,160,280	$1,390,487	$1,697,182	$1,837,835
Total Obligations	$10,566,724	$10,940,382	$12,316,000	$9,659,118

Question 5. The budget justification indicates a future goal of the Readjustment Counseling Service (Vet Centers) is to continue to expand access for readjustment counseling, particularly in underserved areas. Please explain in detail VA's plan to

[1] CHAMPVA: Civilian Health and Medical Program of the Department of Veterans Affairs
FMS: Financial Management System / FMP: Foreign Medical Program / CWVV: Children of Women Vietnam Veterans
FMS: Financial Management System / FMP: Foreign Medical Program / CWVV: Children of Women Vietnam Veterans

expand access, including any plans to increase the number of Mobile Vet Centers, and explain the need for expanding access.

Response. The Senate Veterans' Affairs Committee broadly defines "the purposes of this readjustment counseling provision is to make fully available—and to encourage and facilitate the full use of—the resources of the VA's health-care system to those Vietnam-era Veterans [and now all combat and other eligible Veterans, eligible Servicemembers, and their families] who feel the need for counseling to help them in their readjustment to civilian life." *Senate Report No. 96–100 (April 27, 1979), accompanying Pub. L. 96–22, Veterans' Health Care Amendments of 1979*.

The House Veterans' Affairs Committee outlines 'within the context of readjustment counseling, each Vet Center is tasked with three major functions: outreach, direct service delivery, and referral.' *House Report No. 98–117, accompanying Pub. L. 98–160, Veterans' Health Care Amendments of 1983*.

VA estimates that it will continue to operate the same number of "brick and mortar" Vet Centers in FY 2017 as it did in FY 2014. In FY 2014, the Vet Center program did request and receive VHA approval for 291 new FTE, 63 of which were specifically placed in areas with high concentrations of Active Duty Servicemembers. In addition, 10 new Mobile Vet Centers (MVC) were implemented, bringing the fleet total to 80 MVCs.

The 80 MVC's are a national asset and available upon request to participate and provide services at any event where Veterans, Servicemembers, families, and community stakeholders are present. In order to maximize the impact of the new assets, an overall assessment of the entire MVC fleet was conducted. The plan covered placement of the newly purchased MVCs and an assessment of current assets by having the entire MVC Fleet (70 vehicles) meet the following criteria:

- An MVC was stationed within a 120 minute drive time to all major Active Duty Military Installations and Demobilization Sites.
  - Major Active Duty Military Installations refer to any base where the active duty servicemember population is over 10,000 and the primary function is not basic training or a national training site. (i.e., Great Lakes Naval Station- basic training location, 29 Palms Marine Air Ground Task Force Training Command-national training location).
  - Demobilization sites are determined by DOD. In most instances, major active duty military installations are also demobilization sites.
- An MVC was stationed within a 120 minute drive time to counties with a Veteran population of 5,000–25,000.
  - The additional 20 vehicles will provide outreach and services to over 180 counties that met these criteria; Furthermore over 84% of all counties within the United States will have access to an MVC within a 120 minute drive time.
- Streamlined MVCs were distributed to locations where their size could best be utilized given Department of Transportation regulations, weather, terrain, and road conditions.

There is one exception to the criteria. Ponce, Puerto Rico received a streamlined MVC due to the large National Guard and Reserve Component population. While these individuals may receive their initial demobilization processing in the continental United States, all follow up events are done in Puerto Rico.

The Vet Center service mission is specific, unique, and purposely designed to address the needs of individuals readjusting to civilian life after service in or in support of combat operations, including those who experienced military sexual trauma.

Since 2014, the focus for increasing access to Vet Center services has shifted from opening new "brick and mortar" Vet Centers to providing regularly scheduled services in Vet Center Outstations, with services available 40 hours per week using a small number of counselors and Community Access Points (CAP), with varying levels of service delivery dependent on community demand. These sites are located within the communities of underserved Veteran and Servicemember populations. Vet Centers are staffed with an average of 7 employees and incur overhead costs. Service delivery through Vet Center Outstations and Community Access Points are the most cost efficient methods to provide readjustment counseling in areas geographically distant with smaller, although significant, client populations. These areas simply do not justify a full Vet Center.

Current State: As of the beginning of FY 2016, the program is operating 19 Vet Center Outstations with full-time services available. The program is operating 742 Community Access Points, with 401 sites offering services on a weekly basis, 189 sites offering services on a twice monthly basis, and 152 sites offering services on a monthly basis. As utilization increases/decreases the service level is adjusted accordingly.

Ongoing Evaluation: In FY 2016, each of the 300 Vet Centers has been tasked with 2 evaluations:

First, they must evaluate for appropriate service delivery levels at each of the existing Outstations/CAPs. This evaluation includes a targeted outreach plan to increase local awareness of service availability, including an advertised "Open House" and close collaboration with the local County Veteran Service Officer, local Veteran Service Organizations, and local Congressional office staffers. In addition, Readjustment Counseling Service, which oversees all Vet Centers, has developed and is implementing a plan to acquire broad access to professional media services for the overall purpose of increasing awareness and access to Vet Centers, and specifically targeting awareness of the local services available through Vet Center Outstations and CAPs.

Second, each Vet Center has been tasked with identifying and implementing at least one new CAP in their catchment area this fiscal year. Funding is being made available for hiring additional staff at any site that does not have current staffing necessary to provide these services.

Caregivers and other supports and services of PCAFC affected the perceived wellbeing of caregivers and their families.

Aim 3 examined the use and value of the overall Caregiver Support Program and its component services to caregivers in either PCFAC or the Program of General Caregiver Support Services. The study design for Aim 3 was a quantitatively-driven mixed method design, with qualitative semi-structured interview data, enhanced by survey findings. Survey data will describe frequency of use of services, ratings of helpfulness, and differences by individual and site-level characteristics (e.g., caregiver race, Veteran health status, geographic region, etc.). Interviews were utilized to inform interpretation of the quantitative findings and shed light on other important aspects of caregivers' experiences unanticipated with survey responses.

Aim 4 complements the caregiver survey data on services used by detailing the full delivery costs of the Caregiver Support Program—personnel, programming (e.g., stipend, CHAMPVA), and supporting costs. Preliminary operational costs will be based on a survey of Caregiver Support Coordinators (CSCs), capturing how their time is allocated across the various components of the Caregiver Support Program which they deliver at VAMCs.

Final results will be delivered in summer 2016 and will inform the Caregiver Support Program about its return on investment and provide information on best practices for improving its programs. Understanding the impacts of the Caregiver Support Program on caregivers, Veterans, and VHA is expected to provide the Caregiver Support Program with information about highest value programs and services and an evidence base upon which to make program and planning decisions which optimize services while continuing to meet the requirements of title I of Public Law 111–163.

Question 6. The budget justification for Medical Support and Compliance indicates funding for the Veterans Integrated Service Networks (VISN) headquarters as decreasing by $11 million from the appropriated amount for FY 2017. Recently, VA announced that the number of VISNs would be reduced from 21 to 18.

A. Please provide the Committee with the number of FTE at each VISN headquarters, broken out by VISN and by general schedule or title 38 positions.

Response. See attached.

VISN	Number of FTE General Schedule Positions	Number of FTE Title 38 Positions
1	33	5
2	51	3
4	41	2
5	41	12
6	39	7
7	48	13
8	46	10
9	48	8.5
10	4	80.56
12	34	6
15	45	11
16	—	—
17	49	4
18	23	11

VISN	Number of FTE General Schedule Positions	Number of FTE Title 38 Positions
19	40	16.25
20	48	11
21	41.5	8.2
22	41	8
23	41	11

B. Please provide a detailed plan to reduce the number of VISNs to 18 and a justification why 18 is the appropriate number of VISNs needed.

Response. With the goal of modifying the existing Veteran Integrated Service Network (VISN) structure to bring it in line with *MyVA* districts, a VHA workgroup comprised of Network Directors and relevant Program Office Directors explored options and models and determined that 18 is the appropriate number of VISNs. Several factors were weighed in the process, including alignment with state boundaries, and the number of healthcare systems within each VISN. Realignment within state boundaries allows for better collaboration and interaction with various political representatives, state officials, agencies, and VSOs. Realignment into 18 VISNs allows for a more reasonable span of control, with 6–11 health care systems in the majority of the VISNs, while simultaneously reducing variation in Veteran population, enrollees, users, and budget. Eighteen VISNs will allow for better collaboration, standardization, and sharing of best practices, while not increasing span of control beyond 6–11 health care systems.


VA HEALTH CARE
Defining EXCELLENCE in the 21st Century
Veterans Health Administration

Guiding Principles of VISN Realignment

1. Align VISNs* with MyVA Districts
2. Align VISNs with State Boundaries
3. Right size existing VISNs in terms of # of Health Care Systems and Users
4. Continuity of existing structures unless compelling reason for change

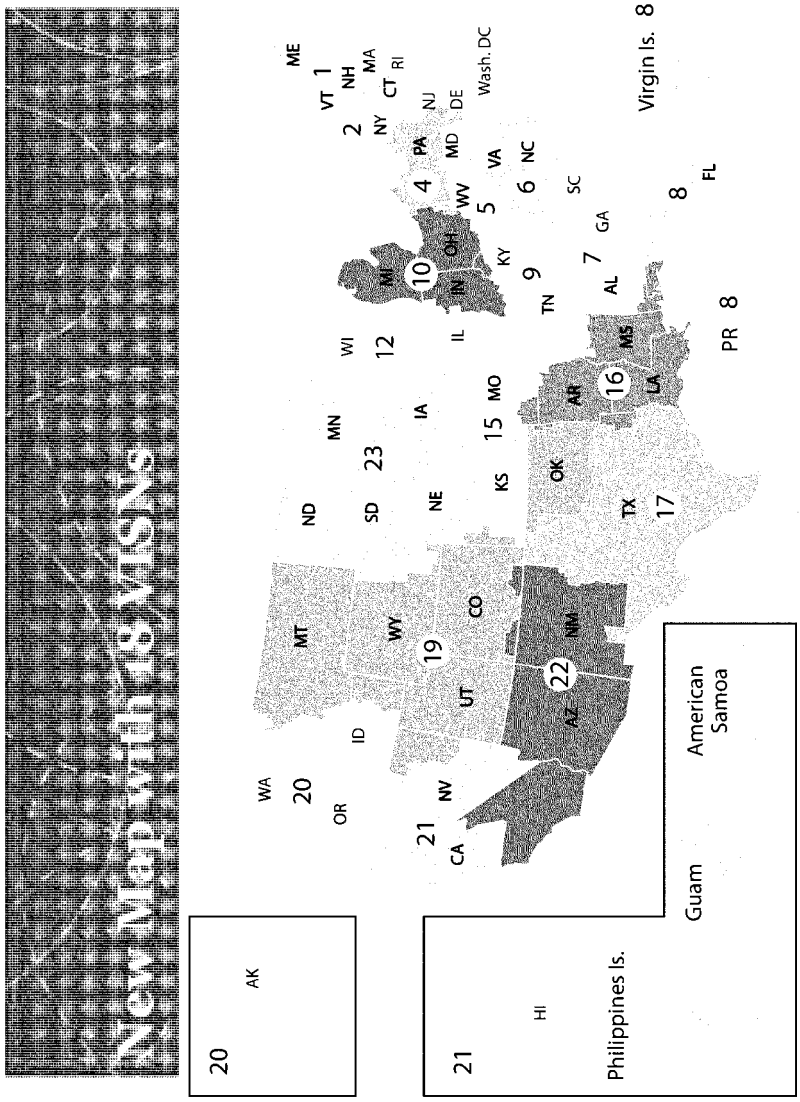
- **Proposal will align the parent facility for every Health Care System (HCS) within VA's Districts. CBOCs will remain affiliated with their current Parent Facility. Some CBOCs will be across District or state boundaries from their parent facility. West Lafayette CBOC moving from Danville to Indianapolis is separate from the VISN Realignment.*

National VISN Realignment Workgroup

- The Office of the DUSHOM chartered a National VISN Realignment Workgroup to assess and analyze the impact of the VISN Realignment Plan.
- The workgroup is responsible for:
  - Developing a set of guiding principles
  - Drafting a general framework for implementation of the realignment plan
  - Developing a communications plan
  - Developing a task analysis and timeline
  - Reviewing internal efficiencies or evaluating reconfigurations that might be made in parallel with VISN re-alignments

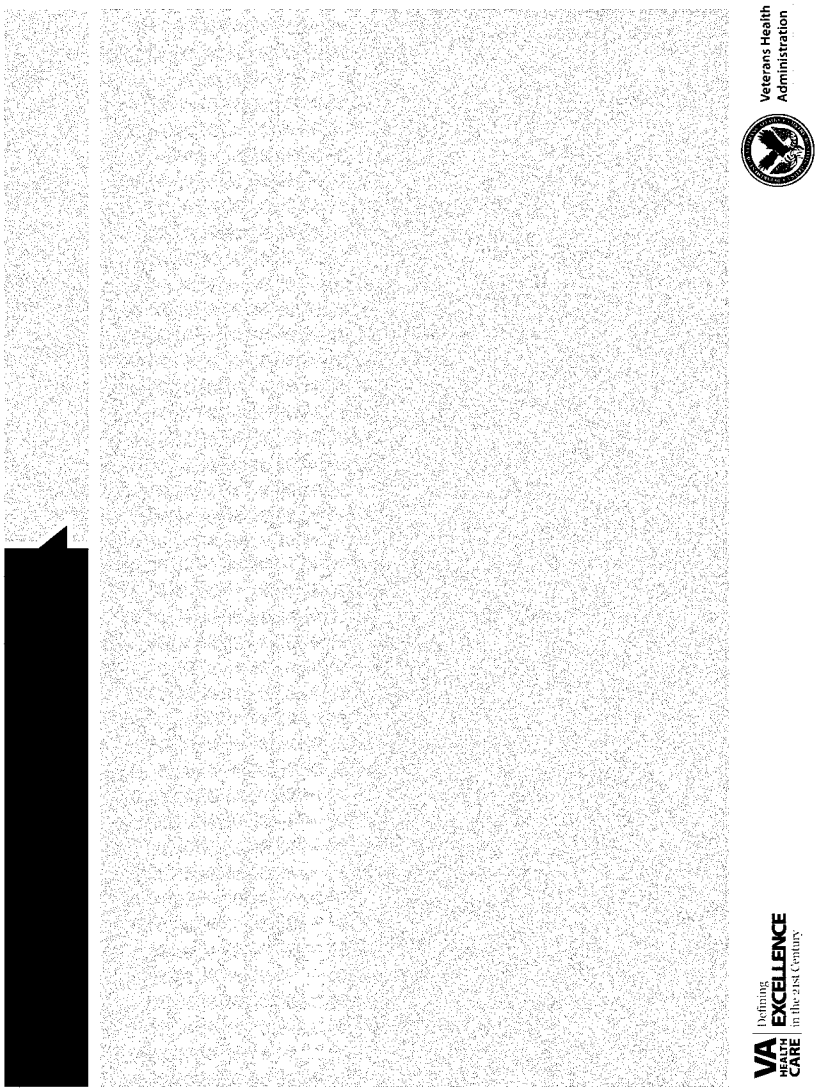
National VISN Realignment Phasing Plan

New VISN Office	Facilities Affected	Original VISN
	Starting FY16	
2 (2 + 3 fully integrated)	VISN 2 VAMCs VISN 3 VAMCs	2+3
10 (10 + 11 fully integrated minus Danville)	VISN 10 VAMCs VISN 11 VAMCs (Danville goes to 12 see below)	10 + 11
12	Danville VAMC	11
19	Oklahoma VAMCs: Oklahoma City and Muskogee	16
21	Las Vegas VAMC	22
All WV facilities to VISN 5	West Virginia VAMCs: Clarksburg (VISN 4); Beckley (VISN 6); Huntington (VISN 9); and Martinsburg (VISN 5)	4, 5, 6, 9
22	All remaining VISN 18 VAMCs: Tucson, Prescott, Phoenix, and Albuquerque (VISN 22 has already supporting VISN 18)	18
17	All VISN 18 Texas VAMCs: Amarillo, West Texas HCS (Big Spring), and El Paso	18
	End of FY17	
17	Houston VAMC	16


New Map with 18 MSNs
20
AK
21
HI
Philippines Is.
Guam
American Samoa
Virgin Is.
PR
WA
OR
CA
ID
NV
MT
WY
UT
AZ
CO
NM
ND
SD
NE
KS
OK
TX
MN
IA
MO
AR
LA
WI
IL
MS
MI
IN
OH
KY
TN
AL
GA
SC
NC
VA
WV
PA
NY
MD
DE
NJ
CT
RI
MA
VT
NH
ME
Wash. DC
FL
1
2
4
5
6
7
8
9
10
12
15
16
17
19
20
21
22
23

Net Result of VISN Realignment

- All VISNs (by Parent Facilities) aligned fully within *My*VA district borders.
- Significant improvement in alignment with State borders (NY, WV, TX, NV now covered by single VISN, exceptions reduced to IL, MI, CA).
- Efficiencies with change from 21 to 18 VISNs with reduction in variation in number of HCS and Users.
- Minimal disruption of patient care with decision to keep CBOCs aligned with current Parent Facilities.


Veterans Health Administration
VA HEALTH CARE Defining EXCELLENCE in the 21st Century

National VISN Realignment Workgroup Membership

- Network Directors of Impacted VISNs (2, 3, 10, 11, 16, 17, 18, 19, 21, 22)
- Informatics/VSSC
- Fiscal
- Human Resources
- Labor Partners
- MyVA
- OIT
- Communications
- Clinical Operations
- Veteran Service Organizations (VSOs)
- Other SMEs as needed.

National VISN Realignment Workgroup Work

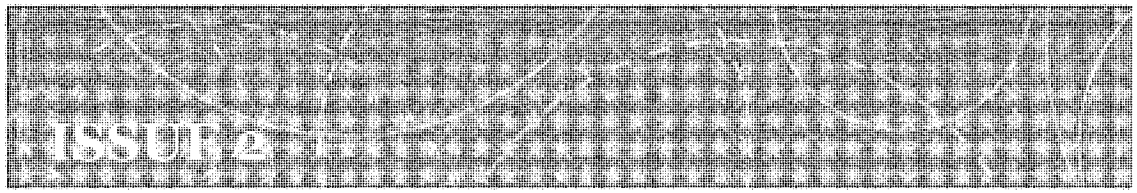
- Developed phasing plan for all local realignments to begin by the start of FY16.
- Assessed and determined how long various elements of local realignments will take (such as HR, Fiscal, etc.).
- Charged four smaller workgroups
  - Naming: determine new VISN nomenclature – complete
  - Culture: address culture challenges with this national VISN Realignment.
  - HR: address various workforce challenges.
  - Technical: address various technical/backend challenges.

VISN Naming

- With the exceptions of VISNs 2, 3, 10, 11, and 18, the rest of the VISNs will keep their current names, i.e. VISN 1 remains VISN 1.
- The newly integrated VISN that contains VISNs 2 & 3 will be called VISN 2, and the new VISN 2's Network Office will be the current VISN 2 Network Office in Albany. The current VISN 3 Network Office in Bronx, NY will be a satellite office for the new VISN 2.
- The newly integrated VISN that contains VISNs 10 & 11 (minus Danville) will be called VISN 10, and the new VISN 10's Network Office will be the current VISN 10 Network Office in Cincinnati, OH. The current VISN 11 Network Office in Ann Arbor, MI will be a satellite office for the new VISN 10.
- The VISN 18 Network Office in Gilbert, AZ will become a satellite office of VISN 22, which has its Network Office in Long Beach, CA.

ISSUE 1

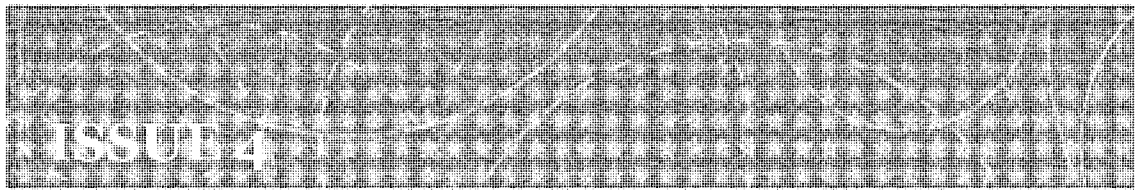
Issue	Proposed Action
New York State is split between 2 VISNs (2 and 3).	**Consolidation of VISN 2 and VISN 3 to a newly integrated VISN that will be called VISN 2 and will be headquartered in Albany, NY with a satellite VISN office in Bronx, NY. This integration will start on October 1, 2015. The Network Director for the newly integrated VISN 2 is being actively recruited. In the meantime, the newly integrated VISN 2 will have partnered leadership with the former Acting Network Director in VISN 2 will be the Network Director (North) for VISN 2, and the former Acting Network Director in VISN 3 will be the Network Director (South) for VISN 2.**
VISN 2 is undersized with only 5 health care systems and 125,000 patients. Current VISN office is in Albany, NY.	
VISN 3 is undersized with only 5 health care systems and 170,000 patients. Current VISN office is in Bronx, NY.	



Issue	Proposed Action
VISN 9 is not aligned with MyVA borders with Huntington WV in the North Atlantic District (District 1).	**VISN 5 will expand to include all 4 West Virginia health care systems, realigning Clarksburg VAMC from VISN 4, Beckley VAMC from VISN 6 and Huntington VAMC from VISN 9. This consolidation will start on October 1, 2015.**
West Virginia is split between 4 VISNs with 4 health care systems (Clarksburg, Huntington, Beckley, and Martinsburg).	
VISN 5 is undersized with only 3 health care systems and 152,000 patients. Current VISN office is in Linthicum, MD.	

ISSUE 3

Issue	Proposed Action
VISN 10 has only 5 health care systems. Current VISN office is in Cincinnati, OH.	**The newly integrated VISN will be called VISN 10, and the headquarters of newly integrated VISN will be in Cincinnati, Ohio at the current VISN 10 Network Office with a satellite office in Ann Arbor, MI. This integration will start on October 1, 2015.** **Danville will be realigned to VISN 12, but because Marion is part of the VISN 15 integrated medical record, it will remain in VISN 15.**
Illinois is split between 3 VISNs with the Chicago area VAMCs in VISN 12 (Jesse Brown, Lovell, and Hines), Danville in VISN 11 and Marion in VISN 15. Current VISN office is in Ann Arbor, MI.	



Issue	Proposed Action
Michigan is split between 2 VISNs with Iron Mountain in VISN 12. However, Iron Mountain is in Upper Peninsula which is connected to Wisconsin and across Lake from mainland Michigan. Iron Mountain is located right on Wisconsin border.	**Leave Iron Mountain with VISN 12. Integrated VISN 10/ VISN 11 will already have 11 HCS**

ISSUE 5

Issue	Proposed Action
Texas is split between 3 VISNs (16, 17, and 18).	**As part of the re-alignment all health care systems in Texas will be transitioned to VISN 17 effective October 1, 2015 with the exception of the Houston VA Health Care System which will remain in VISN 16 until the New Orleans VAMC is activated.**
VISN 18 is not aligned with *My*VA borders, with Amarillo, West Texas and EL Paso in the Continental District (District 4), New Mexico and Arizona in the Pacific District (District 5). Current VISN office is in Gilbert, AZ.	
VISN 16 is large with 560,000 patients, 10 health care systems in 5 states. Current VISN office is Ridgeland, MS.	
VISN 17 has only 4 health care systems. Current VISN office is in Arlington, TX.	

ISSUE 6

Issue	Proposed Action
VISN 16 is large with 478,000 patients, 10 health care systems in 5 states.	**Oklahoma health care systems (Muskogee and Oklahoma City) will move from VISN 16 to VISN 19. This integration will start on October 1, 2015. Houston VA Health Care System will remain in VISN 16 until the new tertiary care facility is activated in New Orleans and will re-align to VISN 17 at that time.**
VISN 19 has only 207,000 patients and 6 health care systems. Current VISN office is in Glendale, CO.	

Issue	Proposed Action
VISN 18 is not aligned with *My*VA borders, with Amarillo, West Texas and El Paso in the Continental District (District 4), New Mexico and Arizona in the Pacific District (District 5).	**By the end of FY16, VISN 18 will be integrated with VISN 22, but until such time, VISN 18 will consist of the VA Health Care Systems in New Mexico and Arizona. The VISN 18 Network Office will remain in Gilbert, AZ.** **When the integration with VISN 22 is complete, the VISN 18 Network Office in Gilbert, Arizona will then become a satellite office of VISN 22, which has its Network Office in Long Beach, California.**
California is split between two VISNs (21 and 22).	**Realign Las Vegas VAMC from VISN 22 to VISN 21. This integration will start on October 1, 2015. Because of the population size and geographic distances (including Hawaii, Philippines, and Guam) the state of California will remain split between two VISNs**
Nevada is split between two VISNs (21 and 22).	

Question 7. The budget justification for Medical Support and Compliance indicates a decrease of approximately $35 million from the FY 2017 appropriated level for VHA Central Office (VHACO).

A. Please provide the Committee with a detailed justification for the decrease in funding for VHACO.

Response. For the past three fiscal years (FY 2013–2015), VHA has seen decreases in VHA Central Office (VHACO) actuals and has re-estimated the out year projections accordingly. These reductions reflect Congressional rescissions (see below "Rescissions, FY 2013-FY 2015") on overall funding including rescissions to the Medical Support and Compliance (MS&C) appropriation in the provision of 2-year funding in the budget year (see below example Public Law 113–76, Section 226). Because of an identified need for MS&C funding at the VA medical centers (VAMCs), and

to help address the recent access crisis, the reductions to this appropriation were imposed on VHACO rather than field organizations.

Rescissions, FY 2013-FY 2015

(dollars in thousands)

Fiscal Year	Public Law (PL)	PL #	Rescission Amount
2013	Consolidated and Further Continuing Appropriations Act, 2013	113-6	($2,039)
2014	Consolidated Appropriations Act, 2014	113-76	($50,000)
2015	Consolidated and Further Continuing Appropriations Act, 2015	113-235	($5,609)

Public Law 113–76, Section 226

SEC. 226. (a) of the funds appropriated in division E of Public Law 113–6, the following amounts which became available on October 1, 2013, are hereby rescinded from the following accounts in the amounts specified:

(1) "Department of Veterans Affairs, Medical Services", $1,400,000,000.

(2) "Department of Veterans Affairs, Medical Support and Compliance", $150,000,000.

(3) "Department of Veterans Affairs, Medical Facilities", $250,000,000.

(b) In addition to amounts provided elsewhere in this Act, an additional amount is appropriated to the following accounts in the amounts specified to remain available until September 30, 2015:

(1) "Department of Veterans Affairs, Medical Services", $1,400,000,000.

(2) "Department of Veterans Affairs, Medical Support and Compliance", $100,000,000.

(3) "Department of Veterans Affairs, Medical Facilities", $250,000,000.

In addition, the 2016 amount reflects the request for an adjustment to the Advance Appropriation of $69.96 million that was not approved in the final enacted appropriation. The reduction of $35 million reflected in the most current submission for FY 2017 continues those projections, as the FY 2015 actual was $52.6 million less than the previous year (see "VHA Central Office Obligations).

B. Please provide the Committee with the number of FTE at VHACO the FY 2017 and FY 2018 budgets would support if this budget was adopted. Please indicate the number of title 5 employees and the number of title 38 or hybrid-title 38 employees.

Response. See table below.

Medical Support & Compliance
Employment Summary, FTE by Grade
VHA Central Office
(Excludes Veterans Choice Act)

GS Grade or Title 38	2017 Estimate	2018 Estimate
SES	5	5
Title 38	143	143
15 or higher	10	10
14	42	42
13	103	103
12	160	159
11	169	168
10	5	5
9	168	167
8	88	88
7	233	232
6	280	279
5	157	156
4	79	79
3	6	6
2	1	1
1	0	0
Wage Board	42	42
Total Number of FTE	1,691	1,685

HOMELESS VETERANS

Question 8. In the last several years, there has been significant momentum in efforts to end veteran homelessness. As the Secretary's testimony mentioned, veteran homelessness has declined by 36 percent since 2009.

A. How does the budget request help focus efforts on those who are most difficult to reach, in addition to those who are at risk for homelessness?

Response. VA's commitment to preventing and ending Veteran homelessness remains firm. VA will continue until the goal of all Veterans having permanent, sustainable housing with access to high-quality health care and other supportive services is met. VA provides a seamless continuum of services for Veterans who are homeless or at risk of homelessness. While significant advances have been made in reducing Veteran homelessness, there are sub-populations of homeless Veterans who are hard to reach and engage in services (i.e., chronically homeless, those with serious mental illness and justice involved). The 2017 President's Budget includes $1.6 billion for VA programs that prevent or end homelessness among Veterans including, funding for case management support for the nearly 80,000 existing Housing and Urban Development-VA Supportive Housing (HUD-VASH) vouchers, grant funding for community-based prevention, and rapid rehousing services provided through the Supportive Services for Veteran Families (SSVF) program, clinical outreach and treatment services through Health Care for Homeless Veterans (HCHV), service intensive transitional housing through the Grant and Per Diem (GPD) and prevention services to justice involved Veterans in the Veteran Justice Program (VJP); and employment supports. These funds are critical to ensure that once communities meet the goal of ending Veterans homelessness they will be able to sustain it and not jeopardize the progress to date or recreate the levels of homelessness among Veterans prior to the investment.

VA has made unprecedented efforts to promote the services available to Veterans who are homeless or might become homeless. A continuum of services has been designed to assist every eligible homeless Veteran, as well as Veterans at risk for homelessness. This homeless continuum assists Veterans in acquiring safe housing, treatment services, clinical outreach, opportunities to return to employment, prevention and rapid re-housing, and benefits assistance. As a result of these efforts, VA is serving more Veterans than ever before with specialized services for Veterans who are homeless or at risk of homelessness. Since 2010, demand for VA homeless-related services has increased by 136 percent. There has been a year to date, 8.4-percent increased demand for homeless services between January 2015 and January 2016 (January 2015: 164,224; January 2016: 178,139).[1]

Since 2010, more than 365,000 Veterans and their family members have been permanently housed, rapidly rehoused, or prevented from falling into homelessness as a result of VA's homeless continuum of services and targeted community resources. In FY 2015 alone, nearly 65,000 Veterans obtained permanent housing through VA Homeless Programs (FY 2014: 50,730), and more than 36,000 Veterans and their family members were prevented from becoming homeless through the SSVF program, including 6,555 children. VA's ability to partner HUD, the U.S. Interagency Council on Homelessness, other Federal agencies, state and local governments, and volunteer organizations all contributed to this significant accomplishment.

VA's programs serving homeless and at-risk Veterans, are outlined below:

The HUD-VASH program subscribes to the principles of the "Housing First" model of care, an evidence based practice model, helps homeless individuals exit from homelessness, remain in stable housing, thus improving ability and motivation to engage in treatment strategies. This program has been successful at rapidly moving individuals into housing and then providing wrap around supportive services as needed. Program goals include housing stability while promoting maximum Veteran recovery and independence in the community for the Veteran and the Veteran's family. The HUD-VASH program targets the most difficult to reach and prioritizes chronically homeless Veterans. In FY 2015, more than 18,200 chronically homeless Veterans were admitted to HUD-VASH case management services.

SSVF is designed to rapidly re-house homeless Veteran families and prevent homelessness for those at imminent risk due to a housing crisis. Funds are granted to private, non-profit organizations and consumer cooperatives that will assist very low-income Veteran families by providing a range of supportive services designed to promote housing stability. In FY 2015, SSVF assisted nearly 99,000 Veterans and

[1] Due to enhanced data capture from VA and community providers and continued refinement of VA's data systems homeless data is constantly refreshed which may cause changes in previously reported data. Updates to homeless data are reflected in monthly refreshes of VA data systems.

their family members (over 157,400 individuals), which included over 18,200 households with children (over 34,600 children). SSVF has the unique ability to shift funds from the rapid re-housing of homeless Veteran families to preventing homelessness for those at-risk. This allows SSVF to adapt to changing local needs and emphasize prevention assistance where local communities have met the Federal benchmarks to end homelessness.

The HCHV program is our primary clinical outreach program to engage the most difficult to reach homeless Veterans and provide street outreach to these Veterans. In addition, case management and HCHV Contract Residential Services ensure that chronically homeless Veterans, especially those with serious mental health diagnoses and/or substance use disorders, are connected to health care and other needed services. Veterans are placed in VA or community-based programs that provide quality housing and services that meet the needs of these special populations.

The GPD program plays a vital role in the continuum of homeless services by providing supportive services to those Veterans who would otherwise be among the unsheltered homeless population, and ultimately transitioning them to permanent housing. Grants offered by the GPD program promote the development and provision of supportive housing and/or supportive services with the goal of helping homeless Veterans achieve residential stability, increase their skill levels and/or income, and realize greater self-determination. The GPD program has more than 650 funding projects and over 14,500 beds nationwide. During FY 2015, 15,507 Veterans exited GPD programs with permanent housing placements.

The VJP and the Health Care for Re-Entry Veterans (HCRV) are designed to target Veterans who are at great risk of becoming homeless due to involvement with the justice system. The Veteran Justice Outreach (VJO) Specialists conduct face-to-face outreach in 1,284 local jails (39 percent of the U.S. total), and staff nearly the entire Nation's Veteran Treatment Courts and other Veteran-focused courts. VJO Specialists have served over 120,000 justice-involved Veterans since FY 2010, including 46,534 Veterans in FY 2015.

The HCRV Specialists provide outreach to Veterans approaching release from State and Federal prisons. They briefly assess reentry Veterans' probable treatment needs, help the Veterans plan to access responsive services upon release, and provide post-release follow-up as needed to ensure Veterans are engaged with services to prevent homelessness. There are currently 44 HCRV Specialist positions nationwide, almost all of which are funded through Veterans Equitable Resource Allocation. While many are based at VAMCs, but they typically serve Veterans in areas much larger than a VAMC catchment, often conducting outreach to prison facilities in at least one entire State, and sometimes an entire VISN. Nationally, HCRV Specialists served over 72,000 re-entry Veterans since FY 2007, including 15,580 in FY 2015.

Low Demand/Safe Havens (LDSH) are a 24-hour per day/7-days per week community-based early recovery model of supportive housing that serves hard-to-reach homeless Veterans with severe mental illness who have been unable to participate in traditional treatment and supportive services. Four LDSH sites were funded as pilot programs in FY 2012 as development projects under the National Center for Homelessness among Veterans (NCHAV) with funding support made available through HCHV. Outcomes of fidelity reviews conducted by NCHAV warranted expansion of the model program to include an additional 18 sites in FY 2013 for chronically homeless Veterans with concurrent mental illness and substance use disorders.

Homeless and at-risk Veterans also need access to employment opportunities to support their housing needs, improve the quality of their lives, and assist in their community reintegration efforts. The Homeless Veteran Community Employment Services (HVCES) program is the only employment program within VHA that specifically targets homeless Veterans. In FY 2015, the number of Veterans exiting homeless residential programs with employment (GPD, CWT/TR, and DCHV) increased by 9 percent. Continued investment in VA's homeless programs is needed to sustain the capacity to address the housing needs of Veterans and maintain the systems put in place to prevent homelessness.

B. As the number declines, what is the vision for the future of VA homelessness programs?

Response. VA's vision for ending homelessness among Veterans is to continue developing a systematic approach in communities whereby any Veteran experiencing a housing crisis may receive the housing and services they need to end their crisis as quickly as possible, while preventing those who are at risk from ever falling into homelessness. These systems enable communities to create a multi-pronged approach addressing the varying health and social situations experienced by Veterans and their families. These approaches must address Veterans with an acute housing

crisis, as well as those Veterans who are at risk of homelessness; recovering from a chronic housing crisis; or chronic health, mental health, and substance use issues. VA and communities must have the systems and services in place to sustain and maintain access to permanent, sustainable housing, high quality health care and other supportive services.

Ending Veteran homelessness does not mean that a Veteran will never again experience a housing crisis. At any given time, a Veteran may become homeless as a result of challenges in their lives. VA's goal is to make these challenges rare, brief and non-recurring. As homelessness among Veterans declines and the needs of Veterans change, VA will shift with the changing needs of Veterans and communities and increase the focus on preventing those who are at risk while maintaining Veterans who are already housed.

VA and Federal partners are pleased by the successes being realized across the country. As of April 15, 2016, 23 communities, the State of Connecticut, and the Commonwealth of Virginia have announced an effective end to Veteran homelessness. In order to remain successful, VA and communities need to be able to sustain the gains that have been made.

VA's vision is based on data collection and research. This approach provides valuable insight into the causes of Veteran homelessness, evidence based practices, and projecting the needs and changing demographics of Veterans. The results of these efforts will allow VA to continue to refine and target homeless programs to best prepare for increasing numbers of female Veterans, returning combat Veterans, as well as other changes in our Veteran population.

C. What potential changes may be needed in the future to ensure the program size and services are appropriate for the level of need?

Response. As VA, Federal, and community partners advance toward the goal of preventing and ending Veteran homelessness and the landscape of needs and services change, it is important to make certain that the housing resources and supportive services in each community are best suited to ensuring that homelessness among Veterans is rare, brief, and non-recurring. As the needs of homeless and at-risk Veterans evolve, VA will continue to transition its focus from "rescue" (i.e., outreach and support) to those seeking housing, to long-term case management of those trying to sustain housing and to prevention efforts. It is important to note that the target populations for VA homeless services are Veterans who are chronically homeless and/or have mental and physical health concerns. These Veterans require long-term, often intensive, case management and other clinical services that will prevent them from returning to homelessness. Therefore, once Veterans are permanently housed, VA will need to continue to provide the wrap around services necessary to ensure housing stability for the Veteran and their family.

Through its research and data collection, VA continues to evaluate and monitor the needs of homeless and at-risk Veterans to ensure that those needs are being met. The areas where there have been large gains in ending Veteran homelessness have been in places that have benefited from targeted investment of resources. Conversely, areas where gains have been lost were in places where the focus shifted to other priorities. In order to sustain the gains and ensure that resources are allocated efficiently, VA will require flexibility in its authorization(s) to transition services at a level commensurate with the population shift (from literally homeless to at-risk) and geographic needs.

In addition to the allocation of resources to meet targeted need, VA is focusing on three areas to enhance homeless services: programmatic transformation in the GPD program, adoption of Coordinated Entry Systems and the use of "By Name Lists" (BNLs), and maximum utilization of all HUD-VASH vouchers. Additionally, VA conducts research to inform the development of evidence-based services that meet the needs of various special populations.

GPD Programmatic Transformation: The GPD Program has been VA's primary transitional housing program for over twenty years. As VA has added programs to the homeless continuum of services, and homelessness has decreased, it is clear that the GPD program must be refreshed to keep pace. VA is exploring an overall program refresh to allow VA to make GPD more efficient and effective as well as responsive to Veteran needs in their respective communities.

In addition, VA has challenged GPD grantees to assess their programs and think about strategies that are currently available to them address needed changes. One option is to ask grantees to consider if Bridge Housing could work in their community. Provided below is a copy of the guidance VA issued to GPD grantees via an Open Letter on March 1, 2016 (see below).

THE DEPUTY SECRETARY OF VETERANS AFFAIRS
WASHINGTON

March 1, 2016

A MESSAGE FROM THE DEPUTY SECRETARY

An Open Letter to the Grantees of the Department of Veterans Affairs (VA) Homeless Providers Grant and Per Diem (GPD) Program

The GPD Program has been providing community-based transitional housing with supportive services since 1994. The Department is grateful for the efforts of all our community partners who have worked for years to address the challenges facing Veterans experiencing homelessness. As VA and our Federal and community partners advance towards the goal of preventing and ending Veteran homelessness, and the landscape of needs and services change, it is important to make certain that the housing resources in each community are best-suited to ensuring that homelessness among Veterans is rare, brief, and non-recurring.

VA expects all grantees to work in partnership with local continuums of care and VA medical centers to make data-informed decisions regarding the types of housing interventions and approaches that will best enable your community to swiftly and directly resolve homelessness among Veterans. One innovation that we encourage grantees to pursue, which aligns with Housing First principles, is the utilization of GPD beds as Bridge Housing. The Bridge Housing model is transitional housing used as a short-term stay when a Veteran has been offered and accepted a permanent housing intervention, but access to that permanent housing is still being arranged. VA strongly supports GPD grantees examining the existing local housing resources and needs and, as appropriate, requesting a change of scope to convert a portion of their existing beds to Bridge Housing.

Through enhanced performance expectations, VA has seen continued improvements in GPD Program housing outcomes with more than 15,500 exits to permanent housing in fiscal year 2015. However, even with these improvements, we know that we need to continue to strengthen all parts of our homeless services continuum to resolve homelessness quickly. VA believes that all grantees should be taking steps to lower barriers to entry, reduce lengths of stay, and improve exits to permanent housing. I urge all grantees to consider how the suggestions outlined in this letter could best be incorporated into your programs, and expect that we will see continued progress on our path to transformation. Your agency's compassionate service to our Nation's heroes is commended, and we look forward to a continued partnership in this time of transition. Enclosed is a document that will provide additional information on VA's overall vision for the GPD Program.

Questions or additional information about this letter should be directed to Mr. Jeffery Quarles, Director, VA GPD National Program Office, by email at Jeffery.Quarles@va.gov or Ms. Chelsea Watson, Deputy Director, VA GPD National Program Office, by email at Chelsea.Watson@va.gov, or by phone at 1 (877) 332-0334.

I appreciate your continued support and commitment to ending homelessness among Veterans.

Sincerely,

Sloan D. Gibson

Enclosure

The Department of Veterans Affairs (VA)
Homeless Providers Grant and Per Diem (GPD) Program
Vision Statement
December 2015

The GPD Program has been providing community–based transitional housing with supportive services since 1994. As VA, our Federal and community partners advance toward ending Veteran homelessness and the landscape of needs and services for homeless Veterans evolves, it is important to ensure that the housing resources in each community are consistent with the Housing First approach; are being aligned with other programs and agencies; and are best-suited to ensuring that homelessness among Veterans is rare, brief, and non-recurring.

The Department's overall vision, in collaboration with Federal and community partners, for the GPD Program is to shift the program to eventually focus on and support three different types of transitional housing models:

- Bridge Housing – emphasizing short lengths of stay and rapid connections to permanent housing.
- Service-intensive transitional housing – transitional housing not being used as Bridge Housing, but in which Veterans are still actively working, with the assistance of appropriate services and supports, to achieve permanent housing as quickly as possible.
- Transition in Place housing – a housing model where Veterans are provided time-limited transitional housing assistance with the lease converting to the Veteran as their permanent housing after a short period of assistance.

The plan encompasses short-range, mid-range and long-range objectives for change to meet the current and future needs of homeless Veterans.

- *Short-range* plans include promoting improved access to services which can be accomplished with lower barriers to entry; promoting short-stay components which provide quick access to permanent housing, referred to as Bridge Housing; and reducing underutilized transitional housing beds.
- *Mid-range* plans involve examining the current transitional housing stock to ensure that transitional housing resources are aligned with the needs in each community.
- *Long-range* plans include those program modifications which would require legislative changes such as certain modifications to the per diem payment system and converting a portion of the national supply of existing transitional housing to permanent housing.

As these plans get implemented, VA is already actively encouraging community leaders—including GPD providers, the local Continuum of Care, and the VA Medical Center—to use data to determine how much and what type of GPD Program-funded housing, along with other housing interventions, will enable a community to most effectively and efficiently end homelessness among Veterans and to be able to meet future needs.

Following is a list of frequently asked questions regarding the GPD Program. Interested stakeholders are always encouraged to contact the GPD Program office at (toll-free) 1-877-332-0334 with questions.

Department of Veterans Affairs
Homeless Providers Grant and Per Diem (GPD)
Bridge Housing
Frequently Asked Questions

VA believes that all grantees should be taking steps to lower barriers to entry, reduce lengths of stay, and improve exits to permanent housing. One innovation that we encourage grantees to pursue, which aligns with Housing First principles, is the utilization of GPD beds as "Bridge Housing". The bridge housing model can offer grantees a level of flexibility to maximize the utilization of their transitional housing beds. VA strongly supports GPD grantees examining the existing local housing resources and needs and, as appropriate, requesting a change of scope to convert a portion of their existing beds to bridge housing. The following are some frequently asked questions related to the bridge housing model.

Question: What is Bridge Housing?
Answer: Bridge Housing is transitional housing used as a short-term stay when a Veteran has been offered and accepted a permanent housing intervention (e.g., Supportive Services for Veteran Families (SSVF), Department of Housing and Urban Development (HUD)-VA Supportive Housing (VASH), Housing Coalition/Continuum of Care) but, access to that permanent housing is still being arranged. Bridge Housing is generally provided for up to 90 days. Goals in the Individual Service Plan (ISP) should be very short-term with the focus on a move to permanent housing.

In order to be successful in Bridge Housing, certain criteria should be met:

- **The Veteran needs a permanent housing plan.** At the time of admission, there should be a reasonable expectation that the Veteran will move into permanent housing within 90 days, as in the following circumstances: Veterans who have and/or are in the process of obtaining a HUD-VASH voucher; Veterans who have permanent housing located, but need assistance and/or extra time before they move in; and Veterans who may be able to regain their permanent housing after resolving short-term issues (such as in the case where a Veteran has been asked to leave his or her family's home).
- **Collaboration with other resources (SSVF, HUD-VASH, local Housing Coalitions/Continuums of Care).** As part of the permanent housing plan, Veterans in Bridge Housing should have the resources available (such as SSVF, HUD-VASH, or some other resource) to help them move into permanent housing quickly.
- **Lower Barriers/Expectations.** Given the short timeframe of Bridge Housing, there should not be an expectation that Veterans in this "track" will complete many parts of the grant project's established program. Goals in the ISP should be very short-term with the focus on the move to permanent housing, rather than the completion of treatment goals. Many Veterans in this track may also have

unresolved mental health or substance abuse issues that might keep them from participating in a traditional grant project program. Those issues should not be regarded as reasons to not link Veterans to appropriate permanent housing options.

Question: Can Bridge Housing be implemented without a formal change of scope?
Answer: The VA GPD National Program Office encourages GPD-funded organizations to submit a written change of scope request prior to implementing a bridge housing model. This will ensure that changes that differ from what was stated in the original application are documented and approved. In addition, this will help our office to ensure that the proposed change to providing short stay services are in line with the guidance our office has provided on Bridge Housing.

Question: Can we convert all the beds in our project to Bridge Housing?
Answer: No, you can only use up to 50 percent of your beds at any given time for Bridge Housing. The addition of Bridge Housing services to the services provided in the original grant application is seen as an enhancement of services and would be allowable under a change of scope. Changing the entire grant project to Bridge Housing would be a substantial change to the original grant application that would likely affect whether the original grant application would have scored as well in the year it was funded and would not be approved.

Question: Do we have to designate a set number of beds for Bridge Housing?
Answer: No, you do not have to designate a fixed number of beds for the Bridge Housing component to your program. Organizations will have a level of flexibility to maximize the utilization of their transitional housing beds, subject to the prohibition discussed above on conversions of over 50 percent of your beds.

Question: If we add Bridge Housing, will our per diem rate change?
Answer: Your per diem rate is based on the daily cost of care for your grant project, minus other sources of income up to the current maximum per diem rate. The Bridge Housing component would only impact per diem to the extent that calculation changed for your grant project (for example, daily cost of care increasing from the addition of 24-hour staff to support the Bridge Housing).

Question: What should we do if we have additional questions about Bridge Housing?
Answer: Contact the VA GPD National Program Office at 877-332-0334.

Veterans Health Administration
February 25, 2016

Coordinated Entry Systems and the use of "By Name Lists" (BNLs): A vital strategy in the Federal approach to ending homelessness is the adoption of Coordinated Entry Systems and the use of BNLs. These approaches require the ability to share Veteran Protected Health Information with community partners in order to develop a fully comprehensive BNL and ensure that all homeless Veterans are prioritized for services in the community. VA is working to identify and implement secure methods for the digital sharing and storage of Veteran information in a way that dually maximizes Veteran security and community-level coordination of services.

Maximum use of HUD-VASH vouchers: VA is working internally and with its Federal partners at HUD and USICH to ensure that we maximize utilization of all HUD-VASH vouchers. Efforts underway within HUD-VASH include targeted allocations for Veterans on Tribal lands and in rural areas, increased use of project-based vouchers, as well as exploratory discussions regarding vouchers for Other Than Honorable Veterans. Concurrently, VA is working on several HUD-VASH accelerator projects focused on cities with low vacancy rates and a backlog of voucher holders seeking housing. Ensuring that Veterans have the case management support in place as they exit homelessness is a critical component of this process. Continued investment in case managers (e.g., 10,000 newly funded HUD-VASH vouchers) through funding provides Veterans with the access and quality services to successfully exit homelessness.

Research: VA recognizes that research is critical to informing the development of evidenced-based services that meet the needs of various special populations (e.g., aging, women, Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn, the chronically homeless). VA's National Center on Homelessness among Veterans is VA's hub for homeless Veteran research. For example, the National Center on Homelessness hosted several Homeless Evidence and Research Synthesis (HERS) symposiums bringing together policymakers, leaders in the field and researchers to discuss various evidence based practices and solutions.

The final proceeding documents from previous HERS symposiums are embedded. These documents highlight the presentations, discussions and suggested recommendations from the events. Opinions expressed in these papers are provided to be thought provoking and challenging, as national policy are developed to address the needs of homeless Veterans. These recommendations do not reflect the current official VA policy.

THE HOMELESS EVIDENCE AND RESEARCH SYNTHESIS ROUNDTABLE SERIES
Aging and the Homeless Community

December 2015

EXECUTIVE SUMMARY

The Aging and the Homeless Community HERS symposium held on November 19, 2015 brought researchers on homelessness and aging together with policy makers and advocates to discuss the projected population growth and special needs of the older homeless Veteran population and the impact this may have for the VA and its community partners.

There is evidence of an aging trend among homeless adults in the United States, including Veterans. The cohort born between 1954 and 1965 faces an elevated risk of homelessness. The median age is over 50, yet this group has health problems similar to those in the general population in their 70s and 80s: high rates of cardio-metabolic diseases and substance use complicated by geriatric conditions such as cognitive deficits, visual and hearing impairments, urinary incontinence, mobility challenges, and the need for assistance with activities of daily living. Mortality rates are high, with heart disease and cancer as the leading causes of death. A current study on palliative and end-of-life care for homeless Veterans indicates that lack of appropriate housing is a significant concern.

All of these issues have important implications for designing both the built environment and care systems and strategies. Suggested recommendations to this end include better integrating VA and community health care, social services, and housing programs to enable Veterans to age in place for as long as possible and avoid nursing home placement; creating more flexible housing criteria; and educating end-of-life and homeless care providers about resources available in and outside of VA.

INTRODUCTION

On November 19, 2015, the U.S. Department of Veterans Affairs (VA) Homeless Programs Office and the National Center on Homelessness Among Veterans (NCHAV) hosted a virtual research symposium on aging and the homeless community. The symposium was the second in the Homeless Evidence and Research Synthesis (HERS) Roundtable Series, for presenting and discussing critical issues affecting Veterans experiencing homelessness.

NCHAV Acting Director Dr. Tom O'Toole welcomed presenters from NCHAV, the VA Eastern Colorado Health Care System, and the University of California, San Francisco, to share their work on issues of aging and homelessness:

- Tom Byrne, PhD, an investigator at NCHAV and Assistant Professor at Boston University, explained why homelessness among older Veterans is likely to increase and the projected impact on the use of health services.
- John Schinka, PhD, an investigator at NCHAV and Professor of Psychiatry at the University of South Florida, presented his research on mortality risk and factors influencing death in older homeless Veterans.
- Evelyn Hutt, MD, a geriatrician-internist and palliative care physician at the VA Eastern Colorado Health Care System and Associate Professor at the University of Colorado School

of Medicine, shared preliminary findings from her study of planning palliative care for homeless Veterans at the end of life.

- Margot Kushel, MD,Professor of Medicine at the University of California San Francisco in the Division of General Internal Medicine at San Francisco General Hospital, discussed emerging clinical issues in the aging homeless population.

Following the presentations, Dr. O'Toole led a roundtable discussion with leaders from the VA and the homeless Veterans advocacy community: Baylee Crone, Executive Director, National Coalition for Homeless Veterans; Lisa Pape, National Director of VA Homeless Programs Office; and Dr. Scott Shreve, National Director of VA Hospice and Palliative Care.

PRESENTATIONS

1. Projecting Changes in the Scope and Health Service Utilization of Older Veterans Experiencing Homelessness

Dr. Byrne presented evidence of an aging trend and growth projections in the Veteran homeless population through 2025. He also discussed the potential impact of older homeless Veterans on the cost of VA health services and the implications for service planning.

Aging cohort effect in the single adult male and Veteran homeless population

An analysis of Census data from 1990 through 2010 shows a shift in the age distribution of the single adult male homeless population over time, with a cohort of males born between 1954 and 1965 comprising the bulk of the homeless population in each decade. In 1990, this cohort comprised 23% of the population but by 2010 accounted for 43%.

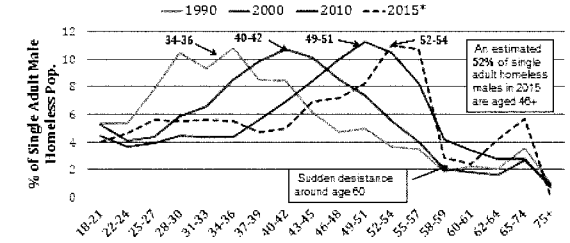
The aging trend among single adults experiencing homelessness is distinct from the aging of the general population: in 2010, the single largest age group among homeless adult males was those aged 49-51, who constituted 11.3% of the single adult male homeless population. By comparison, males aged 49-51 represented only 5.9% of the general adult male population. This trend is consistent in every state and city across the country and for the Veterans who used VA specialized homeless programs from 2000–2010.

Projecting changes in size of population and use of health services

Dr. Byrne and his NCHAV colleagues worked with a team of demographers to create projections of future age distributions of single adult and Veteran homeless populations in 2015, 2020, and 2025. The estimated age distribution for 2015, shown in Figure 1, continues to shift to the right, with a sudden drop-off in the homeless population after age 60. Dr. Byrne maintained that mortality alone is not the cause; it may also be that people are accessing Social Security benefits and may have increased ability to afford housing or may be entering nursing homes.

Additional projections focused on the percentage change in the number of Veterans experiencing homelessness on a given night in 2015, 2020, and 2025, stratified by age. Veterans in the 62–74 age bracket are projected to grow by 50–250%, depending on their age and year in question. The number of Veterans age 60 and older is projected to increase from 16,921 in 2015 to 21,350 in 2020, levelling off at 22,175 in 2025, as this age cohort reaches its life expectancy.

Figure 1. Projected Age Distribution of Single Adult Homeless Population in 2015



*Estimated Source: Author Estimates Based Data from U.S. Census Bureau Decennial Census Special Tabulation and AHAR Report

Average life expectancy for single homeless adults is 64 for males and 69 for females in some studies. Given that homeless individuals 50 and older have health problems similar to those in the general population in their 70s and 80s, the growth in the older homeless Veteran population will have a large impact on VA health care resources. Byrne and colleagues looked at the VA health care costs incurred by users of VA homeless programs by discrete age categories and found that health care costs for this population tend to increase with age, particularly inpatient care, as shown in Figure 2.

Figure 2: Health Care Costs for Homeless Veterans

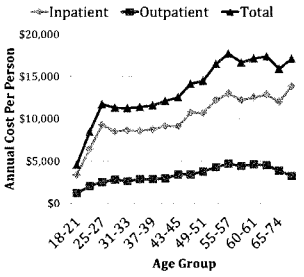
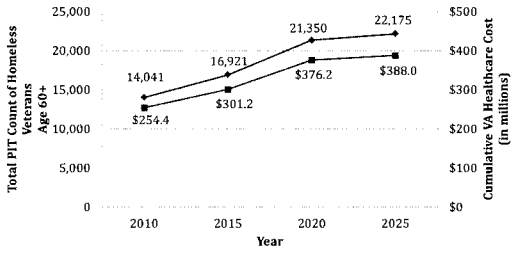


Figure 3 illustrates the mapping of estimated health care costs onto the population projections for Veterans aged 60 or more to gauge the cumulative impact on the VA health care system.

Figure 3: Projecting Health Care Costs



Implications of aging trend

The aging homeless Veteran population will require us to address geriatric conditions and end-of-life issues in HUD-VASH and other VA homeless programs, which may include staff training, building and facility changes to accommodate accessibility challenges faced by an older population, and increased systematic efforts to target older Veterans experiencing homelessness.

2. Mortality Risk and Factors Influencing Death in Older Homeless Veterans

Dr. Schinka presented his recent research on mortality and risk factors influencing deaths among older homeless Veterans. Today, 35% of the people who enter VA homeless programs are age 55 or older, many with health problems and high rates of nonfatal suicidal behavior.

Mortality patterns in Veterans 55 or older

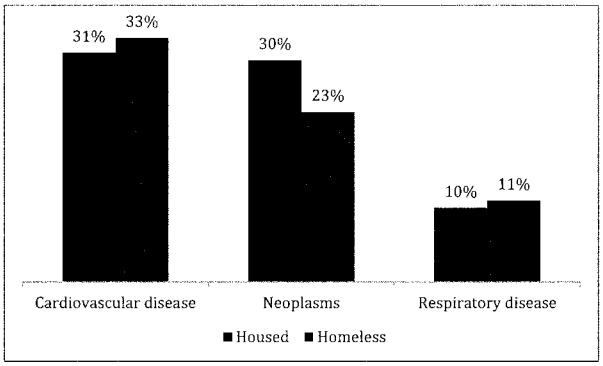
Dr. Schinka and his colleagues examined mortality patterns in 4,775 Veterans 55 or older who entered national VA homeless programs in 2000–2003. Using VA administrative data and Centers for Disease Control and Prevention National Death Index records, they found that 1,560 (35%) homeless Veterans died from all causes, compared with 3,649 (18%) of a housed control group; these differences were magnified when the impact of increasing age (55–59 vs 60+) was considered. (See Table 1)

Table 1. Mortality Rate Among Housed and Homeless Veterans

Age	Housed	Homeless
55–59	15%	31%
60+	24%	43%

Eleven causes of death accounted for 95% of deaths of Veterans in both groups, most frequently cardiovascular diseases, neoplasms, and respiratory diseases (See Figure 4). Compared with the control group, the homeless group had higher proportions of deaths due to digestive diseases, mental or behavioral disorders, infectious or parasitic diseases, and accidents or self-harm. Deaths due to neoplasms and to endocrine, nutritional, or metabolic diseases were more common in the control group versus the homeless group. Death by suicide was rare, but the odds of dying by suicide were greater in homeless Veterans (0.4%) than those who were housed (0.2%).

Figure 4. Causes of Death Among Housed and Homeless Veterans

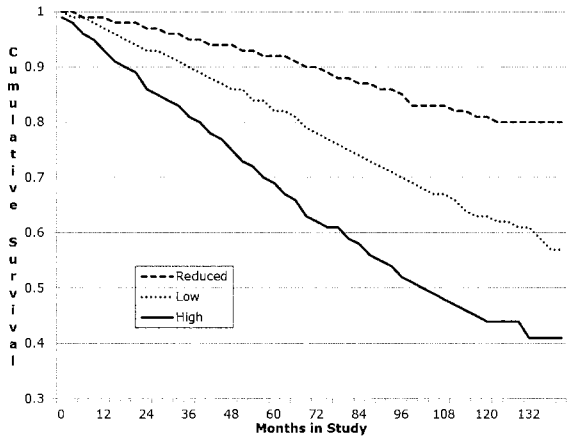


Predictors of death among older homeless Veterans

In another set of analyses, Dr. Schinka and colleagues examined predictors of death in a subsample of 3,620 homeless Veterans who completed a structured interview formerly required for admission to VA homeless programs, which captured sociodemographic, psychosocial, health, housing, alcohol abuse, and employment data. Five variables—serious medical problem, hospitalization for alcohol abuse, alcohol dependency, unemployment for three years, and age 60 or more—were modestly associated with increased risk of death. Three variables—non-White, drug dependency, and dental problems—were modestly associated with a reduced risk for death. This reduced risk was attributed to living in neighborhoods where both VA and non-VA health and social services were more readily available. A previous study (Nunez, Gibson, Jones, & Schinka 2013) showed that homeless Veterans receiving dental care as part of homeless services had significantly improved housing and employment outcomes. This result was attributed to the direct effect of dental care (e.g., improved nutrition and appearance, reduced pain) and the indirect effect that Veterans stayed in the intervention longer to receive dental care, thereby promoting greater exposure to other therapeutic and training modalities.

To examine the impact of cumulative risk from these eight variables, a risk score was calculated using weighted values based on logistic regression modeling (+1 for variables with HRs greater than 1, -1 for variables with HRs less than 1). The possible range of scores was -3 to 5. Based on the risk score, the full sample was categorized into three groups: reduced risk (risk score less than 0), low risk (risk score of 0-2), and high risk (risk score greater than 2). Figure 5 presents the survival functions for the three groups. Overall, there was a significant difference in the survival functions of the three groups, and all pairwise comparisons of the functions of the groups revealed significant differences.

Figure 5: Mortality Rate for Homeless Veterans by Risk Category



In summary, this research provides support for the hypothesis that homelessness increases mortality rates in older Veterans, especially in those aged 60 and older. While there are several predictors of early mortality for older homeless Veterans, the combination of predictors as an overall risk index may have the potential to identify those Veterans at greatest risk.

3. Planning Palliative Care for Homeless Veterans at the End of Life

Dr. Hutt discussed an ongoing study funded by VA Health Services Research and Development (HSR&D) in 2013 to inform palliative care for homeless Veterans. The study was motivated by the experiences of the inpatient palliative care team at the Denver VA Medical Center where great need was observed.

The goals of the study are to:

- Characterize existing approaches to the care of homeless Veterans at the end of life;
- Understand barriers and facilitators to providing excellent end of life care for homeless Veterans; and
- Develop a program framework for meeting their needs that can be tested and replicated across the nation.

Dr. Hutt and her team conducted an email survey of end of life and homeless care programs at 152 VA Medical Centers (VAMCs) and achieved a 33% response rate. Respondents to this survey reported that they treated an average of 9.4 homeless Veterans at end of life annually; the most critical challenge was a lack of appropriate housing. To understand the problem in greater depth,

the team conducted visits to four VAMC sites that were chosen based on the size of the homeless population and the strength of their program either in homeless care, end-of-life care, or both. The team conducted 21 key informant interviews with decision makers in palliative care and homelessness inside and outside the VA, 33 interviews with homeless Veterans with chronic illness, and 10 focus groups with front line providers and middle managers. The interviews focused on substance abuse and mental illness; pain management strategies; need for cross specialty educational activity; location of care and associated regulations; advance directives and how to access resources; burial assistance; grief loss and family support; entitlement and service connection; and culture of homelessness.

Barriers and facilitators to care

Findings from the interviews revealed that:

- Symptom management in the context of addiction, unstable housing, and behavioral health problems is challenging.
- Current housing options are too often limited to places that insist on functional independence and a "clean and sober" lifestyle.
- Discontinuity of care between and within VA systems restricts end of life care delivery.
- VA regulations challenge collaboration with community providers, to the detriment of frail, vulnerable homeless Veterans.
- Dedicated homeless and end of life program staff collaborate informally.

Ways to improve care

During the study's final year, a National Policy and Program Development Forum is bringing together focus group participants from each site with national VA palliative and homelessness care leadership to develop policies, collaborations, and programs to facilitate high quality end of life care for homeless Veterans. At an initial meeting in Philadelphia in the summer of 2015 the following preliminary recommendations were made and are in the process of being refined:

- Educate end of life providers about needs of those with unstable housing and homeless care providers about palliative care.
- Educate end of life and homeless care providers about VA resources that are available.
- Facilitate ongoing informal communication among VA and non-VA homeless and palliative care providers.
- Develop more flexible housing criteria for those needing palliative care.
- Establish policy that gives homeless Veterans at the end of life priority housing access.
- Pilot test intense collaboration between Homeless Patient Aligned Care Team (HPACT) program and VA end of life providers.

Stakeholders interested in moving any of these items forward should contact Dr. Hutt.

4. The Aging of the Homeless Population: Emerging Clinical Issues

Dr. Kushel described the clinical issues presented by the aging homeless population and the implications for practice and policy. Homeless Veterans have a median age over 50 with health problems similar to people in the general population who are in their 70s and 80s. Key health concerns include chronic diseases, substance use, and geriatric conditions such as cognitive,

functional, and visual impairment, falls, and incontinence. These issues have implications for designing both the built environment and care systems and strategies for these individuals who may be at high risk for nursing home placements.

Managing chronic diseases

High rates of cardio-metabolic illnesses such as heart disease, diabetes, and stroke are related to high rates of smoking and poor access to care. The leading causes of mortality in homeless individuals 45 and older are heart disease and cancer. Managing chronic disease is a tremendous challenge, requiring longitudinal coordinated care. Individuals need to adhere to complex medication regimens, follow special diets, and perform recommended activities, which is particularly difficult tasks for individuals who are homeless. Guidelines for care management also need to be considered not just in terms of age, but also with respect to life expectancy and co-morbidities.

Substance use

A major concern for homeless older Veterans is the rising rate of substance use. Illicit substance use (cocaine and heroin) disorders have decreased with age in the homeless population, but remain higher than the general population or than the older homeless population from 20 years ago. Many treatment facilities are not designed to serve older people with the functional impairments and chronic disorders associated with alcohol and drug abuse.

Geriatric conditions

Older homeless Veterans have high rates of geriatric conditions such as dependency on assistance with activities of daily living (ADL) and independent activities of daily living (IADL); urinary incontinence; falls; cognitive impairment; depression; and visual and hearing impairments.

Similarly, high rates of cognitive impairment, strongly associated with alcohol use disorders, have been found. Recent studies by Dr. Kushel and her colleagues at the University of California San Francisco yielded the following findings regarding older homeless individuals:

- 39% had difficulty with one or more ADLs and 17% with tbree or more
- 49% reported difficulty with at least one IADL
- 27% reported difficulty walking
- 38% showed global cognitive impairment and 17% had moderate to severe impairment
- 40% demonstrated executive function impairment, a disorder which affects the ability to manage complex tasks
- 34% reported one or more falls in the past six months
- 48% screened positive for incontinence
- 45% had visual impairments and 36% were bearing-impaired

ROUNDTABLE DISCUSSION

Tom O'Toole thanked the presenters for the information they had shared and acknowledged that it had raised awareness and introduced many questions.

1. *What particular information or disconnects jumped out at you from the presentations?*

Ms. Crone responded that the data confirmed what community agencies are seeing in the field, which is working to support the rapidly aging Veteran cohort with ADLs and end of life issues. She stated that the sharp decrease in the Veteran homeless population at age 60 was a testament to the good work being done at the community level to respond to these individuals as they increasingly reach out for help. She added that the projected Point-in-Time counts and age distributions presented by Tom Byrne spoke to the need to improve targeting of the population, to continue HUD-VASH, and to develop new collaborations to meet the needs of aging Veterans.

Ms. Pape said that policy changes would be needed to accommodate the aging population bubble; changes would include expanding the current focus on job readiness and independent living in homeless programs to building capacity for the management of chronic disease and cognitive deficits. This would involve the coordination of medical, mental health, social work, legal, and community partnerships.

Dr. Shreve cited VA budget constraints as an issue. He also pointed to the challenge of providing programs like assisted living that do not fall within VA's legislative authority for housing supports. He raised the question of how much programs like Veteran Directed Care have been used to assist with the population.

2. *There seems to be a "disconnect" between what we're seeing "on the ground" in the communities and the policies, procedures, and mechanisms in place to care for the aging homeless population. It often feels like we live in a system of silos that do not necessarily speak to each other: the Homeless Programs Office, Geriatrics and Extended Care, and community partners. Who should own this?*

Dr. Hutt suggested that Ms. Pape and Dr. Shreve assemble a cross-disciplinary task force from VA Homeless Programs, Geriatrics and Extended Care, and community partners with the understanding that "we all own it." In her experience, putting the right people in the room together from the various silos will provide good ideas and energy.

Ms. Pape concurred with Dr. Hutt, emphasizing the importance of the community partners for their ability to do some of the work that is closed to the VA because of authority or legislative restrictions. She also welcomed participation from friends in Congress, the National Coalition of Homeless Veterans, and the National Alliance to End Homelessness.

Ms. Crone spoke of the opportunity such a task force would provide to identify gaps in expertise and resources and work towards filling them. As an example, she referenced the lack of financing for senior housing, which is connected to community services that can help Veterans maximize the amount of time that they are in their home so that they are aging in place instead of having to go to nursing facilities.

3. *Where do you see community providers within the mix?*

Ms. Crone offered four roles for community providers:

- Source of information: a means to identify what is and is not working in the field and where the gaps are.
- Conduit to services: a referral source for other needed services.

- Help in accessing benefits: many communities have experience working with SOAR (Supplemental Security Income Outreach Access & Recovery) and in pursuing Social Security and VA benefits.
- Providing housing opportunities: expertise in developing affordable housing and leveraging complicated financing tools to increase housing stock.

Dr. Shreve expressed the opinion that a homeless program might take the lead in a collaborative effort, with tighter linkages to the GeriPACT outpatient team and palliative care specialist support. The palliative care specialist could also empower the HPACTs to do more primary palliative care. In addition, there could be a stronger effort to educate primary care providers and front line social workers not involved with the homeless program. He also suggested the We Honor Veterans program as a mechanism for the VA to partner with 2,900 of the 5,000 hospice organizations nationwide that have made a commitment to improve the care of Veterans at the end of life and are adept at quickly enrolling Veterans in hospice.

4. *Can you speak more specifically to the unique challenges you have seen in the context of palliative care, end of life care, and care for cognitively impaired and functionally frail aging homeless Veterans? What is going to work and not work with individuals who may have co-occurring addictive behaviors and compliance issues?*

Dr. Shreve indicated that the 106 inpatient hospice units at 168 VAMCs are committed to doing whatever it takes to help a Veteran at the end of life. He stressed the importance of making community providers aware that every enrolled Veteran is entitled to hospice, regardless of their income. Policy and law require that VA must provide inpatient care with a hospice team if it is needed, unlike the Medicare model for general inpatient care under hospice.

5. *What targets should we be focusing on to provide care for rapidly aging frail older homeless and formerly homeless Veterans?*

Dr. Shreve: Increase the percentage of homeless Veterans who die with hospice services.

Ms. Crone: Ensure that Veterans are able to age in place, maintaining their independence and stability, for as long as possible by targeting integrated VA and community health care, social services, and housing programs to where they live.

Dr. O'Toole: Promote the financial cost and improved quality of care benefits of an aging-in-place strategy.

Ms. Pape: Identify a geriatric advocacy organization partner like NCHV to help us in this effort. Reach out as well to the U.S. Department of Health and Human Services.

Dr. O'Toole thanked everyone for their participation in the symposium, concluding that there were many excellent efforts underway to support older homeless Veterans and that it is important to make sure that people are aware of them.

SUGGESTED RECOMMENDATIONS

During the presentations and roundtable discussion a number of suggestions were made for improving the care of older homeless Veterans.

- Establish a joint homeless care/end of life care task force to develop recommendations for providing quality health care and appropriate housing accomodations for older homeless and formerly homeless Veterans. The task force should include community providers and other VA partners such as the U.S. Department of Health and Human Services
- Increase systematic efforts to identify and target older Veterans who may be at risk for or experiencing homelessness.
- Create more flexible housing criteria for homeless or formerly homeless Veterans needing palliative care.
- Develop better integrated VA and community health care, social services, and housing programs to enable Veterans to age in place for as long as possible and avoid nursing home placement both to promote independence and well-being and to lower costs.
- Promote the development of mental health and substance use treatment programs that are tailored to serve older people with functional impairments and chronic disorders.
- Consider cognitive and functional impairments of the older homeless population in the design and outfittting of housing and service spaces, living spaces, and the supports available within that housing.
- Develop a plan to educate end of life and homeless care providers in the VA and the community about VA structure, eligibility, housing, and end of life resources, including palliative care and hospice.
- Facilitate ongoing informal communication and collaboration among VA and non-VA homeless and palliative care providers.

NOTE: Opinions expressed in this paper represent only the position of the National Center on Homelessness Among Veterans, presenters and panel members and do not necessarily reflect the official policy of the U.S. Department of Veterans Affairs.

GLOSSARY OF TERMS

Activities of Daily Living (ADL): basic self-care tasks that include eating, toileting, grooming, bathing, walking and transferring (such as moving from bed to wheelchair).

Assisted Living Facilities (ALF): places where Veterans can live in a rented room or apartment with some shared living spaces and a trained caregiver on duty 24 hours a day, 7 days a week. This person can help the Veteran with activities of daily living such as bathing and getting dressed. Veterans may also be able to have the VA arrange for a health professional (e.g., a nurse) to visit and give them extra care. The VA does not pay for the Veteran's rent, which usually includes basic services. However, the VA may pay for some of the extra services the Veteran may need in an Assisted Living Facility.

VHA Geriatrics and Extended Care (GEC): a set of VA programs and partnerships designed to support the health, independence, and well-being of Veterans in the face of aging, disability, or illness. Programs include a broad range of Long Term Services and Supports, including Geriatric and Palliative Care, in home and community-based, residential and nursing home settings.

VHA Geriatric Patient Aligned Care Team (GeriPACT): Patient Aligned Care Teams (PACTs) that specialize in providing care for older and chronically ill Veterans who have complicated health problems that are made even more challenging by social factors. Their needs therefore cannot be addressed in the primary care clinic staff (PACT) alone. GeriPACTs include health care providers from a variety of disciplines. The team is usually led by a GeriPACT provider such as a physician

(MD or DO), physician assistant (PA), nurse practitioner (NP), or clinical pharmacist. Other team members include nurses, social workers, pharmacists and mental health providers. Dieticians, rehabilitation professionals, and chaplains may become involved as well.

VHA Health Care for Homeless Veterans (HCHV): program that initially served as a mechanism to contract with providers for community-based residential treatment for homeless Veterans. Many HCHV programs now serve as the hub for a myriad of housing and other services that provide VA with a way to reach and assist homeless Veterans by offering them entry to VA care. Another aspect of HCHV is the Contract Residential Treatment program, which places Veterans with serious mental health diagnoses into quality, community-based supportive housing.

VHA Homeless Patient Aligned Care Team (H-PACT): H-PACT provides a coordinated "medical home" specifically tailored to the needs of homeless Veterans. At selected VA facilities, Veterans are assigned to an H-PACT care team that includes a primary care provider, nurse, social worker, homeless program staff and others who provide medical care, case management, housing and social services assistance, to provide and coordinate the health care they may need while assisting them in obtaining and staying in permanent housing.

VHA Homeless Providers Grant and Per Diem Program (GPD): The GPD program allows VA to award grants to community-based agencies to create transitional housing programs and offer per diem payments. The purpose is to promote the development and provision of supportive housing and/or supportive services with the goal of helping homeless Veterans achieve residential stability, increase their skill levels and/or income, and obtain greater self-determination. GPD-funded projects offer communities a way to help homeless Veterans with housing and services while assisting VA medical centers (VAMC) by augmenting or supplementing care.

Housing and Urban Development - Veterans Affairs Supportive Housing (HUD-VASH) Program: HUD-VASH is a collaborative program between the Department of Housing and Urban Development (HUD) and VA. Eligible homeless Veterans receive rental support from HUD in the form of a Housing Choice or Project Based Section 8 voucher as well as case management and supportive services from VA. These efforts collectively support housing stability and the recovery from physical and mental health problems, substance use disorders, and functional concerns contributing to and/or resulting from homelessness. HUD-VASH subscribes to the "Housing First" model, a best practice that has demonstrated that housing the homeless individual helps him/her to exit from homelessness, which then improves the ability and motivation to engage in treatment strategies. The program's goals include housing stability while promoting maximal recovery and independence in the community for the Veteran and the Veteran's family.

Instrumental Activities of Daily Living (IADL): complex skills needed to successfully live independently that include managing finances, handling transportation, shopping, preparing meals, using the telephone and other communication devices, managing medications, and housework and basic home maintenance.

SOAR: SSI Outreach Access & Recovery: national project funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) that is designed to increase access to Supplemental Security Income (SSI) and Social Security Disability Income (SSDI) for eligible adults who are experiencing or at risk of homelessness and have a mental illness, medical condition, and/or a co-occurring substance use disorder. Using a three-pronged approach of strategic

planning, training, and technical assistance (TA), the SOAR TA Center coordinates this effort at the state and community level.

Supportive Services for Veteran Families (SSVF): The SSVF program was authorized by Public Law 110-387 and provides supportive services to very low-income Veteran families that are currently in or transitioning to permanent housing. SSVF is designed to rapidly re-house homeless Veteran families and prevent homelessness for those at imminent risk due to a housing crisis. Funds are granted to private non-profit organizations and consumer cooperatives that will assist very low-income Veteran families by providing a range of supportive services designed to promote housing stability.

Veteran Directed Care (VDC): program that helps Veterans continue to live at home or in their community. VDC provides skilled services, case management, and assistance with activities of daily living (e.g., bathing and getting dressed) or instrumental activities of daily living (e.g., fixing meals and taking medicines) for Veterans who are isolated or whose caregiver is experiencing burden. Veterans in this program are given a flexible budget for services that can be managed by the Veteran or the family caregiver.

We Honor Veterans: a program of the National Hospice and Palliative Care Organization (NHPCO) in collaboration with the Department of Veterans Affairs (VA) that invites hospices, state hospice organizations, Hospice-Veteran Partnerships and VA facilities to join a pioneering program focused on respectful inquiry, compassionate listening and grateful acknowledgment. By recognizing the unique needs of America's veterans and their families, community providers, in partnership with VA staff, will learn how to accompany and guide them through their life stories toward a more peaceful ending.

PRESENTER AND PANELIST BIOGRAPHIES

Thomas Byrne, PhD

Tom Byrne, PhD is an Investigator at the VA National Center on Homelessness Among Veterans and an Assistant Professor at the Boston University School of Social Work. As part of the research team at the National Center, Tom conducts research on a number of topics related to homelessness among Veterans and VA specialized homeless programs in support of VA's efforts to prevent and end homelessness among Veterans.

Baylee Crone, MS

Baylee Crone, Executive Director for the National Coalition for Homeless Veterans (NCHV), is a national voice in efforts to end veteran homelessness. In this capacity, she provides leadership and management over NCHV's Technical Assistance, Policy, and Communications activities and serves NCHV's Board of Directors to execute NCHV's mission and goals. As the only national organization solely committed to ending veteran homelessness, NCHV is a trusted source of information, training, and guidance for community organizations, philanthropic and corporate partners, and government employees at the state, regional, or Federal level. Ms. Crone earned a Master's Degree in Vocational Rehabilitation Counseling with an emphasis on Traumatic Brain Injury at the George Washington University and a Bachelor's Degree in Political Science with an emphasis in Public Service and Global Security from the University of California, Santa Barbara.

Evelyn Hutt, MD

Evelyn Hutt, MD founded and led the health services research effort at the VA Eastern Colorado Health Care System from 2002-2013. As a geriatrician-internist and palliative care physician, she has a long-standing interest in the care of underserved populations, and is currently funded by VA HSR&D to study Planning Palliative Care for Homeless Veterans at the End of Life. She has completed projects aimed to improve the care of pneumonia and heart failure in nursing home patients, and attends on the Palliative Care Consult Service at the Denver VAMC. In 2013-14 she extended her mentoring to faculty at the Institute of Palliative Care in Africa while on sabbatical in Uganda.

Margot Kushel, MD

Margot Kushel, MD is a Professor of Medicine at the University of California San Francisco in the Division of General Internal Medicine at San Francisco General Hospital. Margot's research interests include the health and health care utilization patterns of homeless adults and other vulnerable populations, with a focus on improving outcomes among older homeless adults. Her research is informed by her 20 years of experience as a practicing internist at San Francisco General Hospital. She is the PI of two NIA funded R01s that focus on older homeless adults. She is a practicing general internist at San Francisco General Hospital.

Thomas O'Toole, MD

Dr. Tom O'Toole is the Acting Director of the National Center on Homelessness among Veterans and National Director of the Homeless Veterans Patient Aligned Care Team (H-PACT) Program for the Department of Veterans Affairs. He is a general internist based at the Providence VA Medical Center in Rhode Island and a Professor of Medicine at Brown University. His research for the past 25 years has focused on access to care, health and social service needs and intervention studies for homeless and other vulnerable and disadvantaged populations with funding from VA HSR&D, NIH, SAMSHA, and private foundations. He has published over 70 articles and book chapters on the subject.

Lisa M. Pape, LISW

Lisa M. Pape, LISW, currently serves as the Executive Director, Homeless Programs for the Veterans Health Administration (VHA) within the Department of Veterans Affairs (VA). Prior to her current role, she worked for many years holding progressively responsible positions at the VA Louis Stokes Medical Center in Cleveland. Her focus is on operationalizing plans and approaches designed to most effectively meet the needs of the nation's Veterans who are homeless or at risk of becoming homeless. Her primary efforts include oversight and implementation of homeless programs nationwide that provide prevention, outreach, treatment, transitional and permanent housing solutions and supportive services. Ms. Pape is the recipient of NASW's Knee/Wittman Outstanding Achievement Award in Health and Mental Health Policy among her many awards and recognitions.

John A. Schinka, PhD

John A. Schinka is an Investigator at the VA National Center on Homelessness Among Veterans conducting research on risks and outcomes in aging homeless Veterans. Prior to joining the Center,

Dr. Schinka served as the Director of the Neuropsychology and Memory Disorder Clinics at the Tampa VAMC. He is a Professor of Psychiatry and of the School of Aging Studies at the University of South Florida. Dr. Schinka is a Fellow of the American Psychological Association and the recipient of several research awards from the Association. He has also received the national VA Outstanding Professional Services Award. Dr. Schinka's research has focused primarily in the areas of cognition, aging, and neuropsychology.

Scott Shreve, MD

Dr. Scott Shreve is the National Director of the Hospice and Palliative Care Program for the Department of Veterans Affairs. He is responsible for all policy, program development, staff education and quality assurance for palliative and hospice care provided or purchased for enrolled Veterans. Dr. Shreve has led the implementation and oversight of the Comprehensive End-of-Life Care Initiative from 2009 to 2012 to change the culture of care for Veterans with serious illness and to ensure reliable access to quality palliative care. Clinically, Dr. Shreve commits half of his time to front line care of Veterans as the Medical Director and teaching attending at a 17 bed inpatient Hospice and Palliative Care Unit at the Lebanon VA Medical Center in Central Pennsylvania. Dr. Shreve is also an Associate Professor of Clinical Medicine in Penn State's College of Medicine.

THE HOMELESS EVIDENCE AND RESEARCH SYNTHESIS ROUNDTABLE SERIES
Enumeration of Homelessness

November 2015

INTRODUCTION

On July 14, 2015, the U.S. Department of Veterans Affairs (VA) Homeless Programs Office and the National Center on Homelessness Among Veterans (NCHAV) hosted a virtual research symposium on the enumeration of homelessness. The symposium inaugurated the Homeless Evidence and Research Synthesis (HERS) Roundtable Series, a quarterly forum to present and discuss critical issues affecting Veterans experiencing homelessness.

In 2010 the VA launched an initiative to end Veteran homelessness by 2015. During the past five years, the primary measure used to gauge the progress of this effort has been the Point-in-Time (PIT) count led by the U.S. Department of Housing and Urban Development (HUD). However, as counting methodologies have been expanded and refined, it has become clear that a variety of data sources are needed to reflect more accurately where progress is being made and where additional efforts should be directed. As local communities, such as New Orleans and Houston, declare victory in ending Veteran homelessness, there has been an increased focus on creating a process to validate their Veteran homelessness counts. There has also been discussion on the possible methods that could be used to go beyond counting homeless Veterans in order to look more qualitatively at how they are being served.

In this dynamic context, NCHAV Acting Director Tom O'Toole welcomed presenters from NCHAV, Abt Associates, and UNITY of Greater New Orleans to share their research and experience with measuring homelessness. Dan Treglia, a researcher at NCHAV, provided an overview of the methodologies used in conducting PIT counts for the sheltered and unsheltered homeless population nationwide. Larry Buron, Principal Associate at Abt Associates, discussed how annual Homeless Management Information System (HMIS) national estimates are currently derived from the Annual Homeless Assessment Report (AHAR) to Congress. Steve Metraux, an investigator at NCHAV and Associate Professor at the University of the Sciences, shared his examination of incidence measures of homelessness among service members separating from the military since September 11, 2001. Finally, Martha Kegel, Executive Director of UNITY of Greater New Orleans, described the use of person-level rosters to identify and target efforts.

Following the presentations, Dennis Culhane, NCHAV Research Director and Dana and Andrew Stone Chair in Social Policy at the University of Pennsylvania, led a roundtable discussion with federal agency leaders:

- Lisa M. Pape, Executive Director, Veterans Health Administration Homeless Programs Office
- Richard Cho, Senior Policy Director, U.S. Interagency Council on Homelessness (USICH)
- William Snow, SNAPS Specialist, Office of Special Needs Assistance, Community Planning and Development, U.S. Department of Housing and Urban Development (HUD)

PRESENTATIONS

1. Point-in-Time Counts: Estimating the Unsheltered Homeless Population

Dan Treglia provided an overview of the Point-in-Time (PIT) count. PIT counts are conducted in all Continuums-of-Care (CoCs) at least once every other year during the last 10 days of January. CoCs are local planning bodies responsible for coordinating the full range of homelessness services in a geographic area, which may cover a city, county, metropolitan area, or an entire state. They are diverse in terms of geography, size, and population density; they range from New York City with 8.5 million people living in 469 square miles to the state of Montana, home to 1 million in an area spanning approximately 147,000 square miles. Regardless of size and complexity, various PIT count procedures must account for all people experiencing homelessness in the CoC, both those who are unsheltered (living in a place not designed or ordinarily used as a regular sleeping accommodation) and those who are sheltered (living in emergency shelters or transitional housing projects).

Counting methodologies

For unsheltered homeless persons, estimates are made from street-based counts, service-based counts, or a combination of the two.

Street-based counts usually take place at night when people would be bedding down or sleeping and typically work best in more condensed, urban settings. The procedure employs three basic methods, depending on the size and characteristics of the CoC, including:

1. **Canvasing the entire area** – This method is appropriate for CoCs, such as Boston (89 square miles), that are small enough for those conducting the actual count to cover the entire area.
2. **Canvasing the central downtown and known homeless hotspots** – This method can be appropriate for larger cities where homelessness is heavily concentrated in a downtown area, like Philadelphia (143 square miles).
3. **Canvasing a sample of areas** – This method, deemed scientifically rigorous by HUD in 2008, is appropriate for large metropolitan areas such as New York City. This method divides the CoC into small areas, such as census tracts or block groups, and then samples these areas in one of two ways: (a) simple random sample, which draws a certain percentage of sections to count or (b) stratified sample, which divides the area into two parts based on previous counts and other institutional knowledge: places one would expect to find homeless people and places one would not.

There are several advantages of a street count, including a decreased likelihood of double counting, the fact that CoCs typically have a good understanding of covered areas, and there are no recall problems on the part of respondents. However, disadvantages of this approach include a potential for missing the "invisible homeless" (people staying in abandoned buildings or in hidden or dangerous public spaces), overlooking people who do not appear to be homeless, the difficulty of conducting this process in large geographies, and the scheduled count being affected by the weather.

Service-based estimates gather information from individuals accessing service organizations and public facilities such as soup kitchens, bus stations, housing agencies, and Social Security offices. They are asked where they slept on count night within seven days of the count night. This method is particularly appropriate for large jurisdictions and those with a challenging terrain (i.e. rural communities). In order to avoid duplicating counts across multiple services and nights, identifiers are used for people, such as components of name, date of birth, and Social Security numbers (e.g. initials, month and year of birth, and last four digits of the SSN, or a combination of those). The advantage of service-based enumeration is that it is a useful method for large and challenging areas and as such is able to reach the "invisible homeless" and other hard-to-reach populations such as youth. However, not all people experiencing homelessness access services and may be missed in the count, while others may be double counted or incorrect information may be provided due to recall errors.

Improving PIT reliability

Regardless of the counting methodology, it is important to assure reliability of the PIT count, which can be improved in a number of ways:

- Employ quality assurance audits of the street count. For example, decoys are employed to pose as homeless persons on the night of the count and the count is adjusted upwards based on how many decoys are missed. In New York City this practice is conducted by an independent entity and requires a large sample for statistical rigor.
- Use service-based enumerations to supplement street counts. If using both, you must make sure that the service-based count is only counting people who would have been invisible to counters.

2. Estimating the Number of Homeless Veterans: An Approach from the AHAR

Larry Buron described the AHAR process and how it is used to estimate the number of Veterans experiencing homelessness. First published in 2007, the AHAR is a two-part report to Congress: the first part provides estimates of the number of people staying on the streets or in a homeless shelter on a single night; the second part provides annual estimates of people accessing a homeless shelter or transitional housing program. The AHAR includes national counts of persons who are homeless—as individuals or part of a family—as well as their characteristics, geographic location, prior living arrangement, and patterns of homeless shelter use.

Where do the data come from?

The data for the single night counts of sheltered and unsheltered persons are collected locally using the PIT count procedures discussed by Dan Treglia. CoCs report these data as part of their application for homelessness and housing services funding from HUD.

The data for the 12-month reports on sheltered homeless persons are derived from local HMIS, administrative databases used by homeless service providers to track service users for case management purposes. Throughout the country, local HMIS contain federally standardized data, which allow apple-to-apple comparisons across communities and the ability to aggregate the data.

The share of providers that use HMIS varies across communities, but typically more than 75% of the beds in a CoC are recorded in HMIS.

How are the data collected?

CoCs submit aggregate, de-identified data in prescribed reporting tables for six household-project type categories: families in emergency shelters; individuals in emergency shelters; families in transitional housing; individuals in transitional housing; families in permanent supportive housing; and individuals in permanent supportive housing. The first four categories reflect people who are homeless; the last two indicate individuals who are no longer homeless. CoCs complete these tables for all homeless persons and separately for Veterans.

At what geographic level are data collected?

Data are collected from two types of geographies: sample sites and contributing communities. Sample sites are Community Development Block Grant (CDBG) jurisdictions, which make up CoCs. The 102 sample sites include central cities, urban counties, cities of greater than 50,000, and non-entitlement or generally rural communities. Contributing communities can be either CoCs or the balance of a CoC once the sample site(s) are removed.

How are data adjusted?

In cases where some homeless providers in a community do not participate in HMIS, HUD extrapolates within sample sites and contributing communities to produce a full enumeration. The sample sites are also weighted up to represent non-contributing CoCs such that the weighted sample sites plus the contributing sites are nationally representative.

What are advantages and shortcomings of the data?

An advantage of the AHAR is that it offers one-year estimates that provide a long-term understanding of shelter use, a rich set of data to capture demographic characteristics and service use patterns, and estimates that are based on a very thorough data cleaning process. However, there are also shortcomings of the AHAR data: the estimates do not account for people who never use a shelter during a 12-month period; domestic violence providers are prohibited from participating in HMIS in accordance with the Violence Against Women Act, which leads to a potential underestimate of women and children experiencing homelessness; and it is difficult to produce estimates at smaller geographic levels due to the sampling strategy.

How does the AHAR describe Veterans experiencing homelessness?

During 2013, nearly 140,000 Veterans used an emergency shelter or transitional housing, a 1.3% decrease from 2012 and a 6.5% decrease from 2009. Ninety-eight percent of Veterans were unaccompanied; 91% were male; and 43% were aged 51–61 years. About half of Veterans experiencing homelessness identified as white/non-Hispanic, had a disability, and were already homeless before they began their first shelter stay in 2013.

3. The Incidence and Timing of Homelessness Among Post 9/11 Era Veterans

Steve Metraux presented an alternative to the traditional approaches of enumerating Veterans experiencing homelessness, which were discussed by Treglia and Buron, tracking patterns of homelessness by matching administrative data records. While this approach is not intended to replace the PIT count or HMIS data collection, it has the potential to provide insights and identify trends to supplement existing knowledge. Metraux identified this alternative approach by following more than 1.5 million Veterans in 11 annual successive cohorts of persons who separated from the military between 2002 and 2012. Using data from the VA Defense Information Repository (VADIR), VA's electronic medical record, and the VA Homeless Registry, this study identified Veterans who became homeless and when during the five years post-discharge from the military.

Incidence of homelessness post-discharge

As indicated in Table 1, 58,784 Veterans (3.73%) became homeless in the first five years after returning to civilian life. For later cohorts, the rates of homelessness increased over the five-year period, from 1.66% for Veterans discharged in 2002 to 3.88% for those discharged in 2007. While the incidence rate may not be problematic when compared with other populations, the rate of increase over time raises some questions. The rate also increased significantly each year: in 2004 it was one-tenth of a percent; in 2010 it was seven times as high; and by 2012, it was 14 times as high. Not only did the incidence of homelessness increase over time, the risk for homelessness did as well. Hazard rates—the rate at which events happen (shown in Table 2) —indicated that the risk for homelessness increased steadily for Veterans who exited the military in later years, from 1.26 in 2003 to 11.35 in 2012.

Table 1: Incidence of Homelessness Post-Discharge

Separation Year	# Separated	# Became Homeless	% Became Homeless
2002	43,472	721	1.66%
2003	72,086	1,522	2.11%
2004	107,670	3,101	2.88%
2005	133,789	4,630	3.46%
2006	157,291	5,618	3.57%
2007	171,626	6,666	3.88%
2008	186,162	7,754	4.17%
2009	198,737	8,478	4.27%
2010	203,160	8,299	4.08%
2011	215,955	8,527	3.95%
2012	86,734	3,468	4.00%
Total	**1,576,682**	**58,784**	**3.73%**

Table 2: Hazard Rates for Homelessness by Military Separation Year, Branch and Discharge Type

Separation Year	2003	1.26
	2004	1.83
	2005	2.40
	2006	2.85
	2007	3.76
	2008	4.90
	2009	6.15
	2010	7.56
	2011	9.63
	2012	11.35
Experienced Combat		2.10
Female		1.02
Branch	Army	1.68
	Airforce	0.71
	Navy	0.94
	Coast Guard	1.29
Discharge Type	Honorable	1.64
	Under honorable conditions	4.56
	Bad conduct	1.96
	Other than honorable	2.23
	Dishonorable	2.82

Characteristics related to homelessness post-discharge

This study identified a number of characteristics related to post-discharge homelessness:

- ***Discharge status*** – Veterans with a general discharge, indicating a satisfactory discharge but with some problems, had the highest incidence of homelessness (9.7%), followed by those with a dishonorable discharge (6.3%), and the three remaining discharge dispositions—honorable, other than honorable, and bad conduct—with incidence rates around 4%. This finding may appear counterintuitive, as other research has shown a clear connection between discharge type and risk for subsequent homelessness. However, "bad" discharges make a Veteran ineligible for some VA services, and thus would preclude their representation in this study.
- ***Branch of service*** – Veterans who served in the Army, representing about half of all Veterans in the study, had the highest homelessness incidence (4.6%), followed by the Navy (3.3%) and the Marines (3.1%).
- ***Combat experience*** – About 35% of the Veterans in the study experienced combat and had about twice the rate of homelessness as compared to non-combat Veterans. Moreover, combat experience doubled the hazard of becoming homeless. These findings are consistent with previous research indicating deployment in Iraq and Afghanistan as being related to higher homelessness risk.

Advantages of using administrative data to assess Veteran homelessness

Administrative data has the advantages of being practical, comprehensive, and longitudinal, with the capacity for examining subgroups and adding more data. However, challenges with obtaining access to data and data quality may complicate its use. The data are also limited as they do not identify how long Veterans remain homeless and in what manner their homelessness was resolved. With the right data, these findings can extend the incidence count and examine the ability of available services to engage homeless persons and support their housing stability. Such a shift would be more in line with evaluating the evolving parameters on what it means to "end" homelessness.

4. The Role of the Master List, PIT, HMIS and VA Data in Ending Veteran Homelessness: A Ground-Level View

From the perspective of UNITY of Greater New Orleans, the CoC Lead Agency, Martha Kegel shared what it actually takes to "get to zero" Veteran homelessness on the gronnd, person by person. She described the process undertaken in New Orleans as part of Mayor Landrieu's commitment to the Mayors Challenge to End Veteran Homelessness campaign launched by First Lady Michelle Obama. This effort, in partnership with USICH, VA, and HUD, made New Orleans "the first city to effectively end Veteran homelessness," reaching what Kegel termed "functional zero."

Developing the master list

According to stakeholders in New Orleans functional zero is reached when, "Every newly discovered Veteran living on the streets or in emergency shelter is provided permanent housing within an average of 30 days of finding them, unless they choose to enter a longer-term treatment program instead."

In order to reach functional zero, New Orleans first developed a plan to identify all homeless Veterans and how to quickly house them. Between June and July 2014, using HMIS, the 2014 PIT, the local Permanent Supportive Housing Registry, and extensive, systematic outreach, UNITY compiled a comprehensive master list of all Veterans known to be living in emergency shelter, on the streets, or in abandoned buildings. Each night, HMIS staff entered shelters and outreach workers combed the streets looking for Veterans. The master list is dynamic and never closed. In New Orleans, quarterly PIT nighttime street snrveys ensnre periodic comprehensive scans of the streets. The list is also verified to ensure that it only contains Veterans who are literally homeless: living on the streets or in emergency shelters.

Kegel argued that a master list is essential to reaching functional zero for a number of reasons:

- The list brings all partners together, focusing housing resources on those living on the streets or in shelters who should receive the highest priority for honsing.
- The list adds a critical source of data to compensate for some of the shortfalls of PIT and HMIS data, as identified by Treglia and Buron.
- The list provides a check against VA homeless data, which inclndes Veterans who are not on the streets or in shelters bnt may be categorized at risk of homelessness.

The New Orleans experience found that close communication between the VA and the CoC is essential. The CoC typically has the best capacity to locate homeless Veterans, while the VA is able to verify their Veteran status, whether they are eligible for VA health care, and what VA-funded housing programs may be available to them. In New Orleans, 10–20% of those who claim to be homeless Veterans did not actually serve in the military.

Housing Veterans

Using these sources they identified 236 Veterans by name. SSVF agencies quickly performed assessments and placed confirmed Veterans in apartments. Those ineligible for SSVF were placed in rapid rehousing. Between July 25, 2014, and January 2, 2015, the city permanently housed 227 Veterans who had been living on the streets or in emergency shelter. The nine remaining Veterans, who had adamantly refused housing, were assigned to the city's Rapid Response for Homeless Veterans Initiative, a program which continuously follows up with resistant Veterans to encourage them to consider permanent housing. As of July 2, 2015, an additional 72 Veterans had been permanently housed, including five of the nine who had refused housing during the Mayors Challenge Campaign. The average length of time to housing was 22 days (median 15 days).

Maintaining functional zero

Kegel concluded her presentation by making a strong argument that VA housing resources should not be reduced for communities that have acbieved functional zero. Rather, these resources should be increased to sustain efforts to keep Veteran homelessness at bay, particularly given their disproportionate rates of poverty and disability. Communities have learned how to target these resources to the intended populations; a reduction in these resources "would undermine the goal of ending Veteran homelessness everywhere."

ROUNDTABLE DISCUSSION

Acknowledging the important information shared about measuring homelessness, roundtable moderator Dennis Culhane suggested the discussion might also take into account other homeless measurement concepts such as program performance, supply and demand, and gaps analysis, since "the reason we're counting homelessness is to determine unmet need." He proceeded with questions, as follows.

1. *What do you think about communities that are claiming to have ended Veteran homelessness while we know there are still Veterans experiencing homelessness in those communities?*

William Snow said that New Orleans has shown that it is possible to end Veteran homelessness and that there is hope; it takes determination, tools to track progress, and resources. Richard Cho commented that it was challenging to come up with a single formula for determining whether communities have ended homelessness. The real question is: Does the community have the resources to identify and rapidly house homeless Veterans? He added that there is a need to focus more on prevention, particularly among newly returning service members.

2. *As communities get close to zero, does that mean that resources should be redirected? How should we be thinking about strategic use of resources?*

Snow said that Veterans are not the only people experiencing homelessness. HUD is always contending with the question of maximizing the use of resources across all populations in need, particularly those with the most severe needs. Lisa Pape emphasized that within the VA, decisions will be data driven and gap analysis will be applied. Kegel reiterated her plea that Congress make more resources available to sustain the progress that has been achieved.

3. *Should we be trying to promote a different approach to how we assess our progress?*

Tom O'Toole observed that we have socialized the initiative to end Veteran homelessness around the PIT count metric. As methods become further refined, we see that a composite measure is more appropriate, one which could more accurately reflect where progress is being made and where additional efforts need to be directed. Once this measure is determined, we need to communicate it as clearly and effectively as the concept of the Point-in-Time count has been communicated.

Pape echoed the importance of communicating progress through measures outside of the PIT. As we get closer to the goal, the PIT can provide a false impression because it only tells a piece of the story. In 2014, the Veteran PIT number was 49,333; yet during the same year VA housed 70,500 Veterans, over 100,000 people if you add the household members in the families served. Pape explained that we have to find a different way to tell that story to the public and ensure that they know that their tax dollars are being spent in a way that is helpful.

Snow underscored O'Toole's argument about the limitations of a single data source. He contended that the PIT is a good but blunt instrument; when you get close to zero you need a much more refined tool, such as a master list. The master list will drive improvement in the data quality of the PIT count as well.

Cho agreed, saying that we must use multiple data sources since none of them tell us the whole picture of the extent of homelessness for any population, let alone Veterans. When communities approach the federal government to request verification that they have ended Veteran homelessness we ask them to indicate all of the data sources they are using to substantiate their claim, including PIT, HMIS, VA's Homeless Registry, and master lists. They are also asked about the system they have in place to house Veterans.

4. *Do you think, at a federal level, through the VA or NCHAV or USICH, that we should be creating a dashboard where communities could more regularly update the data that they have, where it could be more systematically established as to what databases they are pulling from?*

Cho agreed that a dashboard could be helpful in capturing what is common to all communities, while recognizing that communities are very different and there are nuances to take into consideration.

5. *We may have a paradox when we use multiple measures where we see an increase in homelessness (Metraux's work) while communities are getting to zero because we have more program slots. The more access and programs we create, the more people we count and serve under the homeless label. How should we be characterizing and contextualizing this?*

Cho made the point that the reason everyone is counting Veterans is so that they can be served. Metraux's study backs up the anecdotes we have been hearing about Iraq and Afghanistan Veterans and underscores the need to continue the partnership between VA and DoD to reach out to service members who are transitioning to civilian life.

6. *The metrics of the number of people leaving homelessness and not returning demonstrate that we have served people effectively. How can we advance this cause – that these metrics are as important as the PIT count?*

Snow responded that HUD is now asking CoCs how long people have been homeless. Pape indicated that VA is shifting its thinking about how success is measured. Treglia pointed out that PIT and HMIS are in a vacuum; neither measure captures the numbers coming in or exiting or what the programs are.

7. *Are we moving into a more stock and flow way of characterizing the problem? What is the unmet need number, qualitatively or quantitatively?*

Cho maintained that we will learn about unmet need from the information we receive from communities who want their claims validated.

SUMMARY

Since the VA launched its initiative to end Veteran homelessness by 2015, the primary gauge of progress has been the Point-in-Time (PIT) count. However, as enumeration methodologies have been expanded and refined and as the number of homeless in some communities have declined to a level where counting processes and estimates become less reliable, it has become clear that a variety of data sources are needed to reflect more accurately where progress is being made and where additional efforts should be directed. During this symposium experts shared the pros and cons of four methods to measure homelessness:

1. **PIT count** – This count indicates how many people across the nation were staying in homeless shelters or transitional housing as well as in unsheltered situations on a given night in January. It relies on street-based counts and service enumerations to account for the "invisible homeless". Sampling methods are used to estimate numbers of homeless individuals in large and densely populated areas and the reliability of the PIT is improved by using a decoy method to check count accuracy. It is limited by the "one night" incidence focus, the challenges of consistency in counting methods across communities, and limits associated with population estimates.

2. **Annual estimate of people accessing a homeless shelter or transitional housing program based on Homeless Management Information System (HMIS) data** – This method provides demographic characteristics and a long-term understanding of service use patterns. However, the estimates do not account for people who never use a shelter or women and children who are being served by domestic violence providers.

3. **Tracking patterns of homelessness by matching administrative data records** – This method has the potential to provide insights and identify trends to supplement more traditional methods of measuring homelessness. However, challenges with obtaining access to data and data quality may complicate its use.

4. **Master list of named homeless Veterans at the community level** – UNITY of Greater New Orleans used this method to compile a comprehensive named list of all Veterans known to be living in emergency shelter, on the streets, or in abandoned buildings using a variety of data including HMIS, the 2014 PIT, and extensive, systematic and ongoing outreach. The advantage of this approach is that it uses identified individuals to determine actual population counts. Challenges include how individuals in transitional housing are considered, how recidivism is incorporated, and its dependence on ongoing/continuous outreach which may be more difficult in some communities/geographic settings.

SUGGESTED RECOMMENDATIONS

1. Communities should indicate all of the data sources used to substantiate their claim of ending Veteran homelessness, including PIT, HMIS, VA's Homeless Registry, and master lists. As the New Orleans example of reaching functional zero attests, we cannot rely on a single data source such as the PIT to measure homelessness; these multiple sources should be able to validate each other in achieving this goal.

2. Develop a federal dashboard where communities can regularly update their data on Veteran homelessness and indicate clearly the databases they are using.

3. Consider other measurement concepts such as program performance, supply and demand, and gaps analysis. For example, current methodologies do not identify how long Veterans remain homeless, in what manner their homelessness was resolved, or how long they remained housed. Measures should reflect more accurately the quality and effectiveness of services to determine where progress is being made and where additional efforts need to be directed.

4. Sustain and increase VA housing resources for communities that have achieved functional zero to keep Veteran homelessness at bay. SSVF providers are on the front lines, in shelters and on the streets, preventing homelessness from occurring, while HUD-VASH is keeping vulnerable Veterans housed. Communities have learned how to target these resources to the intended populations; a reduction in these resources would undermine the goal of ending Veteran homelessness everywhere.

5. Explore the extent to which an increase in the rate of homelessness among newer Veterans of the Afghanistan and Iraq conflicts with earlier onset of homelessness is driven by increased need or the availability of new services such as SSVF and HUD-VASH.

6. Focus more on prevention, particularly among newly returning service members. Continue the partnership between VA and the Department of Defense to reach out to service members who are transitioning to civilian life.

NOTE: Opinions expressed in this paper represent only the position of the National Center on Homelessness Among Veterans, presenters and panel members and do not necessarily reflect the official policy of the U.S. Department of Veterans Affairs.

GLOSSARY OF TERMS

Continuum of Care (CoC): local planning body responsible for coordinating the full range of homelessness services in a geographic area, which may cover a city, county, metropolitan area, or an entire state.

Housing and Urban Development - Veterans Affairs Supportive Housing (HUD-VASH) Program: HUD-VASH is a collaborative program between the Department of Housing and Urban Development (HUD) and VA. Eligible homeless Veterans receive rental support from HUD in the form of a Housing Choice or Project Based Section 8 voucher as well as case management and supportive services from VA. These efforts collectively support housing stability and the recovery from physical and mental health problems, substance use disorders, and functional concerns contributing to and/or resulting from homelessness. HUD-VASH subscribes to the "Housing First" model, a best practice that has demonstrated that housing the homeless individual helps him/her to exit from homelessness, which then improves the ability and motivation to engage in treatment strategies. The program's goals include housing stability while promoting maximal recovery and independence in the community for the Veteran and the Veteran's family.

Mayors Challenge to End Veteran Homelessness: campaign launched in June 2014 by First Lady Michelle Obama as a collective call to mayors and other state and local public officials to leverage federal, local, and nonprofit efforts to end Veteran homelessness in their respective communities by the end of 2015.

National Homeless Registry: The National Homeless Registry is a comprehensive database of information about Veterans who have accessed homeless services provided by VA administered programs, external Federal agencies and other private and public entities. The registry is also used to identify and collect information about Veterans who are at risk for homelessness.

Permanent Supportive Housing: decent, safe, affordable, community-based housing that provides tenants with the rights of tenaucy and links to voluntary and flexible supports and services for people with disabilities who are experienciug homelessness. Permaneut supportive housing is a proven, effective means of reintegrating chronically homeless and other highly vulnerable homeless families and individuals with psychiatric disabilities or chronic health challenges into the community by addressing their basic needs for housing and providing ongoing support.

Rapid Rehousing: Housing targeted to individuals and families who are experiencing homelessness (residing in emergency or transitional shelters or on the street) and need temporary assistance in order to obtain housing and retain it (HUD Homelessness Prevention and Rapid Re-Housing (HPRP) Notice, March 19, 2009).

Rapid Response for Homeless Veterans Initiative: program run by UNITY of Greater New Orleans to ensure that all newly homeless Veterans get permanent housing within an average of 30 days.

Supportive Services for Veteran Families (SSVF): The SSVF program was authorized by Public Law 110-387 and provides supportive services to very low-income Veteran families that are currently in or transitioning to permanent housing. SSVF is designed to rapidly re-house homeless Veteran families and prevent homelessness for those at imminent risk due to a housing crisis. Funds are granted to private non-profit organizations and consumer cooperatives that will assist very low-income Veteran families by providing a range of supportive services designed to promote housing stability.

Transitional Housing: a project that is designed to provide housing and appropriate supportive services to homeless persons to facilitate movement to independent living. The housing is short-term, typically less than 24 months. In addition to providing safe housing for those in need, other services are available to help participants become self-sufficient.

PRESENTER AND PANELIST BIOGRAPHIES

Larry Buron

Dr. Larry Buron is an applied economist specializing in housing policy and the impact of government programs on labor market and quality of life outcomes of individuals and communities. During his 20 years at Abt Associates, he has been the Project Director and lead quantitative analyst in designing and implementing studies of the Section 8/Housing Choice Voucher program, the Low-Income Housing Tax Credit program, the HOPE VI program, and homeless assistance programs. He was the project director for the development of the initial Annual Homeless Assistance Report (AHAR) and has served as quantitative analyst, data collector, or reviewer on subsequent AHARs.

Richard Cho

Richard Cho is Senior Policy Director for the United States Interagency Council on Homelessness, where he coordinates USICH's Federal policy efforts and the implementation of Opening Doors. Prior to joining USICH in 2013, Richard spent 12 years working at the Corporation for Supportive Housing, most recently as the Director of Innovations, where he advanced supportive housing innovations for vulnerable populations including homeless populations with complex health needs who were high utilizers of crisis health services and/or correctional settings, families with recurring child welfare involvement, and more. Richard has a Master's in City Planning from Massachusetts Institute of Technology and is currently pursuing a Doctorate in Public Administration at New York University.

Dennis Culhane

Dennis Culhane is Director of Research for the National Center on Homelessness Among Veterans and the Dana and Andrew Stone Chair in Social Policy at the University of Pennsylvania. His primary area of research is homelessness and related housing interventions. Dr. Culhane also directs the Actionable Intelligence for Social Policy initiative, a MacArthur Foundation-funded project to promote the development of integrated database systems by states and localities for policy analysis and systems reform.

Martha Kegel

Martha J. Kegel is an attorney and Executive Director of UNITY of Greater New Orleans, a collaborative of 60 agencies providing housing and services to prevent, reduce and end homelessness in the New Orleans area. Ms. Kegel is a graduate of Stanford Law School, a former Skadden Fellow, and served as a law clerk for the chief judge of the federal 5th Circuit Court of Appeals. She formerly directed a legal services project for the homeless, served as Executive Director of the Louisiana ACLU and Associate Director of the Northern California ACLU, and was the 2002 recipient of the Louisiana State Bar Association's Career Public Interest Award.

Stephen Metraux

Stephen Metraux is an Investigator at the VA National Center on Homelessness Among Veterans and an Associate Professor of Health Policy and Public Health at University of the Sciences. His research involves projects that assess the risk factors for homelessness among Veterans returning from Iraq and Afghanistan, looking at the correlates of homelessness and other outcomes among Veterans after release from jail, and how aging and mortality-related issues impact homeless Veterans. Along with his work at the VA, Dr. Metraux has done extensive research on homelessness and housing, mental illness and community integration, prison reentry, and other aspects of urban health.

Thomas O'Toole

Dr. Tom O'Toole is the Acting Director of the National Center on Homelessness among Veterans and National Director of the Homeless Veterans Patient Aligned Care Team (H-PACT) Program for the Department of Veterans Affairs. He is a general internist based at the Providence VA Medical Center in Rhode Island and a Professor of Medicine at Brown University. His research for the past 25 years has focused on access to care, health and social service needs and intervention studies for homeless and other vulnerable and disadvantaged populations with funding from VA HSR&D, NIH, SAMSHA, and private foundations. He has published over 70 articles and book chapters on the subject.

Lisa Pape

Lisa M. Pape, LISW, currently serves as the Executive Director, Homeless Programs for the Veterans Health Administration (VHA) within the Department of Veterans Affairs (VA). In this role she serves as the principle advisor to VA and VHA leadership on policy, management and operations of a continuum of programs for homeless or at risk for homeless Veterans, including prevention services, outreach, treatment, transitional and permanent housing solutions and supportive services. Ms. Pape has been with the Department of Veterans Affairs for over 20 years primarily serving Veterans in homeless and residential programs.

William Snow

William Snow has several years of experience with HUD's Continuum of Care programs. Since joining HUD, Mr. Snow has worked closely to analyze HUD's homeless data sources to learn how to make data systems more efficient and to use the data to help stakeholders understand the nature of homelessness and the efforts of providers to prevent and end homelessness. Mr. Snow works closely with HUD's policies regarding data, including the Point-in-Time Count, Housing Inventory Count, the CoC Annual Performance Report, and the system-level performance measures. Prior to coming to HUD, Mr. Snow worked at Abt Associates while earning his joint degree in law and public policy.

Dan Treglia

Dan Treglia is a Research Assistant at the National Center on Homelessness Among Veterans and a PhD student at the University of Pennsylvania's School of Social Policy and Practice, focusing on the dynamics of shelter use among homeless Veterans. Prior to enrolling in this program he worked at the New York City Department of Homeless Services conducting program evaluation and research of trends and dynamics in homelessness, with a focus on quantitative methods. He has a Master's degree in Public Policy from Harvard's Kennedy School of Government and a Bachelor's degree in Political Science from Penn.

In summary, the strategies outlined above are critical to ensuring that programs and services match Veteran need. Evidence and data show the importance of strategically aligning housing resources in such a manner as to create a crisis response system that quickly resolves an individual's or family's homelessness by providing the appropriate permanent housing option along with the necessary supports. Achieving such alignment challenges the provider community at all levels to develop new approaches and refine existing programs that are cost effective and in line with proven best practices.

Question 9. One of the "Breakthrough Outcomes for 2016" is to "continue progress toward an effective end to veteran homelessness by permanently housing or preventing homelessness for an additional 100,000 veterans and their family members."

A. What is the total number of veterans for whom VA intends to provide permanent housing or prevent homelessness in 2016?

Response. In FY 2015, nearly 65,000 homeless Veterans were permanently housed through VA's homeless programs. After including their family members, that number increased to over 100,000.

Based on previous year's performance, VA expects to permanently house or prevent from homelessness approximately 100,000 people in 2016. This number includes Veterans and their family members. Out of 100,000 people, VA projects that approximately 73,000 Veterans will obtain permanent housing or be prevented from homelessness at exit from a VA homeless program.

B. Of this number, how many does VA intend to place in permanent housing?

Response. VA anticipates that all of the Veterans referenced above will be permanently housed or maintained in permanent housing. Veterans could be placed in permanent housing from any of VHA's homeless programs (HUD-VASH, SSVF, GPD, HCHV, Domiciliary Care for Homeless Veterans (DCHV), Compensated Work Therapy/Transitional Residence program (CWT/TR), and the justice programs).

C. How many would be placed in transitional housing?

Response. Transitional housing is not part of the Breakthrough Outcomes for 2016; however, transitional housing, available through the GPD program, will remain part of VA's continuum of homeless services. In FY 2015, 23,894 Veterans entered GPD programs, and there were 15,727 exits to permanent housing. Through February 2016, there have been 9,760 entries into GPD funded programs. During the same period, there have been 6,813 exits to permanent housing. It is anticipated that the use of VA transitional housing through the "bridge housing" model will increase the overall utilization of VA funded projects.

D. How many would benefit from prevention services?

Response. VHA implemented a national, health system-based universal screen for homelessness and risk of homelessness. The goal of this screener is to enhance the rapid identification of Veterans who very recently became homeless or are at imminent risk of homelessness, and to ensure that they access appropriate assistance to achieve housing stability. This instrument is administered by providers during Veterans' outpatient visits at VHA facilities across the country.

During FY 2015, 3,529,695 Veterans responded to VHA's screener for homelessness and risk. Of those, 0.65 percent (n=23,103) screened positive for homelessness and 0.57 percent (n=20,230) screened positive for risk. Approximately three out of five Veterans who screened positive for homelessness or risk requested follow-up services to address their housing instability. Among Veterans who requested follow-up, 71.5 percent of those who screened positive for homelessness, and 65.1 percent of those who screened positive for risk received a follow-up service within 30 days.

Between the first quarter of FY 2013—when screening for homelessness and risk began—and the fourth quarter of FY 2015, the proportion of Veterans who screened positive for homelessness decreased by 32.9 percent and the rate of positive screens for risk decreased by 57.8 percent. Of the Veterans who initially screened positive for either homelessness or risk and responded to a rescreen at least 6 months later, 74.6 percent resolved their housing instability, and 92.1 percent of Veterans who reported risk of homelessness screened negative during the subsequent screen.[2]

E. How was this goal determined?

Response. VA believes the goal of permanently housing or preventing homelessness for an additional 100,000 Veterans and their family members represents the best direct measurement of the initiative's national impact. The specific target of 100,000 was determined by examining the number of Veterans and family members

[2] Data as of March 31, 2016. Due to enhanced data capture from VA and community providers and continued refinement of VA's data systems, homeless data is constantly refreshed, which may cause changes in previously reported data. Updates to homeless data are reflected in monthly refreshes of VA data systems.

permanently housed or prevented from homelessness in 2015 to establish a baseline for this measure. In 2015, the number of Veterans and family members permanently housed or prevented from homelessness was approximately 118,000. Because 2015 included several temporary "surge efforts" that generated large numbers of permanent housing placements that level of placements is unlikely to be repeated in 2016. Additionally VA's Homeless Gap Analysis model projects the 2016 homeless Veteran population to drop approximately 16 percent from 2015 levels; 100,000 is therefore a cautiously ambitious target for 2016.

Question 10. The written testimony indicates that, in FY 2015, VA provided services to more than 365,000 homeless or at-risk veterans through VHA homeless programs. Please list how many veterans have been served through VHA homeless programs for each fiscal year, beginning with FY 2010.

Response. VA has made unprecedented efforts in engaging, reaching and serving Veterans who are homeless or might become homeless. The Secretary's testimony references that in FY 2015, more than 365,000 homeless or at-risk Veterans served through VHA's homeless programs. This number represents the total number of homeless and at-risk Veterans served in VHA and the Veterans Benefits Administration (VBA). The following chart outlines the total number of homeless and at-risk Veterans served by VA by fiscal year.[3]

Fiscal Year	Total number of homeless and at-risk Veterans served by VA (data as of March 31, 2016)
2015	376,619
2014	367,798
2013	348,825
2012	236,942
2011	192,702
2010	160,927

Question 11. What metrics are used to determine the number of those who are prevented from becoming homeless?

Response. The SSVF program, VA's primary homelessness prevention program, offers grants to non-profit organizations to not only rapidly re-house Veterans and their families, but directs substantial efforts to preventing homelessness. The following metric is used to determine the number of those who are prevented from becoming homeless:

- How many at-risk Veteran families receive SSVF homeless prevention services, and of those served, how many maintained permanent housing upon program exit.

The SSVF program tracks outcome measures specifically tied to preventing homelessness as it offers services specifically designed to keep at-risk Veterans and their families in permanent housing. Data used for this metric is acquired from the Homeless Management Information System (HMIS). HMIS data is input by SSVF grantees and community providers.

VA's homeless programs have always had a dual focus on housing unsheltered (street) homeless Veterans and increasing exits to permanent housing of sheltered homeless Veterans. The homeless programs' continuum of services includes both prevention and treatment services to assist those Veterans who are on the streets or in shelters today, and prevention for those at risk of homelessness from starting that downward spiral. Although other VA programs may not have such a singular focus as SSVF, VA considers many programs along the continuum as offering and providing prevention services. The primary goal of HUD-VASH is to move Veterans and their families out of homelessness and into stable permanent housing (rescue), and then to provide the supports needed to sustain the Veteran and their family in their housing (prevention).

VA also has several programs that provide time-limited housing to Veterans along with supportive services, treatment, vocational assistance, etc. These programs provide the necessary "bridge" between streets and permanent housing by providing transitional residence (rescue) and services designed to improve housing stability that will give Veterans the supports necessary to avoid re-experiencing homeless-

[3] Data as of March 31, 2016. Due to enhanced data capture from VA and community providers and continued refinement of VA's data systems homeless data is constantly refreshed which may cause changes in previously reported data. Updates to homeless data are reflected in monthly refreshes of VA data systems.

ness (prevention). VJP prevents homelessness by providing outreach and linkage to VA services for Veterans at early stages of the justice system and address the community re-entry needs of incarcerated Veterans in order to reduce the impact of medical, psychiatric, and substance abuse problems upon community readjustment. HVCES program provides services to both homeless and at-risk Veterans that increase access to employment opportunities to support their housing needs, improve the quality of their lives, and assist in their community reintegration efforts.

MEDICAL CARE COLLECTIONS FUND

Question 12. The budget indicates that the VHA Chief Business Office has implemented an expanded revenue enhancement plan that focuses on immediate, mid-term, and long-term improvements to business processes.

A. When was this plan implemented?

Response. The VHA Chief Business Office has historically adapted the expanded revenue enhancement plan that resulted in several key initiatives leading to improvements in revenue. The broader plan has resulted in several key initiatives and improvements including:

- Implementation of seven industry-modeled regional Consolidated Patient Accounting Centers (CPAC) standardizing and optimizing the billing and collections activity from 153 VAMCs; completed in FY 2012.
- Electronic denials management
- Implementation of electronic payments and remittance advices
- Electronic Pharmacy claims
- Establishment of a National Payer Relations Office

B. What are the targeted improvements included in the plan?

Response. Ongoing Key Revenue Operations initiatives include:

- Sustain and enhance Revenue Operations
- Maximize use of Payer Relations Office—conducting new or re-verifications of existing third party agreements. Implementation of a payer compliance tool that supports management oversight of insurance companies' compliance with established agreements.
- Continued work through legislative proposals to maximize revenue. Examples include recognizing VA as a participating provider, aligning with best practices on collection of health information exchange.
- Optimize business process through effective use of technology and advanced business analytics.
- Attract, develop, and retain skilled, engaged and empowered workforce.
- Develop and enhance technology to standardize and automate business rules and create efficiency.
- Implementation of Lean and Lean Six Sigma (Lean/LSS), continuous process improvement program. Tracking well in year 4 of a 5-year maturity model.
- Planned implementation of Tiered Medication Copayment System.

C. Is there a timeline over which the improvements will be pursued?

D. How has this plan impacted collections?

Response (C&D). While not all initiatives are directly tied to impact collections, the implementation of CPACs has resulted in substantial improvements to total collections. A 23-percent increase in total Medical Care Collection Fund (MCCF) collections was realized from FY 2012 to FY 2015. Other benefits achieved through consolidation are:

- Standardized, consistent and stable performance leading to stronger collections across all VAMCs
- Industry best practice internal control framework proactively prepares and positively positions CPAC for future audits
- Deployed LEAN/LSS across the CPACs supporting employee engagement, informed decisionmaking and an organizational change management approach that supports the CPAC infrastructure.

Question 13. VA is projecting an increase in Medical Care Collections Fund collections in 2016. Please explain, in detail, what factors contribute to the projected increase.

Response. VHA utilizes the Integrated Collections Forecasting Model (ICFM) to estimate the 10-year collections as an input to the President's Budget. ICFM draws upon numerous predictive variables and historical data sources to forecast collections. Based on the model updates at the time of budget development, ICFM projected an increase of $87.5M in the MCCF for FY 2016. These estimates were not further adjusted for additional policy considerations such as the impact of Veteran Choice Program.

The projected increase is due the net impact of the following:

- A FY 2015 collections baseline of $3.451B;
- Projected workload growth from FY 2014 Enrollee Health Care Projection Model (EHCPM) resulting in higher bill volumes;
- Anticipated increases to third party reasonable charges with a stable collections to billing ratio

CAREGIVERS

Question 14. The 2016–2018 "Future Goals" for the Caregivers Program indicate supporting the evaluation of program components under the Caregivers and Veterans Omnibus Health Services Act of 2010 through the Partnership Evaluation Center. Please explain, in detail, what aspects of the program will be evaluated, how they will be evaluated, and how VA will use the evaluation results to make improvements to the program.

Response. The Caregiver Support Program National Office has partnered with VHA's Health Services Research and Development Service Quality Evaluation Research Initiative to collaboratively fund the VA Caregiver Support Program Partnered Evaluation Center (VA-CARES), a long-term project that will use a mixed methods approach to provide an evaluation of short- term impacts of the Caregiver Support Program. The research study is organized into four Aims, described below.

In Aim 1, VA-CARES closely examined health care utilization through an analysis of medical records for VA-provided and VHA purchased care, comparing health care utilization of Veterans whose caregivers are participating in the Program of Comprehensive Assistance for Family Caregivers (PCAFC) to healthcare utilization of a control group, one year prior to and up to three years following application to PCAFC.

Aim 2 considers caregiver well-being. VA-CARES distributed surveys to caregivers to assess how training, the stipend for eligible primary family caregivers, and other supports and services of PCAFC affected the perceived wellbeing of caregivers and their families.

Aim 3 examined the use and value of the overall Caregiver Support Program and its component services to caregivers in either PCFAC or the Program of General Caregiver Support Services. The study design for Aim 3 was a quantitatively-driven mixed method design, with qualitative semi-structured interview data, enhanced by survey findings. Survey data will describe frequency of use of services, ratings of helpfulness, and differences by individual and site-level characteristics (e.g., caregiver race, Veteran health status, geographic region, etc.). Interviews were utilized to inform interpretation of the quantitative findings and shed light on other important aspects of caregivers' experiences unanticipated with survey responses.

Aim 4 complements the caregiver survey data on services used by detailing the full delivery costs of the Caregiver Support Program—personnel, programming (e.g., stipend, CHAMPVA), and supporting costs. Preliminary operational costs will be based on a survey of Caregiver Support Coordinators (CSCs), capturing how their time is allocated across the various components of the Caregiver Support Program which they deliver at VAMCs.

Final results will be delivered in summer 2016 and will inform the Caregiver Support Program about its return on investment and provide information on best practices for improving its programs. Understanding the impacts of the Caregiver Support Program on caregivers, Veterans, and VHA is expected to provide the Caregiver Support Program with information about highest value programs and services and an evidence base upon which to make program and planning decisions which optimize services while continuing to meet the requirements of title I of Public Law 111–163.

HEALTH PROFESSIONALS EDUCATIONAL ASSISTANCE PROGRAM

Question 15. Please list the top five positions for which benefits under the Health Professionals Educational Assistance Program, including the Education Debt Reduction Program, the Employee Incentive Scholarship Program, and the Health Professional Scholarship Program, were used in 2015 and how much funding went toward each position. What are the projections for 2016?

Response. The Education Debt Reduction Program (EDRP) is a critical tool for recruiting physicians and other direct health care providers to work with VHA. VHA has the authority to offer education debt reduction payments for employees with qualifying loans for positions that are determined to be difficult for recruitment and retention based on local facility needs. Participants receive education debt reduction payments up to a maximum award amount of $120,000 over 5 years while they remain employed by VHA in a position that qualified them for the award.

The following table shows the top five occupations for which new awards were approved in FY 2015 and the total award amounts projected for the associated awards. These participants are currently serving in their first service period and will receive their first EDRP reimbursement in FY 2016. VHA projects to offer a minimum of 900 additional new awards this year, primarily in the occupations designated as mission critical by VA: physicians, nursing, psychology, physician assistant, and physical therapy.

The average award amounts and overall funding needs of the program are increasing under the new maximum award amount of $120K (or $24K per year). In FY 2014, VHA made approximately 650 new awards, bringing the total number of EDRP participants to over 2,000. In FY 2015, EDRP reimbursed those participants nearly $11M (participants in these years were at the pre-VACAA maximum award amount of $12K per year or less). VHA anticipates reimbursing the current participants nearly $23M in FY 2016, and $37M in FY 2017 based on the increase in program participants and average award amounts.

FY 2015

(New Awards)

Occupation	Participants	Funding
Medical Officer	307	$30,120,574
Nurse	210	$9,313,726
Pharmacist	102	$9,447,553
Psychologist	79	$6,949,085
Physician Assistant	43	$3,875,563

The Employee Incentive Scholarship Program authorizes VA to award scholarships to employees pursuing degrees or training in health care disciplines for which recruitment and retention of qualified personnel is difficult. Participation in the program is field-driven and dependent on the number of employees recommended by facilities. The following table shows the top five occupations for which new awards were approved and will result in a service obligation period in those occupations. At the time of this report, VHA is conducting its second FY 2016 Application Cycle, and therefore, the FY 2016 figures below reflect only the new applications submitted and approved through October 31, 2015.

FY 2015

(New Awards)

Occupation	Participants	Funding
Registered Nurse (***includes NP, CNS, aNd CNL***)	1,234	$22,370,753
Licensed Practical/Vocational Nurse	11	$156,059
Physical Therapist	7	$76,897
Pharmacist	5	$131,096
Social Worker	5	$111,064

FY 2016

(New Awards—through Oct 31, 2015)

Occupation	Participants	Funding
Registered Nurse (includes NP, CNS, and CNL)	610	$11,202,684
Licensed Practical/Vocational Nurse	8	$103,646
Physical Therapist	8	$109,397
Physician Assistant	4	$80,756
Occupational Therapist	3	$59,854

Health Professionals Scholarship Program awards scholarships to VA and non-VA employees pursuing degrees of training in health care disciplines for which recruitment and retention of qualified personnel is difficult. Scholarship covers tuition, stipend and required fees; recipients are required to complete a service obligation at a VA health care facility after program completion. Health Professional Scholarship Program is currently accepting applications for Registered Nurses (including Nurse Practitioners). We anticipate that we will award 25 scholarships.

Question 16. The budget notes that VA currently has 370 buildings that are vacant or less than 50 percent occupied, which costs VA $26 million annually to maintain and operate. Please provide a list of these buildings.

Response. The list is attached. The list is comprised of buildings that were predominantly vacant (more than 50 percent) at the end of FY 2015. Most of the buildings are currently being used for swing space, as VA considers reuse alternatives or disposal options.

VA Vacant Buildings - FY 2015

Buildings > 50% vacant/unoccupied - Sorted by VA Network and Station Name

Fiscal Year	Admin	Network	Station Name	Station Number	Realpropid	Building Number	Function Title	Historical Status	Year Built	Usage Classification	Total GSF	Vacant Sq Ft	%Vacant
2015	NCA	1	ANNAPOLIS, MD	801	8012001	2001	Lodge / Admin Building	Yes	1940	Public Facing Facility	1,865	1,865	100.00%
2015	NCA	1	LOUDON PARK, MD	816	8162001	2001	VACANT - Lodge	Yes	1870	Housing	1,600	1,600	100.00%
2015	NCA	1	SEVEN PINES, VA	878	8782101	2101	VACANT - Lodge/Office (Meigs)	Yes	1874	Office	1,934	1,934	100.00%
2015	NCA	1	STAUNTON, VA	880	8802101	2101	VACANT - Lodge/Office (Meigs)	Yes	1872	Office	1,534	1,534	100.00%
2015	NCA	1	WASHINGTON CROSSING PA	926	926HA-2	HA-2	Scott Farm Barn	Yes	1870	All Other	2,503	2,503	100.00%
2015	NCA	1	WASHINGTON CROSSING PA	926	926HA-5	HA-5	VACANT - Scott Farm Small Barn	Yes	1870	All Other	345	345	100.00%
2015	NCA	1	WINCHESTER, VA	882	8822001	2001	VACANT - Lodge (Meigs)	Yes	1870	Housing	2,772	2,772	100.00%
2015	NCA	2	NASHVILLE, TN	865	865HA-3	HA-3	VACANT - Utility Building	Yes	1887	All Other	625	625	100.00%
2015	NCA	2	PORT HUDSON, LA	870	8702101	2101	VACANT - Lodge/Office (Meigs)	Yes	1879	Office	3,000	3,000	100.00%
2015	NCA	2	RALEIGH, NC	873	8732101	2101	VACANT - Lodge/Office	Yes	1938	Office	3,267	3,267	100.00%
2015	NCA	2	SALISBURY, NC	876	8762101	2101	VACANT - Lodge/Office	Yes	1934	Office	3,000	3,000	100.00%
2015	NCA	3	HOUSTON, TX	851	8512501	2501	House/Residence (Outleased)	No	1963	Housing	1,237	1,237	100.00%
2015	NCA	4	ALTON, IL	800	8003001	3001	VACANT - Storage Building	Yes	1939	Warehouses (Storage/Sheds)	180	180	100.00%
2015	NCA	4	ALTON, IL	800	800HA-2B	HA-2B	VACANT - Storage Building	Yes	1939	Industrial	180	180	100.00%
2015	NCA	4	JEFFERSON CITY, MO	853	8532101	2101	VACANT - Lodge/Office	Yes	1870	Office	2,034	2,034	100.00%
2015	VHA	1	Bedford	518	51841	41	Vacant Storage	Yes	1939	All Other	4,560	4,560	100.00%
2015	VHA	1	Bedford	518	51840	40	Vacant Storage	Yes	1929	All Other	4,456	4,456	100.00%
2015	VHA	1	Bedford	518	51854	54	Vacant Storage	Yes	1939	All Other	3,408	3,408	100.00%
2015	VHA	1	Bedford	518	51842	42	Vacant Storage	Yes	1939	All Other	3,220	3,220	100.00%
2015	VHA	1	Bedford	518	51869	69	Vacant Storage	Yes	1930	All Other	1,704	1,704	100.00%
2015	VHA	1	Manchester	608	6085	5	Vacant - Administrative	Yes	1949	Office	5,210	4,618	88.60%
2015	VHA	1	Manchester	608	6082	2	Vacant - Director's Quarters	Yes	1949	Office	2,766	2,384	86.19%
2015	VHA	1	Manchester	608	60611	11	Smyth Tower- Historic Landmark	Yes	1988	All Other	1,817	1,116	61.42%
2015	VHA	1	Northampton	631	63120	20	Vacant Admin.	Yes	1923	Office	20,784	20,784	100.00%
2015	VHA	1	Togus	402	40221	21	Storage Barn	Yes	1887	Warehouses (Storage/Sheds)	15,518	15,518	100.00%
2015	VHA	1	Togus	402	40236	36	Historic Hotel Bldg	Yes	1909	Service	9,768	9,768	100.00%
2015	VHA	1	Togus	402	40269	69	Resident's Quarters	Yes	1878	Housing	4,196	3,692	87.99%
2015	VHA	1	Togus	402	40233	33	Housekeeping Qtrs Single	Yes	1910	Housing	3,457	3,457	100.00%
2015	VHA	1	Togus	402	40234	34	Housekeeping Qtrs Single	Yes	1910	Housing	2,930	2,930	100.00%
2015	VHA	1	Togus	402	402222	222	Mothballed	Yes	1950	Service	2,184	2,184	100.00%
2015	VHA	1	Togus	402	402245	245	Sewage Treatment Plant	No	1984	Service	2,013	2,013	100.00%
2015	VHA	1	VACHS, Newington	689A4	689A44	4	Vacant	Yes	1932	All Other	12,394	12,394	100.00%
2015	VHA	1	VACHS, Newington	689A4	689A444T	44T	Vacant	No	1984	Service	2,630	2,630	100.00%
2015	VHA	2	Albany	528A8	528A8X2	X2	PRRTP in Troy NY	No	1929	Housing	2,280	2,280	100.00%
2015	VHA	2	Albany	528A8	528A8X4	X4	PRRTP in Delmar NY	No	1891	Housing	1,720	1,720	100.00%
2015	VHA	2	Albany	528A8	528A8X3	X3	PRRTP in Albany NY	No	1935	Housing	1,496	1,496	100.00%
2015	VHA	2	Batavia	528A4	528A46	6	Womens PTSD	Yes	1932	Housing	4,323	4,323	100.00%
2015	VHA	2	Batavia	528A4	528A47b	7b	Vacant Quarters	Yes	1933	Housing	3,553	3,553	100.00%
2015	VHA	2	Batavia	528A4	528A47a	7a	Vacant Quarters	Yes	1932	Housing	3,553	3,553	100.00%

VA Vacant Buildings - FY 2015

Buildings > 50% vacant/unoccupied - Sorted by VA Network and Station Name

Fiscal Year	Admin	Network	Station Name	Station Number	Realpropid	Building Number	Function Title	Historical Status	Year Built	Usage Classification	Total GSF	Vacant Sq Ft	%Vacant
2015	VHA	2	Batavia	528A4	528A48a	8a	Vacant (Quarters)	Yes	1932	Housing	3,553	3,553	100.00%
2015	VHA	2	Batavia	528A4	528A48b	8b	Vacant (Quarters)	Yes	1932	Housing	3,553	3,553	100.00%
2015	VHA	2	Bath	528A6	528A652	52	Quarters	Yes	1880	Housing	3,458	3,458	100.00%
2015	VHA	2	Bath	528A6	528A654	54	Quarters	Yes	1880	Housing	3,148	3,148	100.00%
2015	VHA	2	Bath	528A6	528A657	57	3-Car Garage	Yes	1950	Warehouses (Storage/Sheds)	2,559	2,559	100.00%
2015	VHA	2	Bath	528A6	528A651	51	Quarters	Yes	1880	Housing	2,516	2,516	100.00%
2015	VHA	2	Bath	528A6	528A650	50	Quarters	Yes	1880	Housing	2,491	2,491	100.00%
2015	VHA	2	Bath	528A6	528A656	56	Quarters	Yes	1880	Housing	2,023	2,023	100.00%
2015	VHA	2	Bath	528A6	528A655	55	Quarters	Yes	1880	Housing	1,899	1,899	100.00%
2015	VHA	2	Bath	528A6	528A653	53	3-Car Garage	Yes	1880	Warehouses (Storage/Sheds)	1,859	1,859	100.00%
2015	VHA	3	Brooklyn	630A4	630A43	3	Vacant Admin	No	1950	Service	5,240	5,240	100.00%
2015	VHA	3	Brooklyn	630A4	630A416	16	ORTP Trailer	No	1988	Hospital	3,616	3,616	100.00%
2015	VHA	3	Lyons	561A4	561A455	55	Vacant Dom (Psychiatric)	Yes	1940	Dormitories/Barracks	79,400	79,400	100.00%
2015	VHA	3	Lyons	561A4	561A49	9	MAS/EMS/Vacant	Yes	1930	Hospital	44,100	22,228	50.40%
2015	VHA	3	Montrose	620	6208	8	Vacant Bed Bldg	Yes	1947	Hospital	48,300	48,300	100.00%
2015	VHA	3	Montrose	620	62010	10	Vacant Bed Bldg	Yes	1947	Hospital	47,510	47,510	100.00%
2015	VHA	3	Montrose	620	6209	9	Vacant Bed Bldg	Yes	1947	Hospital	47,510	47,510	100.00%
2015	VHA	3	Montrose	620	6207	7	Vacant/SPD Storage	Yes	1947	Hospital	47,261	30,702	64.96%
2015	VHA	3	Montrose	620	62025	25	Vacant	Yes	1947	Office	36,640	36,640	100.00%
2015	VHA	3	Montrose	620	6202	2	Theater	Yes	1947	Service	27,077	25,602	94.55%
2015	VHA	3	Northport	632	6322	2	Vacant	Yes	1927	Hospital	74,125	74,125	100.00%
2015	VHA	3	Northport	632	6321	1	Vacant	Yes	1927	Office	25,098	25,098	100.00%
2015	VHA	3	Northport	632	63237	37	Vacant	Yes	1931	Office	21,468	21,468	100.00%
2015	VHA	3	Northport	632	63218	18	Vacant	Yes	1927	Hospital	20,886	20,886	100.00%
2015	VHA	3	St. Albans	630A5	630A593	93	EMS/Vacant NHCU	Yes	1948	Service	40,510	27,450	67.76%
2015	VHA	3	St. Albans	630A5	630A592	92	Shops/Vacant NHCU	Yes	1948	Service	37,984	23,742	62.51%
2015	VHA	3	St. Albans	630A5	630A590	90	Vacant Radiation Therapy	Yes	1948	All Other	6,122	6,122	100.00%
2015	VHA	4	Altoona	503	5034	4	ACS - Primary Care	No	1950	Office	3,155	1,878	59.52%
2015	VHA	4	Butler	529	5293	3	Empty Building	Yes	1938	Other Institutional Uses	26,982	26,982	100.00%
2015	VHA	4	Lebanon	595	59526	26	Old Non-Housekeeping Qtrs.	Yes	1950	Housing	7,079	7,079	100.00%
2015	VHA	4	Pittsburgh, Highland Drive	646A5	646A51	1	Vacant - Clinical/Inpatient Psych	Yes	1953	Hospital	186,814	186,814	100.00%
2015	VHA	4	Pittsburgh, Highland Drive	646A5	646A54	4	Vacant - Administration	Yes	1953	Office	119,275	119,275	100.00%
2015	VHA	4	Pittsburgh, Highland Drive	646A5	646A52	2	Vacant - Clinical/Inpatient Psych	Yes	1953	Hospital	101,945	101,945	100.00%
2015	VHA	4	Pittsburgh, Highland Drive	646A5	646A55	5	Vacant - Domiciliary	Yes	1953	Hospital	65,710	65,710	100.00%
2015	VHA	4	Pittsburgh, Highland Drive	646A5	646A58	8	Vacant - Rec Hall/Education	Yes	1953	Other Institutional Uses	49,863	49,863	100.00%
2015	VHA	4	Pittsburgh, Highland Drive	646A5	646A57	7	Vacant - N&FS	Yes	1953	Service	48,600	48,600	100.00%
2015	VHA	4	Pittsburgh, Highland Drive	646A5	646A56	6	Vacant - Eng/EMS/SWS	Yes	1953	Office	46,240	46,240	100.00%
2015	VHA	4	Pittsburgh, Highland Drive	646A5	646A59	9	Vacant - Gym	Yes	1953	Other Institutional Uses	24,900	24,900	100.00%
2015	VHA	4	Pittsburgh, Highland Drive	646A5	646A5CC	CC	Vacant - Connecting Corridors	Yes	1953	Other Institutional Uses	18,754	18,754	100.00%
2015	VHA	4	Pittsburgh, Highland Drive	646A5	646A513	13	Vacant	Yes	1953	Office	8,680	8,680	100.00%
2015	VHA	4	Pittsburgh, Highland Drive	646A5	646A510	10	Vacant - Chapel	Yes	1953	Other Institutional Uses	7,271	7,271	100.00%

VA Vacant Buildings - FY 2015

Buildings > 50% vacant/unoccupied - Sorted by VA Network and Station Name

Fiscal Year	Admin	Network	Station Name	Station Number	Realpropid	Building Number	Function Title	Historical Status	Year Built	Usage Classification	Total GSF	Vacant Sq Ft	%Vacant
2015	VHA	4	Pittsburgh, Highland Drive	646A5	646A514	14	Vacant	Yes	1953	Office	6,730	6,730	100.00%
2015	VHA	4	Pittsburgh, Highland Drive	646A5	646A516	16	Vacant	Yes	1953	Other Institutional Uses	6,400	6,400	100.00%
2015	VHA	4	Pittsburgh, Highland Drive	646A5	646A512B	12B	Vacant	Yes	1953	Office	4,600	4,600	100.00%
2015	VHA	4	Pittsburgh, Highland Drive	646A5	646A512A	12A	Vacant	Yes	1953	Office	4,168	4,168	100.00%
2015	VHA	4	Pittsburgh, Highland Drive	646A5	646A511	11	Administrative Offices	Yes	1953	Office	3,841	3,841	100.00%
2015	VHA	4	Pittsburgh, Highland Drive	646A5	646A533	33	Vacant - FMS/EMS Storage	No	1988	Warehouses (Storage/Sheds)	768	768	100.00%
2015	VHA	5	Perry Point	512A5	512A59H	9H	VACANT/ Formerly NCCC Dormitory	Yes	1924	Dormitories/Barracks	54,515	54,515	100.00%
2015	VHA	5	Perry Point	512A5	512A515	15	Vacant (formerly NCCC)	Yes	1918	Office	17,277	17,277	100.00%
2015	VHA	5	Perry Point	512A5	512A51085	1085	VILLAGE HOUSING / VACANT (Formerly NCCC)	Yes	1918	Housing	3,641	3,641	100.00%
2015	VHA	5	Perry Point	512A5	512A51093	1093	VILLAGE HOUSE / VACANT	Yes	1918	Housing	3,641	3,641	100.00%
2015	VHA	5	Perry Point	512A5	512A51131	1131	VILLAGE HOUSE / VACANT	Yes	1918	Housing	3,641	3,641	100.00%
2015	VHA	5	Perry Point	512A5	512A51132	1132	VILLAGE HOUSE / VACANT	Yes	1918	Housing	3,641	3,641	100.00%
2015	VHA	5	Perry Point	512A5	512A51152	1152	VILLAGE HOUSE / VACANT	Yes	1918	Housing	3,641	3,641	100.00%
2015	VHA	5	Perry Point	512A5	512A51155	1155	VILLAGE HOUSE / VACANT	Yes	1918	Housing	3,641	3,641	100.00%
2015	VHA	5	Perry Point	512A5	512A51156	1156	VILLAGE HOUSE / VACANT	Yes	1918	Housing	3,641	3,641	100.00%
2015	VHA	5	Perry Point	512A5	512A51083	1083	VILLAGE HOUSING / VACANT (Formerly NCCC)	Yes	1918	Housing	3,574	3,574	100.00%
2015	VHA	5	Perry Point	512A5	512A51086	1086	VILLAGE HOUSE / VACANT	Yes	1918	Housing	3,574	3,574	100.00%
2015	VHA	5	Perry Point	512A5	512A51095	1095	VILLAGE HOUSE / VACANT	Yes	1918	Housing	3,574	3,574	100.00%
2015	VHA	5	Perry Point	512A5	512A51154	1154	VILLAGE HOUSE / VACANT	Yes	1918	Housing	3,574	3,574	100.00%
2015	VHA	5	Perry Point	512A5	512A51066	1066	VILLAGE HOUSE / VACANT	Yes	1918	Housing	3,078	3,078	100.00%
2015	VHA	5	Perry Point	512A5	512A51125	1125	VILLAGE HOUSE / VACANT	Yes	1918	Housing	3,078	3,078	100.00%
2015	VHA	5	Perry Point	512A5	512A51138	1138	VILLAGE HOUSE / VACANT	Yes	1918	Housing	3,078	3,078	100.00%
2015	VHA	5	Perry Point	512A5	512A51143	1143	VILLAGE HOUSE / VACANT	Yes	1918	Housing	3,078	3,078	100.00%
2015	VHA	5	Perry Point	512A5	512A51146	1146	VILLAGE HOUSE / VACANT	Yes	1918	Housing	3,078	3,078	100.00%
2015	VHA	5	Perry Point	512A5	512A51063	1063	VILLAGE HOUSE / VACANT	Yes	1918	Housing	2,984	2,984	100.00%
2015	VHA	5	Perry Point	512A5	512A51065	1065	VILLAGE HOUSE / VACANT	Yes	1918	Housing	2,984	2,984	100.00%
2015	VHA	5	Perry Point	512A5	512A51067	1067	VILLAGE HOUSE / VACANT (Formerly NCCC)	Yes	1918	Housing	2,984	2,984	100.00%
2015	VHA	5	Perry Point	512A5	512A51068	1068	VILLAGE HOUSE / VACANT	Yes	1918	Housing	2,984	2,984	100.00%
2015	VHA	5	Perry Point	512A5	512A51069	1069	VILLAGE HOUSE / VACANT	Yes	1918	Housing	2,984	2,984	100.00%
2015	VHA	5	Perry Point	512A5	512A51070	1070	VILLAGE HOUSE / VACANT	Yes	1918	Housing	2,984	2,984	100.00%
2015	VHA	5	Perry Point	512A5	512A51078	1078	VILLAGE HOUSE / VACANT	Yes	1918	Housing	2,984	2,984	100.00%
2015	VHA	5	Perry Point	512A5	512A51080	1080	VILLAGE HOUSE / VACANT	Yes	1918	Housing	2,984	2,984	100.00%
2015	VHA	5	Perry Point	512A5	512A51084	1084	VILLAGE HOUSE / VACANT	Yes	1918	Housing	2,984	2,984	100.00%
2015	VHA	5	Perry Point	512A5	512A51106	1106	VILLAGE HOUSE / VACANT	Yes	1918	Housing	2,984	2,984	100.00%
2015	VHA	5	Perry Point	512A5	512A51107	1107	VILLAGE HOUSING / VACANT (Formerly NCCC)	Yes	1918	Housing	2,984	2,984	100.00%
2015	VHA	5	Perry Point	512A5	512A51108	1108	VILLAGE HOUSE / VACANT	Yes	1918	Housing	2,984	2,984	100.00%
2015	VHA	5	Perry Point	512A5	512A51139	1139	VILLAGE HOUSE / VACANT	Yes	1918	Housing	2,984	2,984	100.00%
2015	VHA	5	Perry Point	512A5	512A51147	1147	VILLAGE HOUSE / VACANT	Yes	1918	Housing	2,984	2,984	100.00%
2015	VHA	5	Perry Point	512A5	512A51168	1168	VILLAGE HOUSE / VACANT	Yes	1918	Housing	2,984	2,984	100.00%
2015	VHA	5	Perry Point	512A5	512A51071	1071	VILLAGE HOUSE / VACANT	Yes	1918	Housing	2,811	2,811	100.00%

VA Vacant Buildings - FY 2015

Buildings > 50% vacant/unoccupied - Sorted by VA Network and Station Name

Fiscal Year	Admin	Network	Station Name	Station Number	Realpropid	Building Number	Function Title	Historical Status	Year Built	Usage Classification	Total GSF	Vacant Sq Ft	%Vacant
2015	VHA	5	Perry Point	512A5	512A51082	1082	VILLAGE HOUSE / VACANT	Yes	1918	Housing	2,811	2,811	100.00%
2015	VHA	5	Perry Point	512A5	512A51103	1103	VILLAGE HOUSING / VACANT (Formerly NCCC)	Yes	1918	Housing	2,811	2,811	100.00%
2015	VHA	5	Perry Point	512A5	512A51104	1104	VILLAGE HOUSE / VACANT	Yes	1918	Housing	2,811	2,811	100.00%
2015	VHA	5	Perry Point	512A5	512A51113	1113	VILLAGE HOUSING / VACANT (Formerly NCCC)	Yes	1918	Housing	2,811	2,811	100.00%
2015	VHA	5	Perry Point	512A5	512A51117	1117	VILLAGE HOUSE / VACANT	Yes	1918	Housing	2,811	2,811	100.00%
2015	VHA	5	Perry Point	512A5	512A51121	1121	VILLAGE HOUSING / VACANT (Formerly NCCC)	Yes	1918	Housing	2,811	2,811	100.00%
2015	VHA	5	Perry Point	512A5	512A51127	1127	VILLAGE HOUSE / VACANT	Yes	1918	Housing	2,811	2,811	100.00%
2015	VHA	5	Perry Point	512A5	512A51163	1163	VILLAGE HOUSE / VACANT	Yes	1918	Housing	2,746	2,746	100.00%
2015	VHA	5	Perry Point	512A5	512A51166	1166	VILLAGE HOUSE / VACANT	Yes	1918	Housing	2,746	2,746	100.00%
2015	VHA	5	Perry Point	512A5	512A51169	1169	VILLAGE HOUSE / VACANT	Yes	1918	Housing	2,746	2,746	100.00%
2015	VHA	5	Perry Point	512A5	512A51173	1173	VILLAGE HOUSE / VACANT	Yes	1918	Housing	2,746	2,746	100.00%
2015	VHA	5	Perry Point	512A5	512A51062	1062	VILLAGE HOUSE / VACANT	Yes	1918	Housing	2,726	2,726	100.00%
2015	VHA	5	Perry Point	512A5	512A51073	1073	VILLAGE HOUSING / VACANT (Formerly NCCC)	Yes	1918	Housing	2,726	2,726	100.00%
2015	VHA	5	Perry Point	512A5	512A51074	1074	VILLAGE HOUSE / VACANT	Yes	1918	Housing	2,726	2,726	100.00%
2015	VHA	5	Perry Point	512A5	512A51110	1110	VILLAGE HOUSING / VACANT (Formerly NCCC)	Yes	1918	Housing	2,726	2,726	100.00%
2015	VHA	5	Perry Point	512A5	512A51111	1111	VILLAGE HOUSING / VACANT (Formerly NCCC)	Yes	1918	Housing	2,726	2,726	100.00%
2015	VHA	5	Perry Point	512A5	512A51112	1112	VILLAGE HOUSING / VACANT (Formerly NCCC)	Yes	1918	Housing	2,726	2,726	100.00%
2015	VHA	5	Perry Point	512A5	512A51141	1141	VILLAGE HOUSING / VACANT (Formerly NCCC)	Yes	1918	Housing	2,726	2,726	100.00%
2015	VHA	5	Perry Point	512A5	512A51087	1087	VILLAGE HOUSE / VACANT	Yes	1918	Housing	2,642	2,642	100.00%
2015	VHA	5	Perry Point	512A5	512A51088	1088	VILLAGE HOUSE / VACANT	Yes	1918	Housing	2,642	2,642	100.00%
2015	VHA	5	Perry Point	512A5	512A51164	1164	VILLAGE HOUSE / VACANT	Yes	1918	Housing	2,642	2,642	100.00%
2015	VHA	5	Perry Point	512A5	512A51165	1165	VILLAGE HOUSE / VACANT	Yes	1918	Housing	2,642	2,642	100.00%
2015	VHA	5	Perry Point	512A5	512A51170	1170	VILLAGE HOUSE / VACANT	Yes	1918	Housing	2,642	2,642	100.00%
2015	VHA	6	Asheville	637	6379	9	Vacant Nurses Quarters	Yes	1929	All Other	42,619	42,619	100.00%
2015	VHA	6	Durham	558	5583	3	Vacant Building	No	1953	All Other	5,586	5586	100.00%
2015	VHA	6	Hampton	590	59015	15	Boiler Plant	Yes	1909	Service	22,251	11,780	52.94%
2015	VHA	6	Salem	658	658133	133	Golf Clubhouse	No	1962	All Other	171	171	100.00%
2015	VHA	7	Augusta, Uptown	509A0	509A019	19	Vacant Administrative and Canteen	Yes	1913	Office	50,138	50,138	100.00%
2015	VHA	7	Augusta, Uptown	509A0	509A020	20	Vacant Administrative	Yes	1927	Office	41,482	41,482	100.00%
2015	VHA	7	CAVHCS, Tuskegee	619A4	619A462	62	Vacant	Yes	1936	Dormitories/Barracks	75,042	37,556	50.05%
2015	VHA	7	CAVHCS, Tuskegee	619A4	619A450	50	Vacant	Yes	1932	All Other	73,983	59,397	80.28%
2015	VHA	7	CAVHCS, Tuskegee	619A4	619A469	69	Vacant Space	Yes	1945	Dormitories/Barracks	52,344	38,075	72.74%
2015	VHA	7	CAVHCS, Tuskegee	619A4	619A444	44	Vacant	Yes	1929	Warehouses (Storage/Sheds)	48,724	35,750	73.37%
2015	VHA	7	CAVHCS, Tuskegee	619A4	619A419	19	Vacant Space	Yes	1923	Housing	18,447	13,790	74.75%
2015	VHA	7	CAVHCS, Tuskegee	619A4	619A451	51	Vacant	Yes	1932	All Other	18,391	17,697	96.23%
2015	VHA	7	CAVHCS, Tuskegee	619A4	619A420	20	Vacant Space	Yes	1923	Housing	15,761	13,142	83.38%

VA Vacant Buildings - FY 2015

Buildings > 50% vacant/unoccupied - Sorted by VA Network and Station Name

Fiscal Year	Admin	Network	Station Name	Station Number	Realpropid	Building Number	Function Title	Historical Status	Year Built	Usage Classification	Total GSF	Vacant Sq Ft	%Vacant
2015	VHA	7	CAVHCS, Tuskegee	619A4	619A410	10	Vacant Space	Yes	1923	Office	11,077	9,647	87.09%
2015	VHA	7	CAVHCS, Tuskegee	619A4	619A49	9	Vacant Space	Yes	1923	Office	11,070	8,962	80.96%
2015	VHA	7	CAVHCS, Tuskegee	619A4	619A418	18	Vacant Space	Yes	1923	Office	10,660	7,469	70.07%
2015	VHA	7	CAVHCS, Tuskegee	619A4	619A421	21	Vacant Space	Yes	1923	Housing	5,576	5,576	100.00%
2015	VHA	7	CAVHCS, Tuskegee	619A4	619A422	22	Vacant (Cottage - Housekeeping Quarters)	Yes	1923	Housing	5,576	5,576	100.00%
2015	VHA	7	CAVHCS, Tuskegee	619A4	619A423	23	Vacant (Cottage - Housekeeping Quarters)	Yes	1923	Housing	5,576	5,576	100.00%
2015	VHA	7	CAVHCS, Tuskegee	619A4	619A424	24	Vacant (Housekeeping Quarters)	Yes	1923	Housing	5,576	5,576	100.00%
2015	VHA	7	CAVHCS, Tuskegee	619A4	619A425	25	Vacant (Housekeeping Quarters)	Yes	1923	Housing	5,576	5,576	100.00%
2015	VHA	7	CAVHCS, Tuskegee	619A4	619A426	26	Vacant (Housekeeping Quarters)	Yes	1923	Housing	5,576	5,576	100.00%
2015	VHA	7	CAVHCS, Tuskegee	619A4	619A427	27	Vacant (Housekeeping Quarters)	Yes	1923	Housing	5,576	5,576	100.00%
2015	VHA	7	CAVHCS, Tuskegee	619A4	619A428	28	Vacant (Housekeeping Quarters)	Yes	1923	Housing	5,576	5,576	100.00%
2015	VHA	7	CAVHCS, Tuskegee	619A4	619A429	29	Vacant (Housekeeping Quarters)	Yes	1923	Housing	5,425	5,425	100.00%
2015	VHA	7	CAVHCS, Tuskegee	619A4	619A48	8	Vacant Space	Yes	1923	Office	4,108	3,182	77.46%
2015	VHA	7	CAVHCS, Tuskegee	619A4	619A47	7	Vacant Space	Yes	1923	Office	4,107	3,182	77.48%
2015	VHA	7	CAVHCS, Tuskegee	619A4	619A463	63	Vacant Directors Qrtrs	Yes	1938	Housing	3,766	3,641	96.68%
2015	VHA	7	Dublin	557	55734	34	Vacant Bldg (Land Reversion)	No	1945	All Other	29,520	29,520	100.00%
2015	VHA	7	Dublin	557	55735	35	Vacant Bldg (Land Reversion)	No	1945	All Other	14,890	14,890	100.00%
2015	VHA	8	Orlando	675	675520a	520a	Dom Reception/Elevator	No	2003	Other Institutional Uses	3,816	2,999	78.59%
2015	VHA	8	Tampa	673	67319	19	Unassigned Pending Demo	No	1975	Office	2,398	2,364	98.58%
2015	VHA	9	Huntington	581	58119	19	Engineering Garage (BRAC)	No	1952	Service	3,590	3,590	100.00%
2015	VHA	9	Lexington, Leestown	596	59628	28	Chapel/EMS/Vacant	Yes	1948	Outpatient Healthcare Facility	49,760	30,836	61.97%
2015	VHA	9	Lexington, Leestown	596	5965	5	Vacant Admin/Lab	Yes	1931	Office	24,003	24,003	100.00%
2015	VHA	9	Lexington, Leestown	596	5966	6	Vacant Quarters	Yes	1930	Dormitories/Barracks	5,082	5,082	100.00%
2015	VHA	9	Lexington, Leestown	596	5967	7	Vacant Quarters	Yes	1930	Dormitories/Barracks	5,082	5,082	100.00%
2015	VHA	9	Lexington, Leestown	596	5968	8	Vacant Quarters	Yes	1933	Dormitories/Barracks	4,164	4,164	100.00%
2015	VHA	9	Lexington, Leestown	596	59646	46	Grounds - Office	Yes	1949	Service	2,801	2,801	100.00%
2015	VHA	9	Lexington, Leestown	596	59641	41	Vacant - Previous Lock Shop	No	1951	Service	671	671	100.00%
2015	VHA	10	Chillicothe	538	5382	2	Offices - Vacant	Yes	1923	Office	16,000	16,000	100.00%
2015	VHA	10	Chillicothe	538	5386	6	Offices - Vacant	Yes	1923	Office	16,000	16,000	100.00%
2015	VHA	10	Chillicothe	538	5384	4	Vacant	Yes	1923	Office	15,418	15,418	100.00%
2015	VHA	10	Chillicothe	538	5385	5	Vacant	Yes	1923	Other Institutional Uses	13,558	13,558	100.00%
2015	VHA	10	Chillicothe	538	53825	25	Linen Service	Yes	1929	Service	13,226	9,486	71.72%
2015	VHA	10	Chillicothe	538	53811	11	Vacant	Yes	1923	Office	7,180	7,180	100.00%
2015	VHA	10	Chillicothe	538	53810	10	Vacant	Yes	1923	Office	6,750	6,750	100.00%
2015	VHA	10	Chillicothe	538	53816	16	Quarters - Vacant	Yes	1923	Housing	6,598	6,598	100.00%
2015	VHA	10	Chillicothe	538	538256	256	Water Treatment	No	1970	Industrial	4,413	4,413	100.00%
2015	VHA	10	Chillicothe	538	53814	14	Quarters - Vacant	Yes	1923	Housing	4,343	4,343	100.00%

VA Vacant Buildings - FY 2015

Buildings > 50% vacant/unoccupied - Sorted by VA Network and Station Name

Fiscal Year	Admin	Network	Station Name	Station Number	Realpropid	Building Number	Function Title	Historical Status	Year Built	Usage Classification	Total GSF	Vacant Sq Ft	%Vacant
2015	VHA	10	Chillicothe	538	53813	13	Quarters - Vacant	Yes	1923	Housing	4,325	4,325	100.00%
2015	VHA	10	Chillicothe	538	538206	206	Garage	Yes	1923	Service	1,716	1,716	100.00%
2015	VHA	10	Chillicothe	538	538205	205	Garage	Yes	1923	Service	1,520	1,520	100.00%
2015	VHA	10	Chillicothe	538	538207	207	Garage	Yes	1943	Service	337	337	100.00%
2015	VHA	10	Cincinnati, Fort Thomas	539A	539A1	1	Quarters	Yes	1888	Housing	8,734	8,734	100.00%
2015	VHA	10	Cincinnati, Fort Thomas	539A	539A30	30	Quarters	Yes	1899	Housing	6,485	6,485	100.00%
2015	VHA	10	Cincinnati, Fort Thomas	539A	539A31	31	Quarters	Yes	1892	Housing	6,485	6,485	100.00%
2015	VHA	10	Cincinnati, Fort Thomas	539A	539A6	6	Quarters	Yes	1890	Housing	5,058	5,058	100.00%
2015	VHA	10	Cincinnati, Fort Thomas	539A	539A7	7	Quarters	Yes	1890	Housing	5,055	5,055	100.00%
2015	VHA	10	Cincinnati, Fort Thomas	539A	539A2	2	Quarters	Yes	1889	Housing	4,937	4,937	100.00%
2015	VHA	10	Cincinnati, Fort Thomas	539A	539A3	3	Quarters	Yes	1889	Housing	4,937	4,937	100.00%
2015	VHA	10	Cincinnati, Fort Thomas	539A	539A4	4	Quarters	Yes	1889	Housing	4,937	4,937	100.00%
2015	VHA	10	Cincinnati, Fort Thomas	539A	539A5	5	Quarters	Yes	1889	Housing	4,937	4,937	100.00%
2015	VHA	10	Cincinnati, Fort Thomas	539A	539A8	8	Quarters	Yes	1889	Housing	4,937	4,937	100.00%
2015	VHA	10	Cincinnati, Fort Thomas	539A	539A9	9	Quarters	Yes	1889	Housing	4,937	4,937	100.00%
2015	VHA	10	Cincinnati, Fort Thomas	539A	539A32	32	Quarters	Yes	1892	Housing	4,300	4,300	100.00%
2015	VHA	10	Cincinnati, Fort Thomas	539A	539A33	33	Quarters	Yes	1892	Housing	4,300	4,300	100.00%
2015	VHA	10	Cincinnati, Fort Thomas	539A	539A34	34	Quarters	Yes	1892	Housing	4,300	4,300	100.00%
2015	VHA	10	Cincinnati, Fort Thomas	539A	539A35	35	Quarters	Yes	1892	Housing	4,300	4,300	100.00%
2015	VHA	10	Cincinnati, Fort Thomas	539A	539A86	86	Garage	No	1939	Service	800	800	100.00%
2015	VHA	10	Cincinnati, Fort Thomas	539A	539A146	146	Garage	No	1939	Service	700	700	100.00%
2015	VHA	10	Cincinnati, Fort Thomas	539A	539A147	147	Garage	No	1939	Service	700	700	100.00%
2015	VHA	10	Dayton	552	552129	129	Storage/Vacant	Yes	1881	Warehouses (Storage/Sheds)	18,364	15,879	86.47%
2015	VHA	10	Dayton	552	552116	116	Vacant-Adm Building	Yes	1871	Office	9,158	9,158	100.00%
2015	VHA	10	Dayton	552	552220	220	FORMER Hospitality House	Yes	1885	Housing	7,745	7,745	100.00%
2015	VHA	10	Dayton	552	552225	225	Vacant Liberty House Museum	Yes	1870	All Other	6,960	6,960	100.00%
2015	VHA	10	Dayton	552	552213	213	Vacant Duplex Residence	Yes	1923	Housing	5,760	5,760	100.00%
2015	VHA	10	Dayton	552	552214	214	Vacant Duplex Residence	Yes	1923	Housing	5,760	5,760	100.00%
2015	VHA	10	Dayton	552	552210	210	Vacant Duplex Residence	Yes	1921	Housing	5,760	5,760	100.00%
2015	VHA	10	Dayton	552	552211	211	Vacant Duplex Residence	Yes	1921	Housing	5,760	5,760	100.00%
2015	VHA	10	Dayton	552	552212	212	Vacant Duplex Residence	Yes	1921	Housing	5,760	5,760	100.00%
2015	VHA	10	Dayton	552	552221	221	Vacant RE Office	Yes	1876	Office	4,890	4,890	100.00%
2015	VHA	10	Dayton	552	552223	223	Vacant 4 Car Garage	Yes	1936	Warehouses (Storage/Sheds)	820	820	100.00%
2015	VHA	10	Dayton	552	552222	222	Vacant 3 Car Garage	Yes	1936	Warehouses (Storage/Sheds)	660	660	100.00%
2015	VHA	10	Dayton	552	552228	228	Vacant Single Garage	Yes	1870	Warehouses (Storage/Sheds)	325	325	100.00%
2015	VHA	11	Battle Creek	515	5158	8	Planetree/Veterans Transportation	Yes	1924	Outpatient Healthcare Facility	15,296	10,165	66.46%
2015	VHA	11	Battle Creek	515	51530	30	Grounds/Vacant	Yes	1924	Service	8,983	7,077	78.78%
2015	VHA	11	Danville	550	55012	12	Vacant	Yes	1900	Housing	21,500	21,500	100.00%
2015	VHA	11	Danville	550	55026	26	Garage (Engineering)/Vacant	Yes	1900	Service	16,060	16,060	100.00%
2015	VHA	11	Danville	550	55048	48	Carnegie Library (vacant)	Yes	1907	All Other	14,290	14,290	100.00%

VA Vacant Buildings - FY 2015

Buildings > 50% vacant/unoccupied - Sorted by VA Network and Station Name

Fiscal Year	Admin	Network	Station Name	Station Number	Realpropid	Building Number	Function Title	Historical Status	Year Built	Usage Classification	Total GSF	Vacant Sq Ft	%Vacant
2015	VHA	11	Danville	550	55032	32	Quarters	Yes	1900	Housing	7,708	7,708	100.00%
2015	VHA	11	Danville	550	55033	33	Quarters	Yes	1899	Housing	7,162	7,162	100.00%
2015	VHA	11	Danville	550	55037	37	Quarters	Yes	1901	Housing	6,161	6,161	100.00%
2015	VHA	11	Danville	550	55038	38	Quarters	Yes	1901	Housing	5,722	5,722	100.00%
2015	VHA	11	Danville	550	55034	34	Quarters	Yes	1901	Housing	4,942	4,942	100.00%
2015	VHA	11	Danville	550	55040	40	Single Quarters	Yes	1880	Housing	4,515	4,515	100.00%
2015	VHA	11	NIHCS, Marion	610	610122	122	Vacant (Mess Hall & Kitchen)	Yes	1937	Other Institutional Uses	37,135	37,135	100.00%
2015	VHA	11	NIHCS, Marion	610	61025	25	VACANT (Ward Building)	Yes	1930	Hospital	32,892	32,892	100.00%
2015	VHA	11	NIHCS, Marion	610	61010	10	VACANT (Ward Building)	Yes	1898	Hospital	26,452	26,452	100.00%
2015	VHA	11	NIHCS, Marion	610	61011	11	VACANT (Ward Building)	Yes	1898	Hospital	26,124	26,124	100.00%
2015	VHA	11	NIHCS, Marion	610	6107	7	VACANT (Ward Building)	Yes	1893	Hospital	24,116	24,116	100.00%
2015	VHA	11	NIHCS, Marion	610	6109	9	PRINT SHOP/MAIL ROOM	Yes	1923	Service	20,442	13,419	65.64%
2015	VHA	11	NIHCS, Marion	610	6103	3	VACANT (Ward Building)	Yes	1889	Hospital	20,289	20,289	100.00%
2015	VHA	11	NIHCS, Marion	610	6101	1	VACANT (Ward Building)	Yes	1889	Hospital	20,288	20,288	100.00%
2015	VHA	11	NIHCS, Marion	610	6104	4	VACANT (Ward Building)	Yes	1889	Hospital	20,286	13,004	64.10%
2015	VHA	11	NIHCS, Marion	610	61018	18	VACANT (Ward Building)	Yes	1896	Hospital	19,058	19,058	100.00%
2015	VHA	11	NIHCS, Marion	610	61060	60	VACANT (Admin. Offices/ Ed. Therapy)	Yes	1890	Office	18,126	18,126	100.00%
2015	VHA	11	NIHCS, Marion	610	61024	24	VACANT (Ward Building)	Yes	1896	Hospital	17,380	17,380	100.00%
2015	VHA	11	NIHCS, Marion	610	61050	50	VACANT (Canteen)	Yes	1890	Other Institutional Uses	10,765	10,765	100.00%
2015	VHA	11	NIHCS, Marion	610	610CC-2	CC-2	VACANT - Connecting Corridor-2	No	1979	All Other	7,492	7,492	100.00%
2015	VHA	11	NIHCS, Marion	610	61034	34	QUARTERS (Director)	Yes	1896	Housing	7,030	7,030	100.00%
2015	VHA	11	NIHCS, Marion	610	61032	32	QUARTERS	Yes	1897	Housing	6,668	6,668	100.00%
2015	VHA	11	NIHCS, Marion	610	61026	26	QUARTERS	Yes	1923	Housing	6,232	6,232	100.00%
2015	VHA	11	NIHCS, Marion	610	61027	27	QUARTERS	Yes	1921	Housing	6,232	6,232	100.00%
2015	VHA	11	NIHCS, Marion	610	61029	29	QUARTERS	Yes	1921	Housing	6,232	6,232	100.00%
2015	VHA	11	NIHCS, Marion	610	61042	42	VACANT (Supply Service Building)	Yes	1905	Service	5,025	5,025	100.00%
2015	VHA	11	NIHCS, Marion	610	61035	35	QUARTERS (VACANT)	Yes	1908	Housing	4,490	4,490	100.00%
2015	VHA	11	NIHCS, Marion	610	61037	37	QUARTERS	Yes	1916	Housing	3,170	3,170	100.00%
2015	VHA	11	NIHCS, Marion	610	610119	119	Vacant INCINERATOR	Yes	1934	Industrial	815	815	100.00%
2015	VHA	11	NIHCS, Marion	610	610125	125	2-Car Garage	No	1941	Housing	420	420	100.00%
2015	VHA	11	NIHCS, Marion	610	61091	91	Single Garage	Yes	1915	Housing	400	400	100.00%
2015	VHA	11	NIHCS, Marion	610	61094	94	Single Garage	Yes	1915	Housing	400	400	100.00%
2015	VHA	11	NIHCS, Marion	610	61075	75	Vacant Sewage Plant Lab.	Yes	1905	Service	350	350	100.00%
2015	VHA	11	NIHCS, Marion	610	610105	105	Gate House	Yes	1897	Facility Security	250	250	100.00%
2015	VHA	11	NIHCS, Marion	610	610120	120	Vacant Pump House, Well No. 3	No	1936	Industrial	169	169	100.00%
2015	VHA	11	NIHCS, Marion	610	610128	128	Transformer Bldg. (Abandoned)	No	1940	Industrial	24	24	100.00%
2015	VHA	12	Milwaukee	695	6952	2	Vacant Historic - Potential EUL	Yes	1869	All Other	133,730	131,430	98.28%
2015	VHA	12	Milwaukee	695	69541	41	Vacant Ward Memorial Theater - Potential EUL	Yes	1881	Other Institutional Uses	21,986	21,986	100.00%
2015	VHA	12	Milwaukee	695	69545	45	Vacant Old Power Plant - Potential EUL	Yes	1895	Warehouses (Storage/Sheds)	20,920	20,920	100.00%

VA Vacant Buildings - FY 2015

Buildings > 50% vacant/unoccupied - Sorted by VA Network and Station Name

Fiscal Year	Admin	Network	Station Name	Station Number	Realpropid	Building Number	Function Title	Historical Status	Year Built	Usage Classification	Total GSF	Vacant Sq Ft	%Vacant
2015	VHA	12	Milwaukee	695	6951	1	Vacant Historic - Potential EUL	Yes	1896	All Other	17,600	17,600	100.00%
2015	VHA	12	Milwaukee	695	69512	12	Vacant Chapel Historic - Potential EUL	Yes	1889	Other Institutional Uses	7,316	7,316	100.00%
2015	VHA	12	North Chicago	556	55648	48	RE Offices/ IL. Motor Cycle training	No	1929	Office	26,496	13,395	50.55%
2015	VHA	12	North Chicago	556	55633	33	To Be Demolished	No	1930	Service	9,000	9,000	100.00%
2015	VHA	12	North Chicago	556	55634	34	To Be Demolished	No	1930	Service	400	400	100.00%
2015	VHA	12	Tomah	676	6762	2	Vacant	Yes	1932	Dormitories/Barracks	26,756	26,756	100.00%
2015	VHA	15	Kansas City	589	58942	42	WINDSOR MANOR	No	1925	Housing	24,484	24,484	100.00%
2015	VHA	15	Topeka	589A5	589A5254	254	Student Housing	No	1947	Housing	1,639	1,639	100.00%
2015	VHA	15	Topeka	589A5	589A5259	259	Student Housing	No	1947	Housing	1,633	1,633	100.00%
2015	VHA	15	Topeka	589A5	589A5267	267	QUARTERS	No	1947	Housing	1,595	1,595	100.00%
2015	VHA	15	Topeka	589A5	589A5265	265	QUARTERS	No	1965	Housing	1,526	1,526	100.00%
2015	VHA	15	Topeka	589A5	589A5263	263	QUARTERS	No	1947	Housing	1,376	1,376	100.00%
2015	VHA	15	Topeka	589A5	589A5261	261	QUARTERS	No	1947	Housing	1,369	1,369	100.00%
2015	VHA	16	N. Little Rock	598A0	598A075	75	Vacant Animal Facility	Yes	1940	Warehouses (Storage/Sheds)	14,294	14,294	100.00%
2015	VHA	16	N. Little Rock	598A0	598A0158	158	Vacant Storage	Yes	1948	Warehouses (Storage/Sheds)	4,542	4,542	100.00%
2015	VHA	16	N. Little Rock	598A0	598A0176	176	Vacant Storage	No	1975	Warehouses (Storage/Sheds)	3,485	3,485	100.00%
2015	VHA	16	N. Little Rock	598A0	598A0162	162	B75 Compound	No	1955	Warehouses (Storage/Sheds)	320	320	100.00%
2015	VHA	16	New Orleans	629	6291	1	Medical Center (Mostly Closed)	Yes	1952	Hospital	898,651	792,316	88.17%
2015	VHA	16	Oklahoma City	635	635PRRTP-N	PRRTP-N	Friendship House North Shop	No	1982	Industrial	4,674	4,674	100.00%
2015	VHA	17	Bonham	549A4	549A46	6	Crisis Center	No	1948	Other Institutional Uses	7,230	7,230	100.00%
2015	VHA	17	Temple	674	674154	154	Engineering Admin. Offices	No	1942	Office	4,474	4,474	100.00%
2015	VHA	17	Waco	674A4	674A419	19	Vacant	Yes	1932	Office	7,164	7,164	100.00%
2015	VHA	17	Waco	674A4	674A421	21	Vacant Quarters (vacant, historical, no plans)	Yes	1932	All Other	6,105	6,105	100.00%
2015	VHA	18	Albuquerque	501	501T62	T62	vacant	No	1992	Service	1,800	1,800	100.00%
2015	VHA	18	Prescott	649	6494	4	Student Housing	Yes	1905	Housing	6,333	6,333	100.00%
2015	VHA	18	Prescott	649	6492	2	Student Housing	Yes	1905	Housing	6,328	6,328	100.00%
2015	VHA	18	Prescott	649	6495	5	Vacant - Quarters	Yes	1905	Housing	6,208	6,208	100.00%
2015	VHA	18	Prescott	649	6496	6	Quarters	No	1905	Housing	5,742	5,742	100.00%
2015	VHA	18	Prescott	649	64976	76	Vacant - Quarters	No	1922	Housing	4,948	4,948	100.00%
2015	VHA	18	Prescott	649	64977	77	Vacant - Quarters	No	1922	Housing	4,948	4,948	100.00%
2015	VHA	18	Prescott	649	64910	10	Vacant - Quarters	Yes	1905	Housing	4,663	4,663	100.00%
2015	VHA	18	Prescott	649	6497	7	Vacant - Quarters	Yes	1905	Housing	4,663	4,663	100.00%
2015	VHA	18	Prescott	649	6498	8	Vacant - Quarters	Yes	1905	Housing	4,663	4,663	100.00%
2015	VHA	18	Prescott	649	6499	9	Vacant - Quarters	Yes	1905	Housing	4,663	4,663	100.00%
2015	VHA	18	Prescott	649	64924	24	Vacant - Quarters	Yes	1908	Housing	2,132	2,132	100.00%
2015	VHA	18	Prescott	649	64925	25	Vacant - Quarters	Yes	1905	Housing	2,132	2,132	100.00%
2015	VHA	18	Prescott	649	64926	26	Vacant - Quarters	Yes	1905	Housing	1,513	1,513	100.00%
2015	VHA	18	Prescott	649	64927	27	Vacant - Quarters	Yes	1905	Housing	1,513	1,513	100.00%
2015	VHA	19	Fort Harrison	436	4362	2	Vacant Dormitory	Yes	1895	Housing	19,700	18,995	96.42%

VA Vacant Buildings - FY 2015

Buildings > 50% vacant/unoccupied - Sorted by VA Network and Station Name

Fiscal Year	Admin	Network	Station Name	Station Number	Realpropid	Building Number	Function Title	Historical Status	Year Built	Usage Classification	Total GSF	Vacant Sq Ft	%Vacant
2015	VHA	19	Fort Harrison	436	4363	3	Vacant Quarters	Yes	1895	Housing	10,644	10,644	100.00%
2015	VHA	19	Fort Harrison	436	4365	5	Vacant Quarters	Yes	1895	Housing	10,641	10,641	100.00%
2015	VHA	19	Fort Harrison	436	436142	142	Vacant Boiler Plant	Yes	1932	Service	5,427	5,427	100.00%
2015	VHA	19	Fort Harrison	436	43643	43	Vacant Storage	Yes	1905	Warehouses (Storage/Sheds)	4,698	4,698	100.00%
2015	VHA	19	Miles City	436GJ	436GJ10	10	Boiler Plan MC (old)	Yes	1948	Service	5,768	5,291	91.73%
2015	VHA	19	Miles City	436GJ	436GJ2	2	Quarters	Yes	1948	Housing	5,012	2,520	50.28%
2015	VHA	19	Miles City	436GJ	436GJ3	3	Vacant Miles City Police	Yes	1948	Office	3,095	3,095	100.00%
2015	VHA	19	Miles City	436GJ	436GJ4	4	Vacant Quarters	Yes	1948	Housing	2,620	2,620	100.00%
2015	VHA	19	Sheridan	666	66634	34	Vacant-FMS Storage/Safety Office	Yes	1907	Hospital	1,830	1,830	100.00%
2015	VHA	20	Walla Walla	687	68747	47	Vacant Gate House	Yes	1929	Industrial	260	260	100.00%
2015	VHA	20	White City	692	692250	250	LOG AND VACANT	Yes	1942	Housing	22,188	18,742	84.47%
2015	VHA	21	Menlo Park	640A0	640A0323	323	Outlease/Psychiatric	No	1967	Other Institutional Uses	80,300	80,300	100.00%
2015	VHA	21	Menlo Park	640A0	640A0205	205	Medical Research	Yes	1926	Laboratories	72,300	72,300	100.00%
2015	VHA	21	Menlo Park	640A0	640A0348	348	Psychiatric/Research	No	1996	Other Institutional Uses	18,500	13,431	72.60%
2015	VHA	21	Menlo Park	640A0	640A0301	301	Vacant Space	Yes	1929	All Other	15,200	15,200	100.00%
2015	VHA	22	Long Beach	600	6008	8	Education/Clinical Offices	No	1943	Office	36,020	18,624	51.70%
2015	VHA	22	Long Beach	600	6003	3	Vacant/EMS	No	1943	Office	36,000	28,626	79.52%
2015	VHA	22	Long Beach	600	60047	47	Vacant Quarters	No	1944	Dormitories/Barracks	25,200	25,200	100.00%
2015	VHA	22	Long Beach	600	60094	94	Golf House (Vacant)	No	1944	Other Institutional Uses	1,224	1,224	100.00%
2015	VHA	22	Sepulveda	691A4	691A421	21	Vacant Theater	Yes	1954	Other Institutional Uses	20,000	20,000	100.00%
2015	VHA	22	Sepulveda	691A4	691A460	60	Vacant (Research)	Yes	1954	Laboratories	4,995	4,995	100.00%
2015	VHA	22	Sepulveda	691A4	691A491	91	Quarters/Vacant	Yes	1954	Housing	2,758	2,758	100.00%
2015	VHA	22	Sepulveda	691A4	691A475	75	Vacated in 1999	Yes	1954	Housing	2,403	2,403	100.00%
2015	VHA	22	Sepulveda	691A4	691A479	79	Vacant Garage	Yes	1954	Warehouses (Storage/Sheds)	2,120	2,120	100.00%
2015	VHA	22	Sepulveda	691A4	691A471	71	Quarters Vacant	Yes	1954	Housing	1,900	1,900	100.00%
2015	VHA	22	Sepulveda	691A4	691A485	85	Vacant	Yes	1954	Housing	1,819	1,819	100.00%
2015	VHA	22	Sepulveda	691A4	691A474	74	Quarters/Vacant	Yes	1954	Housing	1,758	1,758	100.00%
2015	VHA	22	Sepulveda	691A4	691A488	88	Quarters/Vacant	Yes	1954	Housing	1,577	1,577	100.00%
2015	VHA	22	Sepulveda	691A4	691A481	81	Vacant Garage	Yes	1954	Warehouses (Storage/Sheds)	1,405	1,405	100.00%
2015	VHA	22	Sepulveda	691A4	691A480	80	Vacant	Yes	1954	Housing	1,400	1,400	100.00%
2015	VHA	22	Sepulveda	691A4	691A482	82	Quarters/Vacant	Yes	1954	Housing	1,072	1,072	100.00%
2015	VHA	22	Sepulveda	691A4	691A473	73	Quarters/Vacant	Yes	1954	Housing	998	998	100.00%
2015	VHA	22	Sepulveda	691A4	691A443	43	Incinerator (vacant)	No	1954	Industrial	555	555	100.00%
2015	VHA	22	Sepulveda	691A4	691A476	76	Vacated in 1999	Yes	1954	Housing	380	380	100.00%
2015	VHA	22	Sepulveda	691A4	691A483	83	Vacant Garage	Yes	1954	Warehouses (Storage/Sheds)	342	342	100.00%
2015	VHA	22	Sepulveda	691A4	691A472	72	Garage Vacant	Yes	1954	Warehouses (Storage/Sheds)	315	315	100.00%
2015	VHA	22	West Los Angeles	691	69113	13	Storage	Yes	1929	Warehouses (Storage/Sheds)	52,604	52,604	100.00%
2015	VHA	22	West Los Angeles	691	691156	156	Vacant	Yes	1923	Office	46,476	33,568	72.23%
2015	VHA	22	West Los Angeles	691	691205	205	Mail Room/Reproduction Center	Yes	1937	Service	45,659	29,149	63.84%

VA Vacant Buildings - FY 2015

Buildings > 50% vacant/unoccupied - Sorted by VA Network and Station Name

Fiscal Year	Admin	Network	Station Name	Station Number	Realpropid	Building Number	Function Title	Historical Status	Year Built	Usage Classification	Total GSF	Vacant Sq Ft	%Vacant
2015	VHA	22	West Los Angeles	691	691224	224	Vacant Laundry	Yes	1946	Service	33,137	32,827	99.06%
2015	VHA	22	West Los Angeles	691	691157	157	Vacant	Yes	1923	Office	31,689	23,216	73.26%
2015	VHA	22	West Los Angeles	691	691337	337	Research Animal House	No	1962	Laboratories	12,941	12,941	100.00%
2015	VHA	22	West Los Angeles	691	691264	264	Vacant Annex Theater	Yes	1944	Other Institutional Uses	9,603	6,966	72.54%
2015	VHA	22	West Los Angeles	691	69120	20	Vacant Chapel	Yes	1900	Other Institutional Uses	8,758	8,758	100.00%
2015	VHA	22	West Los Angeles	691	691199	199	Hoover Barracks - Vacant	Yes	1932	Office	3,600	3,600	100.00%
2015	VHA	22	West Los Angeles	691	69166	66	Trolley House	Yes	1890	Other Institutional Uses	600	600	100.00%
2015	VHA	22	West Los Angeles	691	691111	111	Vacant Gate House (West Gate)	Yes	1936	Other Institutional Uses	144	144	100.00%
2015	VHA	23	Black Hills, Fort Meade	568	56863	63	Vacant Chapel	Yes	1904	Service	7,785	7,785	100.00%
2015	VHA	23	Black Hills, Fort Meade	568	56864	64	Vacant Theater	Yes	1931	All Other	4,942	4,942	100.00%
2015	VHA	23	Black Hills, Fort Meade	568	568102	102	Former Swimming Pool - Warehouse/Storage	Yes	1940	Warehouses (Storage/Sheds)	747	747	100.00%
2015	VHA	23	Black Hills, Fort Meade	568	56875	75	Tool House	Yes	1904	All Other	500	500	100.00%
2015	VHA	23	Black Hills, Fort Meade	568	568136	136	Vacant Pump House	Yes	1938	Service	250	250	100.00%
2015	VHA	23	Black Hills, Hot Sprngs	568A4	568A44	4	Domiciliary	Yes	1907	Hospital	18,429	11,660	63.27%
2015	VHA	23	Black Hills, Hot Sprngs	568A4	568A416	16	Greenhouse	Yes	1913	Other Institutional Uses	1,666	1,666	100.00%
2015	VHA	23	Des Moines	636A6	636A66	6	Vacant Quarters	Yes	1933	Housing	3,870	3,870	100.00%
2015	VHA	23	Grand Island	636A4	636A42	2	Director's Quarters	No	1950	Housing	2,883	2,883	100.00%
2015	VHA	23	Minneapolis	618	618219	219	Storage, general	Yes	1895	Warehouses (Storage/Sheds)	1,728	1,728	100.00%
2015	VHA	23	Minneapolis	618	61818	18	Storage	No	1926	All Other	80	80	100.00%
2015	VHA	23	Sioux Falls	438	438T15	T15	Vacant Space	No	1984	ChildCare Center	3,280	3,280	100.00%
TOTAL						**370**		**314**			**5,226,568**	**4,795,797**	

* Buildings that are predominantly vacant, more than 50%. In almost all cases the buildings are not needed long term, but are occasionally used for swing space or storage.

Question 17. The FY 2017 budget requests $528 million in major construction to fund projects in Long Beach, California, and Reno, Nevada. The US Army Corps of Engineers (USACE) will be the construction agent for these two projects as now required by law for any project over $100 million. Please provide the Committee an update on the projects that USACE is the construction agent, to include the Denver project.

Response. The Department of Veterans Affairs (VA) has entered into a master interagency agreement with the U.S. Army Corps of Engineers (USACE) to collaborate on 14 construction projects. USACE will have the lead in the execution of design and construction on the 14 projects. USACE has provided an approach to gaining insight and validation of all VA completed work prior to assuming the lead. The attached addendum outlines the process and provides the status of the agreement for each project.

Addendum to VA Response to Question 17
Senate Committee on Veterans' Affairs
Fiscal Year 2017 Veterans Affairs Budget Hearing
Status of VA and USACE Inter-Agency Agreements (IAA)

The Department of Veterans Affairs (VA) has entered into a master interagency agreement with the U.S. Army Corps of Engineers (USACE) to collaborate on 14 "super" construction projects. The following are the steps VA and USACE have agreed to follow to facilitate partnership on the projects in order to support effective management and minimize future cost increases and delays. The process includes multiple Inter-Agency Agreements (IAAs) based on the current status of each project. These IAAs are required to ensure clear understanding of objectives, cost and deliverables and this process provides for control and management oversight.

I. **IAA #1 – "PMP IAA"**

VA provides USACE with funds to prepare a Project Management Plan (PMP) for their involvement in the project. The effort includes preparing a preliminary schedule and USACE staff budget. VA and USACE enter into an agreement that includes USACE validation of the design of the current project to date, as well as the cost to complete the project as currently scoped. This effort further defines the steps necessary for USACE to execute the project. Detailed execution schedule and project estimate to include contingencies and USACE fees are also prepared at this time. At the conclusion of this effort, VA and USACE will proceed with an IAA to complete the design and move to construction or move to USACE preparation of construction solicitation documents and the management of the construction. USACE's effort for this task is funded from the Advance Planning and Design Fund (APDF).

II. **IAA #2 – "Design IAA"**

If the design is not complete, this IAA will provide funds for USACE to complete the design. This IAA may include moving to construction contract solicitation, award and management of the construction or just design. USACE's effort for this task is funded from the Agency Management (AM) line item.

III. **IAA #3 – "Procurement and Construction IAA"**

This IAA funds the solicitation, award and management of the construction. This IAA may be amended as conditions warrant, such as hazardous waste or asbestos. These activities may be included and funded with the design IAA. USACE's effort for this task is funded from AM. The IAA #3 will be the order that is sent to the committees prior to the release of funds for the construction.

The chart below indicates the projects that have executed IAAs at the time of this report.

	Project Location	Covered Under Master IAA	IAA #1 PMP IAA Issued APDF[1]	IAA #2 Design IAA Issued AM[2]	IAA #3 Procurement & Construction IAA Issued AM[2]
1	Alameda, CA	X			
2	American Lake, WA	X			
3	Canandaigua, NY	X	X		
4	Denver, CO,	X	X	N/A	X
5	Livermore, CA	X	X		
6	Long Beach, CA	X	X		
7	Louisville, KY	X	X		
8	Portland, OR	X			
9	Reno, NV	X			
10	San Diego, CA	X			
11	San Francisco, CA	X	X		
12	Tampa, FL	X	X		
13	West Los Angeles, CA	X			
14	West Los Angeles, CA	X			
	TOTAL		76	**0**	**1**

[1]APDF - Advance Planning and Design Fund
[2]AM - Agency Management Line Item

Question 18. The FY 2017 budget requests $30.2 million for the project in Long Beach, California, and states that this funding will be used for the construction of a Combined Heat and Power plant (CHP). Please provide details on the CHP, including a break out of the $30.2 million for the project.

Response. The FY 2017 budget requests $30.2 million for a proposed cogeneration (Combined Heat and Power (CHP)) system for the VA Long Beach Medical Center. This Cogen system consists of a natural gas engine that generates electricity locally to provide supplemental electricity to the campus carrying approximately 40 percent of the campus load during peak demand periods and up to 90 percent during normal operations. This will result in significant energy cost savings, reduction in carbon emissions and increased reliability. Currently, all electricity is supplied by the local utility company, Southern California Edison. The byproduct (waste heat) from the engine will be captured and used to provide steam to operate the steam turbine of a proposed steam-driven chiller, in turn; the steam-driven chiller will provide chilled water for campus space cooling. A new building will be constructed to house the proposed CHP system. The proposed CHP system output capacity will be between 1 and 3 megawatts of electrical power. The proposed CHP system will provide the following benefits:

1. Lower energy cost by using natural gas to generate electricity locally as opposed to that from a central power station.
2. Lower operating cost by utilizing the waste heat to produce steam.
3. Reduce the greenhouse gas emissions normally associated with electricity and steam production.
4. Improve the reliability of electric and steam services for the campus.

The total FY 2017 amount requested is $30.2 million. Of that amount, $25.9 million is dedicated to the production of the CHP construction documents, and actual construction. The remaining amount, $4.3 million, is required to demolish Buildings 128 and 133.

Question 19. In the hearing, Secretary McDonald mentioned VA's efforts regarding public-private partnerships for construction projects. Please provide an update on VA's efforts in this area, including an analysis of its feasibility and any legislative changes that would need to be made.

Response. VA is assessing strategic partnerships as part of the *MyVA* initiative. Partnerships provide VA with opportunities to expand upon, and maximize the utility of, existing resources in several operational areas; including real estate. VA is presently evaluating potential locations in which a form of a public private partnership (P3) would be helpful.

First, VA has been exploring a potential public private partnership in San Francisco, California. In order to address issues relating to aging infrastructure, the San Francisco VA Medical Center (SFVAMC) has received funding for a major seismic construction project, and needs several other funded projects. VA assessed the total life cycle of SFVAMC's approved capital investment plan, against the discounted present value of potential capital P3 alternatives in the market. VA believes that a P3 could make financial and practical sense toward achieving VA's mission. It could also enable VA to assess prospects for minimizing upfront capital funds, reducing overhead costs, focusing on healthcare outcomes, and fostering VA's ability to better engage community partners, and create jobs and tax revenues for the local economy.

Given the infrastructure costs and challenges at VA's existing campus in San Francisco, VA has determined that a partnership could be an effective, viable opportunity. VA is working with the Office of Management and Budget to develop partnership options while continuing to support various legislative efforts.

Second, in Omaha, Nebraska, VA has received partial funding for a major construction project but likely will not receive full funding in the near term. Concurrently, VA has been made aware of donors in the community that would like to help finance and then construct a needed facility, and donate that facility to VA. Therefore, VA is exploring a P3 opportunity related to the construction of a facility on VA land, built to Federal construction standards. It is anticipated that a P3 in this location could efficiently serve Veterans and taxpayers, while reducing the Government's outlay of capital dollars.

VA would require legislation to support both of the aforementioned P3 options and would need to ensure that its proposed approach is consistent with[* * *]Omaha would likely require authority for VA to enter into a joint agreement for construction of a new medical facility (as defined by 38 U.S.C. § 8101), with a suitable decisionmaking process. San Francisco would require approval to enter into a long-term partnership agreement, which could involve a lease to VA in excess of the current 20-year maximum. VA would also need to ensure the budgetary treatment of P3 projects were compliant with lease scoring rules under Office of Management and Budget Circular A–11.

Importantly, unless and until VA obtains the required authority, and has an opportunity to solicit feedback from the market, VA will not be able to act on potential P3 opportunities.

COMPENSATION AND PENSION

Question 20. The criteria for survivor compensation are outlined on page VBA–68 of the FY 2017 budget request and include this as one of the potential paths to benefits: "[T]he Veteran was a former prisoner of war who died after September 30, 1999." Please clarify whether the September 1999 cutoff was used in VA's budget projections and whether it is used in determining eligibility for survivor compensation.

Response. 38 U.S.C. § 1318 governs the criteria for survivor compensation, also known as Dependency and Indemnity Compensation (DIC). Section 603 of the Veterans' Benefits Act of 2010, Public Law 111–275 (October 13, 2010) removed the qualifying phrase, "who died after September 30, 1999" from 38 U.S.C. § 1318(b)(3), effective October 1, 2011. Therefore, this cutoff date is not used in determining eligibility for DIC and also was not used in VA's budget projections. This cutoff date will be removed from the eligibility requirements in future budget submissions.

VETERANS BENEFITS ADMINISTRATION

Question 21. The large number of appeals pending at VA—about 440,000—is a serious concern.

A. The Inspector General's office recently testified that, in order to reduce the backlog of disability claims, VA "re-allocat[ed] staff to process only claims that affect the backlog while sacrificing other types of claims such as those on appeal." What

steps is VA taking to ensure that processing appeals is a priority for the Veterans Benefits Administration?

Response. VBA has received and completed record-breaking numbers of disability compensation rating claims in recent years, which has resulted in corresponding increases in the volume of appeals. Over the past 20 years, VA appeal rates have held steady between 11 and 12 percent of the total volume of completed disability rating claims. VBA continues to prioritize rating claims as well as place additional focus on appeals. VBA is grateful for the funding that allowed us to hire 100 appeals FTE in FY 2015 and 200 appeals FTE in FY 2016. This fiscal year, VBA increased its appeals workforce from 1,195 employees to over 1,490 employees as of February 2016, and has allocated $10 million in overtime funds to support the appellate workload. VBA's process improvements, such as the Veterans Benefits Management System (VBMS) and the National Work Queue (currently being deployed) are providing increased efficiencies in the claim process, and we are also focused on leveraging our technology initiatives in support of modernizing the appeals process. In a very short period of time, the NWQ-led efficiencies have resulted in the reduction in claims pending initial development, reduction in cycle times for claims waiting for a rating decision, and an equitable distribution of claims pending award and authorization. However, VA will not be able to provide Veterans with timely decisions on their appeals without legislative reform to streamline and modernize the appeal process and additional resources to timely work the current inventory of appeals. Without congressional action to authorize a new appeal process and appropriate funding for additional appeals FTE, VA's appeals inventory will continue to grow and Veterans will have to wait much longer for a resolution of their appeals. VA is working to streamline the appeals process, an initiative that is one of VA's "12 Breakthrough Priorities." In addition, a legislative proposal that VA developed with Veterans Service Organizations and other stakeholders is currently being considered in both the House of Representatives (H.R. 5083 and H.R. 5620) and the Senate (draft bill—SVAC Ranking Member Blumenthal).

VA has brought together the Nation's leading Veteran advocacy groups for their input. They are our steadfast partners in improving the way we deliver services to Veterans.

As a result of that collaboration, VA has put forward a new proposal that would provide veterans with a simple, fair, and transparent appeals process in which, with the appropriate resources provided by Congress in future appropriations, the vast majority would receive a final appeals decision within one year of filing an appeal by 2021. This disentanglement of process is enabled by one crucial innovation—giving veterans multiple paths to adjudicate disputes on a claim, while preserving the effective date that the initial claim was filed. VA's consensus proposal was put forward as a discussion draft by Ranking Member Blumenthal and was the subject of the Committee's May 24, 2016, legislative hearing.

This legislation would modernize the veteran appeals process, better serving veterans, taxpayers, and the Nation for years to come.

B. Some prominent lawyers from Georgia have offered to organize attorneys from the American College of Trial Lawyers to volunteer their services to help resolve the appeals backlog. Will VA commit to closely examining possible options for them to help alleviate the backlog of appeals?

Response. VA is committed to looking for ways to streamline and improve the appeals process.

The Board has worked closely with the American Legion to find a way that the American College of Trial Lawyers (ACTL) can assist them in representing Veterans who present some of the most complex issues. The Board and the American Legion recently signed a Memorandum of Understanding creating a framework for ACTL to prepare Informal Hearing Presentations (IHP or briefs) on behalf of the American Legion, in order to move Veteran's appeals more quickly to the Board for appellate review. The Board looks forward to receiving briefs in the near future from the attorneys of the ACTL.

Question 22. Over the past year, the Inspector General has issued at least 15 reports finding that the Veterans Benefits Administration has not been taking timely action to reduce or discontinue benefits when required by the law and evidence and as a result may disperse millions of dollars in overpayments. Please describe what steps VA is taking—or plans to take—to ensure that the Veterans Benefits Administration is being a good steward of taxpayer dollars.

Response. As VBA continues to receive and complete record numbers of disability compensation rating claims, the result is a corresponding increase in the volumes of non-rating claims (to include benefit reduction cases). VBA completed 3.1 million non-rating actions in FY 2015, the highest production of non-rating work in 20 years

and 72 percent more than in FY 2011. Benefit reviews and award adjustments involving reductions in benefits are often complex, multi-step processes that include due-process notifications prior to making the reductions. These cases frequently involve hearing requests and submission of additional evidence, which extends the processing timeframe. Overpayments can result from processing actions to remove a spouse or child; award adjustments required as a result of a Veteran's receipt of Reserve/National Guard drill pay, changes in income, and numerous other statutory requirements. VBA continues to work to automate and streamline its claims processes including those that relate to benefit reductions highlighted below.

- Removal of a dependent
  – DEPENDENCY RAPID RESPONSE PILOT—All VBA call centers now have the capability to handle dependency adjustments at the point of call, such as removing a spouse due to death or divorce.
  – ONLINE DEPENDENCY CLAIMS—VBA developed the Rules-Based Processing System (RBPS) to automate adjustments for adding or removing dependents. Over 60 percent of the dependency claims filed through RBPS are now automatically processed.
- Drill Pay Adjustments
  – By law, Veterans cannot receive VA benefits and drill pay concurrently. VBA is working with DOD to streamline and automate the drill pay offset process through an upfront agreement from National Guard and Reserve members. This will help reduce the impact of drill reductions and improper payments per OMB Circular A–123 on improper payments.
  – VBA hired employees specifically to assist with non-rating work, initially focusing on drill pay offsets.
- Adjustments to temporary 100 percent disability evaluations
  – VBA is developing a report that will enable ROs to more easily identify and take timely action on cases with temporary evaluations that require review to determine current level of disability. Beginning in April 2016, this report will be distributed to ROs on a weekly basis.
- Pension Income Adjustments
  – VA now has access to a claimant's SSA benefit information and reviews the information when processing an original or supplemental claim. VA also conducts annual computer matches with SSA for the purpose of verifying claimants' social security benefit rates to ensure that VA is counting the correct rates.

Question 23. The FY 2017 budget request includes this information regarding disability claims processing: "Increased automation now enables Veterans to file claims, upload evidence, and check the status of their claims on-line through eBenefits, helping to improve accuracy and productivity." (Page VBA–158)

A. Please quantify the impact automation has had on accuracy and productivity to date.

Response. please refer to response to Question 23B.

B. Please quantify what impact improvements in automation funded by the FY 2017 budget request are expected to have on accuracy and productivity.

Response. VBA has reduced the number of claims pending more than 125 days by 86 percent, from a peak of 611,000 in March 2013 to historic lows—79,004 claims as of March 31, 2016. VBA's process improvements, such as VBMS and the National Work Queue (NWQ), continue to provide increased efficiencies in the claims process. By modernizing from a paper based system to an electronic claims processing system, VBA has increased its claim productivity per claims processor by 25 percent since 2011 and medical issue productivity by 82 percent per claims processor since 2009. In 2017, VBA will build on the success of the transformation initiatives described below to continue this progress.

Veterans Benefits Management System—VBMS, as VBA's key business transformation initiative, provides a paperless claims-processing environment and improved business processes to support timely, high-quality decisions for Veterans and their dependents. VBA's shift to electronic folders in VBMS addressed the inefficiencies of the paper folders and the problems of misplaced files and records. Through a web-based application, multiple, geographically separated users can view the electronic folders simultaneously, thereby minimizing the need for sequential processing and eliminating the delays of receipt of paper folders at ROs. VBMS also provides automation of processes such as the receipt of evidence, movement of claims to the next stage, and updates to the claims status, which means more Veterans are receiving faster decisions. As of March 7, 2016, VBA completed over 4.4 million rating decisions and processed over 2.5 million claims end-to-end in VBMS. In FY 2017,

VBMS will focus on the delivery of electronic service treatment records, establishing one authoritative source for Veteran contact information, and collaborating with the Board of Veterans' Appeals to define the appeals functionality needed both at the regional offices and as part of the broader appeals modernization efforts.

During FY 2017, VBA will continue expanding the delivery of the electronic service treatment records (STRs). In FY 2017, VBMS will be incorporating the Records Management Center (RMC) into VBMS in order to exchange electronic records. Benefits of this implementation include the ability to process requests from field end-users without using legacy systems. Additionally, field end-users will be able to view status requests, eliminating significant burden on the RMC to respond to inquiries and the cumbersome manual work needed in order to process an RMC records request using legacy systems.

VBMS continues to enhance STRs requests from the Department of Defense (DOD). In FY 2017, this will include functionality previously received from legacy systems that would allow VBMS to obtain military service information and treatment records from the Health Artifact and Image Solution (HAIMS). Additional enhancements with the DOD includes receiving electronic STRs prior to discharge for Integrated Disability Evaluation Systems (IDES) claims as well as reporting functionality for subscriptions from VBMS to Data Access Service (DAS).

On FY 2016, VBMS coordinated with US Digital Services to secure a five-percent level of effort in each VBMS release in support of the appeals modernization efforts. At this time, that five-percent level of effort will continue in FY 2017 to support the appeals modernization integration efforts in VBMS.

Question 24. The FY 2017 budget request (page VBA–162) includes this information regarding the Veterans Benefits Management System:

> [The Veterans Benefits Management System] has supported quicker and more accurate delivery of benefits to millions of Veterans and beneficiaries. In addition, the system has improved the overall speed, accuracy, and consistency of decisions for Veterans by providing the tools the workforce needs to meet growing demand and claim complexity.

A. Please quantify the impact the Veterans Benefits Management System has had on the speed, accuracy, or consistency of decisions to date.

Response. Please refer to response to Question 23 under the paragraph "Veterans Benefits Management System."

B. Please quantify what impact future improvements to the Veterans Benefits Management System are expected to have on the speed, accuracy, or consistency of decisions.

Response. Ongoing positive impact to speed, accuracy, and consistency is expected with VBMS functionality planned for FY 2016 and FY 2017. One of VBA's priorities remains the reduction of reliance on legacy systems with a specific focus on decreasing the number of times a user would need to exit VBMS to perform claims processing tasks, allowing for greater consolidated processing.

VA will retire legacy systems when mission needs change, when a new system (e.g. VBMS) has taken on the capabilities of an old system, when system consolidation will improve Veteran service delivery, or when the system is no longer supported by a vendor. As VBMS continues to progress and evolve, development of functionality to encompass other areas of work may provide the opportunity to decommission legacy systems.

Rating Board Automation (RBA) 2000 is one of 11 applications included in the Veterans Service Network (VETSNET) suite. It was previously used to complete disability rating decisions, but these capabilities are now provided by VBMS. There are currently no active RBA 2000 users as this application was retired on January 21, 2016.

While we are unable to provide a timeframe for retirement of other legacy systems, VBA expects to have identified the functionality needed to fully transition from the Modern Award Processing Development (MAP-D) and VETSNET awards applications to VBMS by December 31, 2016. Efforts are also underway toward retirement of Virtual VA and future functionality in VBMS will support those efforts as well.

VBA will collaborate with the VA Office of Information and Technology to accurately address cost and savings projections for IT Appropriations and provide a response by September 30, 2016.

Question 25. According to the FY 2017 budget request, VA is requesting $1.1 billion for "Other Services" for the Veterans Benefits Administration, a $219 million increase over the current estimate for FY 2016. (Page VBA–173) Please provide an itemized breakout of how those funds would be expended in FY 2017.

Response. The discretionary request for $1.1 billion contains contract funding of $732.8 million that directly impacts or supports the delivery of disability compensation claims; $171.6 million to support the delivery of education, vocational rehabilitation and employment, and home loan benefits; and $178.0 million to support mission requirements:

- Contract Medical Examinations ($530.0 million)
- Veterans Claims Intake Program (scanning) ($138.7 million)
- Costs associated with centrally managed services to include Financial Service Center, Debt Management Center, National Archives and Records Administration, Homeland Security, and Human Capital Improvement Program ($110.1 million)
- Transition Assistance Program ($106.9 million)
- Support contracts to provide analytics and innovative Programmatic tools (VA Loan Electronic Reporting Interface, Real Estate Owned and Portfolio Servicing Contract (RPSC), and Appraisal Management Service (AMS)) for VA's Home Loan Program to service and protect loans for Veterans ($57.0 million)
- Program management and systems engineering support services for VBMS ($28.8 million)
- Centralized Mail Processing System ($26.7 million)
- Support contracts for strategic initiatives and solutions enabling an efficient operating environment ($21.9 million)
- Mission support contracts for VBA's 56 regional offices to include VR&E contract counseling, security, maintenance and repairs, GSA overtime utilities, and PCS related expenses ($29.3 million)
- Mission support contracts for VBA central office to include studies and analyses to improve delivery of benefits, technical expertise for key initiatives, and maintenance and repairs ($21.4 million)
- Instructional methodologies and systems that support the training and skills development of the disability compensation workforce ($8.6 million)
- Coordination of business requirements to provide continued execution of VR&E programs and a longitudinal study and field staffing model to improve and enhance Veterans' programs and benefits ($3.0 million)

Question 26. According to the FY 2017 budget request (page VBA–192), Quality Review Teams completed 178,506 in-process reviews during FY 2015 and VA expects those teams to complete 240,000 in-process reviews each year during FY 2016 and FY 2017.

A. How many employees were dedicated to Quality Review Teams during FY 2015 and how much in total was expended for that purpose?

Response. In FY 2015, VBA obligated $71.3 million to support 771 Quality Review Specialists (QRSs) assigned to the Quality Review Teams (QRTs).

B. How many employees are expected to be dedicated to Quality Review Teams during FY 2016 and FY 2017 and how much in total would VA expect to expend for that purpose during those years?

Response. As of March 2016, VBA has 784 QRT members. The ratio of QRSs to claims processors will remain unchanged, resulting in consistent staffing levels for FY 2016 and FY 2017. VBA estimates it will obligate approximately $73.9 million and $76.4 million, respectively.

C. What factors account for the expected increase in the number of in-process reviews completed during FY 2016 and FY 2017?

Response. In 2015, the QRTs were able to complete 178,506 in-process reviews (IPRs) as a result of performing this task on overtime. In 2016, the QRTs will not be performing this task on overtime. The standard goal of required IPRs for each station is 10 percent of its monthly production; therefore, the anticipated number of IPRs for FY 2016 is 120,000. The goal for completed IPR reviews nationwide for FY 2016 and FY 2017 remains at 120,000 IPR reviews for each fiscal year, for a combined total of 240,000 IPR reviews.

Question 27. According to the FY 2017 budget request (page VBA–203), more than 70,000 non-rating actions were completed by the Dependency Claims contractor during FY 2015.

A. In total, how much has VA expended on the Dependency Claims contractor and how much, if any, does VA plan to expend during FY 2016 and FY 2017?

Response. VA spent approximately $4.8 million on the Dependency Claims contract from April 21, 2014, to January 20, 2016. VA anticipates spending approximately $2.4 million per year for FY 2016 and FY 2017.

B. How many non-rating actions does VA expect the Dependency Claims contractor to complete during FY 2016 and during FY 2017

Response. In FYs 2016 and 2017, VA anticipates completion of approximately 30,000 non-rating actions per year.

Question 28. According to the FY 2017 budget request (page VBA–54), VA uses Internal Revenue Service and Social Security Administration records to verify income levels of certain beneficiaries and that process "is the most efficient and effective means VA has of verifying certain types of income, wages, interest, dividends, annuities, etc." On the other hand, the Government Accountability Office made this finding in a report last year:

> VA does not use available third-party earning data to verify veterans' self-attested employment history and income information. Without such verification, VA cannot adequately ensure that the eligibility standards are being met, which places these benefits at risk of being awarded to ineligible veterans.

A. Please provide the Committee with additional information about the process currently used to verify beneficiary incomes and any additional options VA plans to explore if this budget is adopted.

Response. Under current data sharing agreements with the Internal Revenue Service (IRS) and the Social Security Administration (SSA), VA utilizes an upfront income verification process, which allows pension management centers to verify a beneficiary's reported income. This approach allows VA to maintain the integrity of its program, while also reducing improper payments. VA is continuing to work with IRS and SSA to expand this process to all pension-related benefit claims, regardless of the issue, and disability compensation claims based on individual unemployability. VA anticipates expansion of this process by June 2016.

In addition, VBA is transitioning from the paper-based Income Verification Match (IVM) process to a semi-automated, electronic post award audit (PAA) process. In FY 2012, VBA temporarily suspended the release of all paper IVM worksheets to allow for the development and implementation of the PAA process. The PAA process will provide more focused reviews of VA beneficiaries receiving benefits based on self-reported income information to ensure continued program entitlement. VBA is working with VA's Office of Information and Technology to finalize the necessary system requirements and anticipates implementing the PAA process by September 2016.

Question 29. During FY 2015, how much in total did VA expend with respect to the Integrated Disability Evaluation System (IDES) and how many VA employees were dedicated to the IDES process? During FY 2016, how much in total does VA expect to expend with respect to IDES and how many VA employees will be dedicated to the IDES process? During FY 2017, how much in total is VA requesting with respect to IDES and how many VA employees would that level of funding support?

Response. VA's total for FY 2015 was approximately $75,777,099, which excludes VHA for the reasons listed below:

Office of Policy and Planning (OPP)—During FY 2015, OPP spent approximately $1,177,099 which is comprised of $583,692 for a program management support contract, $573,407 in salary for 5 FTE, and $20,000 in travel costs.

Veterans Health Administration (VHA)—VHA does not provide separate funding for the IDES Program. Commencing in FY 2014, funding for this program has been included in VHA's Veterans Equitable Resource Allocation (VERA) model. Staffs located at the VA medical centers (VAMCs) are not solely dedicated to supporting the IDES process.

Veterans Benefits Administration (VBA)—In FY 2015, VBA spent approximately $74.6 million for salaries and other GOE for 638 FTE dedicated to disability claims processing in the Integrated Disability Evaluation System (IDES). Compensation staff and Vocational Rehabilitation and Employment (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.

Response. VA's estimated total for FY 2016 is $77,387,332 which excludes VHA for the reason listed below:

OPP—During FY 2016, OPP should spend approximately $1,187,332, which is comprised of $586,242 for a program management support contract (Final Option Year), $581,090 in salary for 5 FTE, and $20,000 in travel costs.

VHA—VHA does not provide separate funding for the IDES Program. Commencing in FY 2014, funding for this program has been included in VHA's Veterans Equitable Resource Allocation (VERA) model. Staffs located at the VAMCs are not solely dedicated to supporting the IDES process.

VBA—During FY 2016, VBA estimates it will spend approximately $76.2 million to support 638 FTE dedicated to disability claims processing in IDES.

Response. VA's estimated total for FY 2017 is $79,030,375, which excludes VHA for the reason listed below:

OPP—During FY 2017, OPP should spend approximately $1,230,374, which is comprised of $600,000 for a new program management support contract if needed, $590,374 in salary for 5 FTE, and $40,000 in travel costs. The increase in travel is to fund increased site visits to the field.

VHA—VHA does not provide separate funding for the IDES Program. Commencing in FY 2014, funding for this program has been included in VHA's VERA model. Staffs located at the VAMCs are not solely dedicated to supporting the IDES process.

VBA—It is expected that in FY 2017, VBA will maintain staffing at the Providence and Seattle Disability Rating Activity Sites (DRAS) at the same FY 2015/FY 2016 levels and $77.8 million will support 638 FTE.

Question 30. The budget notes that, in 2015, the Insurance Program contacted 1,900 veterans per month as part of a special outreach program. Among the veterans contacted in 2015, how many obtained insurance coverage?

Response. In FY 2015, the special outreach program contacted a total of 23,033 Veterans (for an average of 1,919 per month). A total of 8,235 Veterans' Group Life Insurance policies were issued to those Veterans contacted, i.e., 35.8 percent were granted insurance coverage.

Question 31. To date, how many unique awards have been provided to an estate of a deceased Nehmer class member and what is the total award amount?

Response. As of March 2016, VA has awarded $440,435,895 in monetary benefits to individuals or estates as survivors of deceased Nehmer beneficiaries as required under 38 CFR 3.816(f) to 11,991 individuals. This amount includes persons who paid funeral or last medical expenses on behalf of the Veteran's estate.

BOARD OF VETERANS' APPEALS

Question 32. According to the FY 2017 budget request (page BVA–280), the Board of Veterans' Appeals is undertaking a number of initiatives other than legislative reforms to attempt to improve productivity. Please quantify what level of productivity improvements those efforts are expected to produce.

Response.

TRANSFORMING THE APPEAL PROCESS

VA has made significant progress on its goal to eliminate its disability claims backlog and improve the quality of its initial decisions on claims without seeking significant statutory changes. VBA Transformation Plan focuses on improving personnel performance, redesigning business processes, and replacing paperbound and manual systems with those that are digital and automated. As outlined in VA's appeals plan, VBA and the Board of Veterans' Appeals (Board) can deploy similar people, process, and technology innovations in the appeal process, but those innovations will not provide a real solution without stakeholder support. In this regard, the appeals problem is unique, and one should not view this preliminary plan as providing a comprehensive solution. Absent a comprehensive solution that considers the unique statutory procedures that govern VA's appellate system, VA will use its limited resources as efficiently as possible to decide appeals under the inefficient process required under existing law.

Current law requires that VA maintain a non-linear, multi-step, open-record, administrative appeal process, with jurisdiction over various steps in the process split between VBA and the Board. There is no bright line distinguishing the end of VBA's claim adjudication process from the beginning of the appeal process. Unlike a typical appeal process in which the appellate body reviews the same record as the initial decisionmaker, VA's administrative appeal process has an open record. Under the current framework, appellants, at no cost and without limitation, may submit additional evidence at virtually any time during the pending appeal, regardless of whether the appeal is at VBA or the Board, and VBA must generally reevaluate the claim based upon the new evidence. This feature prolongs the amount of time that Veterans must wait for their appeal to be decided and commits extensive resources to each appeal. As a result, Veterans who receive their initial decisions from VBA in 125 days under the Transformation Plan will nonetheless endure an inefficient VA appeal process. The delays in a benefits system that delivers an initial decision within 125 days and an appellate decision on average in more than 1,000 days may outweigh any benefit to a multi-step, open-record system. Although some individual claimants may be able to take advantage of the current legal framework, it comes

at the cost of failing to provide Veterans as a whole a timely resolution on their appeals.

VBA's Transformation Plan for the initial claim process is structured for the future (more than one million claims annually, multiple complex medical issues in each claim, and electronic submission and processing), while the appeal process set out in current law is an accumulation of processes and procedures that have built up in stages since WWI. The legal framework of the appeal process precedes the all-volunteer military force, the computer revolution, and judicial review of VA's decisions on claims. For example, the Fully Developed Claims program encourages claimants and representatives to build and submit claims before VA renders a decision, while the appeal process encourages them to build their claims after a decision by allowing subsequent submission of evidence in a piecemeal fashion.

VA's Appeals Transformation Plan requires integrated legislative, people, process, and technology initiatives designed to deliver a final agency decision for most Veterans within a year of filing by 2021. As noted above, the current VA appeals process which is set in law, is broken, and is providing Veterans a frustrating experience. It has no defined endpoint and requires continuous evidence gathering and readjudication of the same or similar matter. The present legal framework is complex, inefficient, ineffective, and confusing, and Veterans wait much too long for final resolution of an appeal. Currently, we face an important decision about the future of appeals for Veterans, taxpayers and other stakeholders.

If Congress accepts that the current VA appeals process is broken and that the status quo is unacceptable for Veterans, then there is a choice to be made regarding how to provide Veterans with a timely appeals decision. The 2017 Budget Request outlined that there are essentially two options for ensuring that Veterans receive timely appeals decisions: (1) implement legislative change to streamline the process for new appeals and provide a short-term increase in funding from 2017 to 2021 to address the currently pending 458,000 appeals, or (2) provide significant sustained funding (approximately $1B per year from 2017 on) to continue applying the current inefficient, complex, and confusing VA appeals process. Since submission of the 2017 Budget Request, VA participated in an appeals summit, during which representatives from a wide spectrum of stakeholder groups met with key officials from VBA and the Board to determine how to best reconfigure the current VA appeals process. The result of that summit was a new appeals framework, as encompassed in Senator Blumenthal's draft bill examined in the Committee's May 24 legislative hearing, which if enacted will provide Veterans with timely, fair, quality decisions. If we fail to act now, the magnitude of the problem will continue to compound, such that by the end of 2027, Veterans will be waiting on average 10 years for a decision on their appeal. However, VA cannot fully transform its appeal process without stakeholder support. VA intends to work with Congress and other stakeholders to pursue the comprehensive legislative change required to provide Veterans the timely appeals process that they deserve.

PEOPLE INITIATIVES

VBA is grateful for funding to hire 100 appeals FTE in FY 2015 and 200 appeals FTE in FY 2016. In FY 2016, VBA has increased its appeals workforce to 1,495 employees as of January 2016. To maximize productivity and accuracy of appeals decisions while at the same time minimize training on VA's complex appeals process, VBA hired new employees into the disability claim processing teams and moved seasoned claims processors into the appeals teams.

In FY 2015, the Board was able to hire staff to continue supporting its mission to serve more Veterans and their families. Specifically, in order to both maintain staffing levels and increase capacity where possible, the Board hired 82 staff (including new hires and backfills for attrition), the majority of which were attorneys (68).

If allocated by Congress, the Board will begin the recruitment process for the 242 additional employees immediately upon enactment of the FY 2017 budget in order to support execution of the funding by the end of the fiscal year. In advance of the actual job announcement, the Board is working with the Office of Personnel Management on an aggressive strategic recruitment plan, to ensure successful execution. The 242 additional employees will primarily consist of staff attorneys to draft appeals decisions, with an appropriate complement of administrative support staff and some additional judges. For new attorney staff, the Board has a 6-month training curriculum to ensure thorough training on Veterans benefits law. New judges will undergo rigorous initial training with follow-up mentoring and continuing education for both legal training and leadership training. Administrative staff will also undergo new employee training specific to their business line. Most of the 242 employees

would be staff attorneys. Specifically, the goal is for 145 attorneys, 24 judges, and 73 support staff.

Taking lessons learned from the 2013 hiring surge of 100 attorneys in a 4-month timeframe, the challenges faced would include human resources support, information technology (IT) support, training support, and office space. These challenges would be handled by having a strong recruitment plan in place this year, in advance of the budget enactment, with a tiger team of dedicated personnel to handle the recruitment and on-boarding. The IT needs would also be identified in advance, with a streamlined plan to have the necessary equipment in place in a timely fashion as new hires were on-boarded. The training needs would be handled by having a strong training plan in place, using lessons learned from the large training in 2013, and subsequent trainings. Finally, the office space requirements would be handled by a combination of repurposing existing space for storing paper claims files, and increasing telework for eligible employees.

PROCESS INITIATIVES

(a) STANDARD NOTICE OF DISAGREEMENT FORM

On March 24, 2015, VA's final rulemaking, RIN: 2900-AO81, *Standard Claims and Appeals Forms*, became effective. This rulemaking requires claimants to initiate an appeal using a standard notice of disagreement (NOD) form in cases where such a form is provided by VA. The purpose of this standardization is to improve communications with appellants at the beginning of the appeal process and allow VBA personnel to easily identify and initiate the processing of an appeal. By using the standard form for initiating an appeal, VA need not undergo an inefficient interpretive exercise as to whether a given document is a NOD and can process appeals more expeditiously. By requiring the use of a standard NOD form, all appellants in the appeal process will benefit from shortened processing time and from increased accuracy in identifying contentions claimed.

VA has also recently amended the NOD form to allow claimants to elect either *de novo* review or the traditional appeal process at the time the appeal is initiated. Appeals processing times will be reduced for those claimants who make the election on the form as VA will not have to wait an additional 60 days for the claimant to make the election to begin processing the appeal.

(b) CENTRALIZED MAIL

In May 2014, VBA and the Board initiated a plan to integrate the Board with VBA's Centralized Mail process. In June 2014, the Board formally partnered with VBA's Office of Business Process Integration (OBPI) to begin implementation of Centralized Mail at the Board. The Board has worked very closely with OBPI, leveraging best practices from VBA to implement similar change management strategies by having the Board's mailroom team jointly evaluate the current, As-Is state and develop the future, To-Be state to optimize efficiencies in mail processing. The Board is now currently piloting centralized mail with VBA, and is executing the first phase of this initiative. During this first phase, the Board is shipping appeals-related mail to the scanning vendor. Once scanned, the scanning vendor seamlessly uploads the mail to the Board's Centralized Mail portal, from which the mail can be electronically processed by Board staff.

In the second phase of the Board's centralized mail initiative, Veterans will be able to send their appeals-related mail directly to a new mailing address established for the Board, which will be a P.O. Box affiliated with the scanning vendor. Once successful testing of use of the Board's new P.O. Box has been completed and verified, a regulatory change to the Code of Federal Regulations will be published to update the Board's mailing address.

(c) BOARD HEARINGS

Current law entitles an appellant to an in-person hearing before the Board at its principal location in Washington, DC, or, more frequently, at the appellant's local VBA RO. 38 U.S.C. § 7107(d) (1). The Board is also authorized to offer an appellant a videoconference hearing in cases where the appellant is at the RO and the Veterans Law Judge (VLJ) is in Washington, DC; however, an appellant must affirmatively choose this type of hearing. Statistically, videoconference hearings have been shown to have the same grant rate as in-person hearings. However, the wait times for in-person hearings at ROs (also known as Travel Board hearings) are much greater than for videoconference hearings because VLJs must travel to conduct hearings.

Beginning in June 2015, the Board hosted productive meetings with members of Veterans Service Organization (VSO) leadership to discuss general items of interest, including case inventory, the hearing workload, and hearing wait times. As a result

of these meetings, VSO leadership agreed to take the lead on clarifying the validity of pending hearing requests with their clients. To facilitate the VSO initiative to clarify the validity of pending hearing requests with their clients, the Board provided the VSO workgroup members with hearing data, including a list of each VSO's clients with a pending hearing request, average hearing wait time data by RO, and hearing show rate data for each RO.

VBA's Office of Field Operations is continuing to employ best practices for scheduling hearings. Additionally, to better align Veteran expectations with the current process, the workgroup has discussed implementation of moving hearing election from the VA Form 9 to the arrival of case at the Board and discussed discipline in rescheduling hearings following a no show, or repeated requests for postponement.

Despite these efforts to increase efficiency in scheduling and conducting Board hearings, significant legislative reform related to Board hearings is required. Senator Blumenthal's draft bill examined in the Committee's May 24 legislative hearing provides such reform. That legislation provides that the Board will determine whether a Board hearing will be held either (1) at the Board's principal location or (2) by picture and voice transmission at a VA facility with suitable facilities and equipment. Providing for these two types of Board hearings, the draft bill retains a Veteran's ability to present testimony before a Veterans Law Judge, but improves the appeals process by providing for two types of Board hearings which may be scheduled and conducted much more efficiently, and at decreased cost to the taxpayer, than in-person hearings at VA facilities other than the Board's principal location. If, after being notified of the type of hearing selected by the Board, a Veteran would prefer the other type of hearing; he or she may make such request, which will be granted by the Board. Veterans retain the ability to present testimony during a Board hearing, either in-person before a Veterans Law Judge in Washington, DC, or via videoconference, but the costly and inefficient in-person hearing at the RO (Travel Board hearing) is eliminated.

The draft bill also improves the appeals process for Veterans who do not want a Board hearing. The cases of all Veterans, regardless of whether or not they have requested a Board hearing, must be decided in docket order, with an exception for cases that have been advanced on the docket. The draft bill, however, establishes two separate dockets; a hearing-option docket and a non-hearing option docket, and allows cases before the Board to be decided in regular order according to their respective place on either docket; retaining an exception for cases advanced on the docket. The creation of two separate dockets allows these two different types of appeals to be better managed, and will result in increased efficiency, particularly for those Veterans with cases on the non-hearing option docket.

(d) ALLOCATION OF HEARING RESOURCES

To ensure that available hearing resources are being maximized for Veterans and other appellants across the 56 ROs, the Board thoroughly re-evaluated hearing data regarding utilization rates, oldest docket date cases at each RO, and individual hearing demand by hearing type at each RO when creating the 2016 hearing schedule. With regard to Travel Board (TB) hearings (face-to-face hearings conducted at the RO), the approach was to ensure that available resources were maximized for Veterans by assigning hearing dockets based on each RO's historical hearing utilization rate and its pending TB hearing request volume. With regard to video teleconference hearings (conducted between the Board and the RO), the approach was to target ROs with the oldest pending hearing requests by focusing on those requests with a docket date that is within the Board's docket date range at the time of scheduling formulation. This data-driven model will ensure that limited hearing resources (i.e., approximately 16,000 available hearing opportunities per year with 65,000 Veterans currently awaiting a hearing) are being most efficiently allocated to address the growing volume of pending hearing requests.

(e) CUSTOMER SERVICE IMPROVEMENTS

Consistent with the *MyVA* initiative of improving the Veteran experience, in 2015, the Board initiated a "Veteran Experience Workgroup" to leverage Veteran feedback from the Board's "Voice of the Veteran" survey, and to make meaningful improvements for veterans as they navigate the appeals process. This group of employees from across the Board, including Judges, attorneys, administrative staff, and managers, is focused on identifying areas prime for improved customer service, including Contacts Experience, Hearing Experience, Decision Experience, and Appeals Process Experience. Through continued dialog on these critical areas, the group anticipates generating results-oriented solutions to improving the Veterans' experience with the VA appeals process.

TECHNOLOGY INITIATIVES

Appeals Modernization

The Department is leading an Appeals Modernization initiative to better serve Veterans and their families and provide timely and quality appeals decisions. As a part of this broad initiative, information technology funds have been requested to develop robust paperless functionality in the VA appeals process. This effort is part of the Board's multi-pronged approach to leverage technology, people, process improvements, and long-needed sweeping legislative reform to most effectively serve Veterans and their families in the efficient processing of appeals.

Appeals across the Department are currently processed in a hybrid environment—with continued reliance on paper, and multiple unsynchronized, outdated legacy systems. Manual data entry and lack of appeals-specific paperless functionality creates risk for the Department in workload management, as well as processing delays. Currently, there is minimal appeals-specific paperless functionality in the technology systems, which creates inefficiencies in end-to-end appeals processing.

VA has seen the benefits of people, process and technology transformation at the claims level with increased claims decisions being issued and more Veterans being served—almost 1.4 million in 2015; the same rigorous, multi-pronged efforts to modernize must be applied to the appeals process. The Board is leading this Appeals Modernization initiative, which includes robust IT and FTE components, in order to mitigate risks and to provide timely service to Veterans and their families. Notably, with appeals-specific technology functionality enhancements, Veterans and their families will directly benefit through issuance of more appeals decisions more efficiently. In addition, the Department anticipates gaining future cost savings by being able to retire or "sunset" outdated and unsynchronized legacy systems exclusively used for appeals processing, such as the Veterans Appeals Control and Locator System (VACOLS), which was created in the 1980s.

With FY 2016 IT funding enacted, the Department will be able to begin a multiphase process of enhancing appeals functionality in the paperless environment. These enhancements are necessary to keep pace with the transformation of benefits processing that has occurred on the front end (i.e., claims) of the VA benefits system. Initial key appeals-specific functionalities in the paperless environment will focus on seamless integration of systems, and key accountability and workability features.

The Department and Board are appreciative of the attention and funding that has been provided to directly address the technology voids that will become increasingly problematic without implementation of the proper solutions. In preparation for execution of FY 2016 funds, in FY 2015, the Board performed the necessary due diligence and analysis of relevant business requirements to understand the current state of appeals processing and create the structure to enable delivery of technology capabilities in FY 2016 and beyond. In FY 2016, the United States Digital Service at VA (DSVA), using the approach described in detail below, will undertake the replacement of VACOLS system, created in the 1980s, and provide the Department with more secure and efficient processing capabilities. The new tool, called Caseflow, will consist of both commercial off the shelf (COTS) and custom-developed software, as dictated by the needs of the Department. The majority of funds in FY 2016 are to be allocated to contractor support that will be working with the Digital Service Team to design and develop required technology components. These components will build on the first deliverable of FY 2016, Caseflow Certification, which introduces automation and consistency to the process of transferring appeals from local field offices to the Board. The second most significant use of FY 2016 funds supports the planned acquisition of an eReader COTS product, a tool that will enable attorneys and Judges at the Board to efficiently and effectively review electronic appeals documents in a best-practice manner.

UPDATES TO VBMS FOR APPEALS PROCESSING

Automation

VBA's VBMS office is working on leveraging existing VBMS infrastructure to gain efficiencies in processing appeals using calculator tools and rules-based automation.

eFolder Infrastructure

The VBMS eFolder is the electronic replacement for the legacy paper claims folder. The eFolder serves as the primary repository for all electronic documentation related to a particular Veteran. Users would access the eFolder to review all documentation relevant to a Veteran's claim. This would include internal and external stakeholders such as VHA practitioners and VSO representatives. Unlike the paper

claims folder, the VBMS eFolder supports simultaneous access of multiple users to a single Veteran's eFolder.

Correspondence Component

A key component of the new appeals system would be to leverage the new enterprise correspondence component, which is a highly customizable correspondence assembly engine that provides document design functionality and a business-rules engine that enables full automation of letter assembly.

SWEEPING LEGISLATIVE REFORM NEEDED TO MODERNIZE THE APPEALS PROCESS

While VA is applying lessons learned from the transformative changes that allowed it to reduce the disability claims backlog, and applying people, process, and technology initiatives to the appeals process to gain efficiency in the way appeals are managed and processed, these measures will not be enough. Fundamental legislative reform is essential to ensure Veterans have a timely, fair, and quality appeals process. To this end, the President's 2017 Budget proposed a simplified appeals initiative—legislation and resources—to provide most Veterans a final decision on their appeal within one year of filing by FY 2021. VA intended that the legislative proposals in the 2017 Budget would be the starting point for the broader conversation about how the Department, Congress, VSO, and other stakeholders can work together to provide Veterans with a simple, timely, transparent, and fair appeals process.

VA has brought together the Nation's leading veteran advocacy groups for their input. They are our steadfast partners in improving the way we deliver services to veterans.

As a result of weeks of listening as a result of that collaboration, VA has put forward a new proposal that would provide veterans with a simple, fair, and transparent appeals process in which, with the appropriate resources provided by Congress in future appropriations, the vast majority would receive a final appeals decision within one year of filing an appeal by 2021. This disentanglement of process is enabled by one crucial innovation—giving veterans multiple paths to adjudicate disputes on a claim, while preserving the effective date that the initial claim was filed. VA's consensus proposal was put forward as a discussion draft by Ranking Member Blumenthal and was the subject of the Committee's May 24, 2016, legislative hearing.

This simple change, along with a few others, will modernize the Veteran appeals process, better serving Veterans, taxpayers, and the Nation for years to come. However, since it was layer upon layer of law that got us tangled, VA will need Congress' help to untangle it, and has been working to make this legislative change a reality, and soon.

INFORMATION TECHNOLOGY

Question 33. The Secretary's testimony at the budget hearing notes significant investment in improving and automating processes related to claims for various benefits, including compensation, pension, and education benefits. The Committee has heard in previous testimony about how certain changes to benefits eligibility often incur relatively high costs just to modify processing systems to accommodate the new rules. Please explain where these various benefits claims systems are in their overall development timeline and what future changes to eligibility will look like in terms of time and cost once development is complete.

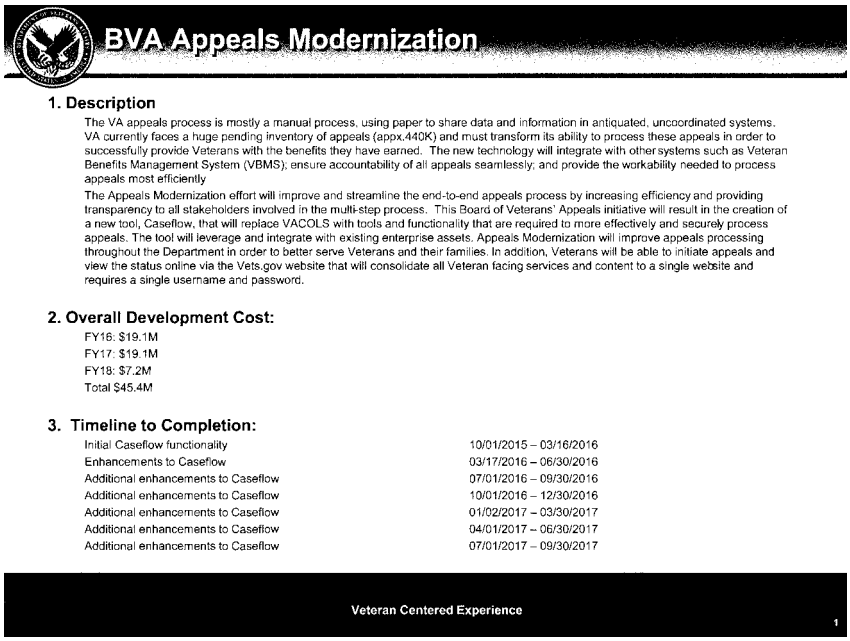
Response. The Office of Information & Technology (OI&T) has utilized the Project Management Accountability System (PMAS) to ensure that VA is developing quality products and overseeing investments responsibly. However, the process has been found to be overly burdensome, administratively heavy, and has inadvertently contributed to increases in project length and overall cost.

To decrease the time to market and lower the overall cost of development, OI&T is pursuing several alternate efforts. First and foremost, OI&T is working closely with VHA, VBA, and BVA on several system modernization efforts—including the BVA modernization effort—that improve the business processes, application of rules, and the replacement of out-of-date software applications with new technology. A summary of these efforts is included in this response.

OI&T is also introducing a new development process called the Veteran-focused Integration Process (VIP). VIP utilizes an agile approach to software development with one single, unified, streamlined release process to deliver high-quality, secure IT capabilities to our Veterans. The VIP process will be governed by the new Enterprise Portfolio Management Office (EPMO). The EPMO provides a consolidated, enterprise-wide approach to identifying, selecting, prioritizing, and successfully exe-

cuting a technology portfolio of projects. It will also emphasize the accumulation of domain knowledge by VA resources and the appropriate allocation of those resources to ensure that OI&T can react more quickly and efficiently to business changes.

Once development is complete on the current suite of Benefits products, the expectation would be that any future enhancements would be able to be done more quickly and at a lesser cost. This is owed to the fact that these are being developed with a Service Oriented Architecture in mind which helps ensure changes are less extensive to accommodate new eligibilities.



BVA Appeals Modernization

1. Description

The VA appeals process is mostly a manual process, using paper to share data and information in antiquated, uncoordinated systems. VA currently faces a huge pending inventory of appeals (appx.440K) and must transform its ability to process these appeals in order to successfully provide Veterans with the benefits they have earned. The new technology will integrate with other systems such as Veteran Benefits Management System (VBMS); ensure accountability of all appeals seamlessly; and provide the workability needed to process appeals most efficiently

The Appeals Modernization effort will improve and streamline the end-to-end appeals process by increasing efficiency and providing transparency to all stakeholders involved in the multi-step process. This Board of Veterans' Appeals initiative will result in the creation of a new tool, Caseflow, that will replace VACOLS with tools and functionality that are required to more effectively and securely process appeals. The tool will leverage and integrate with existing enterprise assets. Appeals Modernization will improve appeals processing throughout the Department in order to better serve Veterans and their families. In addition, Veterans will be able to initiate appeals and view the status online via the Vets.gov website that will consolidate all Veteran facing services and content to a single website and requires a single username and password.

2. Overall Development Cost:

FY16: $19.1M
FY17: $19.1M
FY18: $7.2M
Total $45.4M

3. Timeline to Completion:

Initial Caseflow functionality	10/01/2015 – 03/16/2016
Enhancements to Caseflow	03/17/2016 – 06/30/2016
Additional enhancements to Caseflow	07/01/2016 – 09/30/2016
Additional enhancements to Caseflow	10/01/2016 – 12/30/2016
Additional enhancements to Caseflow	01/02/2017 – 03/30/2017
Additional enhancements to Caseflow	04/01/2017 – 06/30/2017
Additional enhancements to Caseflow	07/01/2017 – 09/30/2017

Veteran Centered Experience

1

VACAA Sections 701 & 702 Enhancements

1. Description

Due to the legislative mandate in Sections 701 & 702 of Public Law 113-146, Veterans Access, Choice, and Accountability Act (VACAA) passed in August 2014 (a.k.a Choice Act), IT Systems need to be changed to provide scholarship benefits to spouses and to allow the VA to disapprove institutions who charge Veterans out of state rates. IT systems impacted by this legislative requirement include : Benefits Delivery Network (BDN), Electronic Certification Automated Processing (ECAP), Long-Term Solution (LTS), Veterans Online Certification of Enrollment System (VA-ONCE), Veterans Online Application Direct Connect (VDC), Web Enabled Approval Management System (WEAMS).

There are two existing Education Service systems that require replacement: VA Online Certification of Enrollment (VA-ONCE) and the Web Enabled Approval Management System (WEAMS). Both of these systems revolve around training facilities and related information, with the VA-ONCE system focused on the interface between VA and the training facilities which allows for student certification. WEAMS is the repository and management system for all approved, suspended and withdrawn programs, to include essential school contact information and other relevant historical data. The system data within WEAMS is included in two public-facing outlets that provide information about Education Facilities: WEAMS Public and the Comparison Tool. The significant amount of overlap between these two systems is one reason to combine them rather than continuing to maintain both of them. The replacement system currently under development is the Veterans Approval, Certification, Enrollment, Reporting and Tracking System (VA-CERTS) and is due to be completed in March 2017. When complete, VA-CERTS will provide the functionality to meet Sections 701 & 702 mandates.

2. Overall Development Cost:

FY15: $7,864,000 (Development Contract and Enterprise Development Environment)

FY15: $ 975,000 (Technical Management Support Services contract)

Additional funds are required for: (1) Enterprise Operations support; (2) VA-CERTS environment [testing to production]; (3) Stakeholder Enterprise Portal (SEP), Identity Access Management (IAM), and VDC application modifications.

3. Timeline to Completion:

VACAA Sections 701 & 702 09/22/2015 – 3/21/2017

Veterans Benefits Management System (VBMS)

1. Description

- The Veterans Benefits Management System (VBMS) is the primary benefits claims system used by Veterans Benefits Administration (VBA) employees to process disability compensation claims. VBMS is a web-based, electronic application that supports the VA's goals to reduce the claims backlog and provide quicker, more accurate, and integrated claims processing across VBA's lines of business.
- Major development under the initial VBMS investment is nearing completion. VBMS development and operational efforts in FY 2016 and FY 2017 will focus on completing end-to-end claims processing capabilities, reducing reliance on legacy systems, and decreasing redundant capabilities across VA. By FY17, VBMS will deploy functionality to support process improvements, workload management across regional offices, and integration with stakeholders to improve the ability for end users to fully process claims within VBMS.
- For FY18 and beyond, VA is focused on a plan to transition VBMS from compensation claims processing to an enterprise-based approach, known as NextGen, that leverages existing infrastructure to meet business needs across VBA and the Department. Planned NextGen capabilities will support an integrated electronic operating environment that provides extensive automation for compensation claims as well as for other lines of business (e.g., pension, education, etc.).

2. Overall Development Cost:

- Total cost of development to date (FY10-FY16) - $597.893M
- Planned development cost through FY17- $75M

3. Timeline to Completion:

- VBMS Increment 13 Start 4/4/16 End 10/3/16
- VBMS Increment 14 Start 10/4/16 End 4/2/17
- VBMS Increment 15 Start 4/3/17 End 10/2/17
- VBMS Increment 16 Start 10/3/17 End 3/5/18

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. DEAN HELLER TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 34. As you know, at the end of 2015, the Senate passed legislation to extend the one-year protection from foreclosure in the Servicemembers Civil Relief Act through 2017.

Unfortunately, although there was support in 2012 and 2014 to ensure this one-year protection was maintained, the House has not yet acted on this legislation, resulting in the expiration of this protection at the end of 2015. Now, servicemembers only receive 90 days of foreclosure protection, right in the midst of their transition to civilian life.

Do you believe this one-year protection from foreclosure is beneficial to veterans who are transitioning to civilian life? Are you supportive of an extension of the one-year protection from foreclosure?

Response. The Servicemembers Civil Relief Act (SCRA) is intended to ease the economic and legal burdens on military personnel during their active service or at the conclusion of active service by postponing, suspending, or mitigating various types of obligations, including mortgage loans. This assistance is critically important as military personnel transition out of active service. VBA supports the extension of the one-year protection from foreclosure.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MIKE ROUNDS TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 35. The one-year protection from foreclosure in the Servicemembers Civil Relief Act expired at the end of 2015 and reverted back to 90 days. Congress acted in 2012 and 2014 to make certain the protection stayed at one year, and the Senate passed a bill to extend for two more years through 2017 but the House has not yet acted. Do you feel the one-year protection from foreclosure has been helpful to veterans as they re-acclimate to civilian life? Would you support an extension of the one-year protection from foreclosure?

Response. The SCRA is intended to ease the economic and legal burdens on military personnel during their active service or at the conclusion of active service by postponing, suspending, or mitigating various types of obligations, including mortgage loans. This assistance is critically important as military personnel transition out of active service. VBA supports the extension of the one-year protection from foreclosure.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. DAN SULLIVAN TO U.S. DEPARTMENT OF VETERANS AFFAIRS

VETERANS' CHOICE, ALASKA PILOT PROGRAM

Question 36. Secretary McDonald, please expand on what progress has been made on the Alaska pilot program as of March 7, 2016.

Response. We are making progress with the Alaska Choice Pilot Program. As of March 7, 2016, the contract revisions have undergone legal review, and we are in the process of defining and gathering data points for measuring success of the pilot. Furthermore, the hiring of additional staff to accommodate the need of the pilot is currently at 75 percent complete.

The Community Care Office developed and submitted a contract modification to the Denver Acquisition and Logistics Center (DALC) supporting a VA pilot in Alaska. The pilot program allows for Alaska VAMC staff to directly coordinate and schedule care using the TriWest network of providers.

The DALC and VA's Office of General Counsel (OGC) recently completed a joint risk assessment of the modification to remove the contactors scheduling requirement. As of March 15, 2016, the DALC is reviewing the modification document and will submit to OGC for final concurrence and submission to the contractor for negotiations.

On November 2, 2015, contract modification number 13 was signed. This modification authorizes TriWest to embed staff at selected VAMCs. Embedded staffing cell composition consists of two Care Coordination Assistants positioned to provide non-clinical support related to authorization entry, appointing and medical documents; and one Operations Manager responsible for supervising embedded staff while acting as the primary liaison with on-site VA staff.

Since implementation, TriWest and VA have embedded staff at the following locations:

- New Orleans, LA VAMC—January 2016
- Dallas, TX VAMC—January 2016
- Anchorage, AK VAMC—January 2016
- Harlingen, TX VAMC—February 2016; Phoenix, AZ VAMC—February 2016.

TriWest and VA are currently coordinating additional embedded staffing sites, which will be implemented over the next 60 to90 days in the following locations:

- Corpus Christi, TX Community-Based Outpatient Clinic (CBOC)
- McAllen, TX CBOC
- Fayetteville, AR VAMC
- Jackson, MS VAMC
- Gulfport, MS VAMC

Initial feedback from VA sites that have already implemented TriWest embedded staff is positive because VA and TriWest are working together in a collaborative approach to improve customer service for Veterans, VA staff, and local providers.

ACCOUNTABILITY

Question 37. Secretary McDonald, you've repeatedly said that in your leadership experience, you need to approach challenges by "changing the culture." How does the reinstatement of directors Diana Rubens and Kimberley Graves speak to the larger process of changing the culture within the VA and how does it restore confidence in our veterans when it restores individuals with track records like theirs, to positions of leadership? How many employees have been fired within the VA workforce as of March 7, 2016 and how many are currently receiving disciplinary action?

Response. The Department complied with an order by the Merit System Protection Board to restore Ms. Rubens and Ms. Graves as Directors in VBA's Philadelphia and Minneapolis regional offices... The Department is demonstrably committed to improving accountability of its senior leaders within the established legal framework. While every outcome may not be what the Department envisions, these cases have not deterred our resolve to continue the reinvention of the Department's corporate culture. The Department will not tolerate misconduct on the part of its senior leaders and we will continue to seek corrective action where warranted.

- In calendar year 2014, VA terminated more than 1,100 employees. In calendar year 2015, VA terminated more than 1,980 employees. (Note: this includes removals and probationary terminations). As of June 28, 2016, we have 945 Probationary Terminations/Removals in calendar year 2016.
- VA has terminated 3,685 employees since Secretary McDonald was confirmed on July 29, 2014. (Note: this includes removals and probationary terminations as of 06/28/16).

VA has initiated 450 disciplinary actions on any basis related to patient scheduling, record manipulation, appointment delays, and/or patient deaths nationwide, since June 3, 2014 (as reported on the June 3, 2016).

DEBT COLLECTORS

Question 38. Dr. Shulkin, I sent you a letter dated January 4, 2016, regarding the issue of veterans in my state who have been hounded by collections agencies for unpaid bills. I brought this issue up the last time we met, and you committed to me at the field hearing in Phoenix back in December, that your office would intervene to make sure that doesn't happen. You committed to me again at the hearing on February 23, 2016 that addressing these claims would be a priority. This letter had pages of cases that I haven't gotten the answers to and there has been no communication with my state or DC staff since February. How and when do you plan on helping these veterans?

Response. VA acknowledges that delayed payments and inappropriately billed claims are unacceptable and have caused stress for Veterans and providers alike. As a result of this issue, Veterans can now work directly with VA to resolve debt collection issues resulting from inappropriate or delayed Choice Program billing. In step with *MyVA* efforts to modernize VA's customer-focused, Veteran-centered services capabilities, a Community Care Call Center has been set up for Veterans experiencing adverse credit reporting or debt collection resulting from inappropriately billed Choice Program claims. Veterans experiencing these problems can call 1–877–881–7618 for assistance.

The new call center will work to resolve instances of improper Veteran billing and assist community care medical providers with delayed payments. VA staff is also trained and ready to work with the medical providers to expunge adverse credit reporting on Veterans resulting from delayed payments to providers.

VA is urging Veterans to continue working with their VA primary care team to obtain necessary health care services regardless of adverse credit reporting or debt collection activity. The new call center is the first step in addressing these issues. Veterans can find this number on the Veterans Choice Program website, http://www.va.gov/opa/choiceact/. VA also issued a news release regarding the call center and including the 800 number to call. Last, posters including information on the call center and the 800 number will be distributed to VAMCs and CBOCs nationwide.

VA is urging Veterans to continue working with their VA primary care team to obtain necessary health care services regardless of adverse credit reporting or debt collection activity. There should be no administrative burden that stands in the way of Veterans getting care.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. RICHARD BLUMENTHAL TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 39. VA's health care system, in particular, its research facilties, have historically been big draws to the best and brightest medical talent, but many clinicians are now discouraged from researching at VA because the facilities are in need of upgrading. The President's request for major and minor construction is $1.025 billion, including grants for state homes and cemeteries. This is a significant decrease from the $1.675 billion that was requested in FY 2016. Most noticeably, the major construction funding request dropped from $1.444 billion in FY 2016 to $528 million in FY 2017. Given the sad state of VA's aging capital infrastructure, and its particular impact on researchers who often also provide direct care to veterans, how do you explain what amounts to an almost 40% decrease in your request for construction funding? Please provide your views on the recommendation in the *Independent Budget* that VA designate at least $50 million in its construction budget for upgrading its research facilities.

Response. With the FY 2017 request, VA is continuing to fund critical Major construction projects that address access, patient safety, and seismic issues in Long Beach, California and Reno, Nevada. The request also includes new cemetery and expansion projects that expand the VA's ability to provide access to burial services and prevent the closure to new interments in existing cemeteries. VA is maximizing future flexibility by not committing to long-term solutions until the Department reviews the recommendations from the Commission on Care, expected June 2016.

While the FY 2017 major construction funding request is less than last year, the request for all of VA's capital accounts—Major, Minor, and NRM—is only 5 percent less than the FY 2016 enacted level. VA is focusing on fixing our existing facilities by completing prior year minor and non-recurring maintenance (NRM) projects, including minor construction projects that enhance VA's research capabilities. VA is also exploring opportunities to engage partnerships opportunities that would reduce upfront capital expenses, resolve costly deferred maintenance, and provide potential lifecycle cost benefits. However, VA's authority to enter into such partnerships is presently limited to the Leasing, Enhanced Use Lease, and Historic Reuse programs. Expanded authority could support resolution of infrastructure deficiencies for some of VA's owned assets while providing an opportunity to realize net lifecycle savings.

Question 40. There is potential for care in the community to top $18 billion in FY 2018 (this was a figure derived from information contained in VA's October 30, 2015 report "Plan to Consolidate Programs of the Department of Veterans Affairs to Improve Acess to Care"), which is $11 billion more than VA currently anticipates spending on traditional non-VA care.

A. Please explain how VA expects to reduce spending on care in the community to $7.5 billion in FY 2018 without impacting access for veterans.

Response. The FY 2018 Advance Appropriation request is an initial amount to enable VHA to begin the year if there is a continuing resolution, and VA expects to revisit the FY 2018 request in the FY 2018 President's Budget. The Advance Appropriation allows VHA to avoid the functional limitations of operating under a Continuing Resolution or in the event of a government shut-down. Funding the Advance Appropriation allows VHA an initial budget to continue operations until the full appropriation amount is signed into law. The "second bite" is intended for the administration to fully evaluate the resource requirements of the VA in context of the entire Federal budget.

B. Please provide an estimate of the number of veterans VA anticipates will be using care in the community and their estimated reliance on VA facilities and providers for receiving health care in FY 2017 and in FY18.

Response. Based on increases since FY 2010, our projections show the unique number of Veterans using Community Care in FY 2017 and FY 2018 to be:

FY	Projected Unique Veterans
FY 2017	1,974,962
FY 2018	2,216,217

Question 41. One of the criticisms of the current Choice Program has been the need for improved coordination of care. VA recognized this in the New VCP when it highlighted the importance of robust care coordination tailored to each veterans's unique needs. I am encouraged that VA recognizes the need to ensure veterans and providers have access to a customer service system to help resolve any inquiries regarding care coordination. It is critical that VA facilities have staff available to support successful implementation of these efforts. Please discuss the rationale for not requesting funds for additional staff to implement the enhanced coordination of care efforts and how you intend to support those efforts with the current staffing levels.

Response. The FY 2018 Advance Appropriation request is an initial amount to enable VHA to begin the year if there is a continuing resolution, and VA expects to revisit the FY 2018 request in the FY 2018 President's Budget. The Advance Appropriation allows VHA to avoid the functional limitations of operating under a Continuing Resolution or in the event of a government shutdown. Funding the Advance Appropriation allows VHA an initial budget to continue operations until the full appropriation amount is signed into law. The "second bite" is intended for the administration to fully evaluate the resource requirements of the VA in context of the entire Federal budget.

Question 42. The Veterans Service Organizations who publish the *Independent Budget* indicated in their written testimony that the Administration's proposal to simplify the VA disability claims appeals process raise many due process concerns. Please discuss the nature of the due process rights veterans have through entitlelemt to disability benefits and how the Administration's proposal to simplify the appeals process would affect these rights. Also, earlier this year, VA released a white paper on the Veteran Appeals Experience. This white paper seemed to indicate that veterans have little awareness of what their due process rights are. What steps is VA taking to preserve those rights in a way that veterans can understand?

Response.

Veteran Appeals Experience: Voices of Veterans and their Journey in the Appeals System

In January 2016, VA Center for Innovation (VACI) completed a findings report on the appeals process for Veterans. To better understand how Veterans experience the appeals process—how the process fits into the context of their lives—a group of six researchers spoke at length with 92 Veterans whose service spanned the periods from World War II, Korea, and Vietnam, to the current conflicts in Iraq and Afghanistan.

Researchers spoke to Veterans at every stage in the appeals process, from those receiving their initial decision to those with final, complete results from the Board. Some were new to the process. Others, such as those who had just had their hearings with the Board, were years into the process.

Human-Centered Design methods were used to understand the needs, behaviors, and experiences of the Veterans in the appeal process. Researchers performed qualitative ethnographic and design activities, driven by a robust and evolving set of questions. Using design thinking and service design practices, researchers mapped, visualized, and synthesized the findings, which are detailed in the full report.

After careful review of the Veteran interviews researchers formed a narrative on how Veterans view the appeals process. Veterans and their families struggle to understand the process or their place in it. They have little understanding of the relationship between steps in the process and sometimes don't even realize when they're making a decision—even if it might delay their appeal for years. They don't distinguish between Veteran Benefits Administration (VBA) and the Board; instead, they simply see VA. Even VSOs are occasionally viewed as part of VA. As is articulated in the Veteran Appeals Experience paper, Veterans do know that the VA appeal process is broken. Researchers found Veterans tended to see the process as adversarial, labor intensive, and filled with endless churn.

VACI's research identified five key themes surrounding Veterans' needs, perceptions, and expectations in their experience with the appeals process. These insights

can guide VA in redesign of appeals and related services that can better meet the needs of Veterans and their families.

The themes, outlined in greater detail in the report, are:

1) The length and labor of the process takes a toll on Veterans' lives.
2) Like in the military, Veterans care deeply about the outcomes of other Veterans.
3) Veterans feel alone in a process they don't understand.
4) The appeals process feels like a fight.
5) Veterans want to be heard.

Overview of the VA Appeal Process

The VA appeals process, which is set in law, is a complex, non-linear process that is unique from other standard appeals processes found in other judicial systems. The current VA appellate process has multiple steps, most of which occur at the agency of original jurisdiction (AOJ), such as, the VHA, VBA, or the National Cemetery Administration (NCA). If a Veteran is not satisfied with the initial AOJ determination, he or she may continue the appeal to the Board of Veterans' Appeals (Board) for a final agency decision. A feature of the current VA appeals process is an open record that, with only narrow exceptions, allows a Veteran, Survivor, or other appellant to submit new evidence and/or make new arguments at most points in the appeals process. Additionally, the duty to assist requires VA to develop further evidence on the Veteran's behalf and pursue new arguments and theories of entitlement. When new arguments are presented and evidence is added or obtained, VA generally must issue another decision considering the new arguments and evidence, which lengthens the timeline for final appellate resolution.

The current VA appeals process takes too long, as there is no defined endpoint or timeframe; is too complex, as Veterans do not understand the process; and involves continuous evidence-gathering and re-adjudication that delays the Department in reaching a final decision. VA's appeals process essentially contains another claims process, as new contentions are picked up as part of the appeal, rather than initiated as a new claim.

Sweeping legislative reform, in conjunction with modernization of appeals processing technology, is needed to ensure that Veterans receive timely and quality appeals decisions. With sweeping legislative reform, VA could provide Veterans with a simplified appeals process under which Veterans receive a final, fair appeals decision significantly faster than the current appeals process, which has no predictable end and can continue for many years. Conversely, if substantial legislative reform does not occur, Congress will need to provide significant sustained funding for VA to hire additional employees to apply the current inefficient process created by existing law to the constantly growing appeals workload.

While business process improvements/initiatives will provide some assistance in streamlining the current inefficient appeals process, VA will not be able to keep up with the growing appeals workload without a significant sustained increase in resources or sweeping fundamental legislative reform. Such fundamental legislative reform is reflected in H.R. 5083. This legislation replaces the current appeals process with a new framework consisting of differentiated lanes, which give Veterans clear options after receiving an initial decision on a claim. One lane would be for a quick review of the same evidence by a higher-level claims adjudicator in the AOJ; one lane would be for submitting additional evidence with a new claim to the AOJ; and one lane would be the appeals lane for seeking review by a VLJ at the Board. Furthermore, hearing option and non-hearing option appeals at the Board would be handled on separate dockets so these distinctly different types of work can be better managed. In order to make sure that no lane becomes a trap for any Veteran that misunderstands the process or experiences changed circumstances, a Veteran who is not fully satisfied with the result of any lane would have one year to seek further review while preserving an effective date for benefits based upon the original filing of the claim. For example, a Veteran could go straight from an initial AOJ decision on a claim to an appeal to the Board. If that decision were not favorable, but it helped the Veteran understand what evidence was needed to support the claim, then the Veteran would have time to submit that evidence to the AOJ in a new claim without fearing an effective-date penalty for choosing to go to the Board first.

Importantly, this legislative reform protects the due process rights of Veterans by ensuring that Veterans are provided clear and detailed notice when a claim is decided. This new design also contains a mechanism to correct duty to assist errors by the AOJ. If the higher-level claims adjudicator or Board discovers an error in the duty to assist that occurred before the AOJ decision being reviewed, the claim would be returned to the AOJ for correction unless the claim could be granted in full. The Secretary's duty to assist would not apply to the lane in which a Veteran

requests higher-level review by the AOJ or review on appeal to the Board. The duty to assist would, however, continue to apply whenever the Veteran initiated a new claim or supplemental claim. For Veterans who want to submit additional evidence following an AOJ decision on a claim, there would be two options; they could either submit additional evidence with a supplemental claim or file a timely appeal to the Board and elect the Board "hearing option lane" which would allow the Veteran to testify at a Board hearing and submit evidence at the Board hearing or within 90 days thereafter. Alternatively, a Veteran on the hearing option docket could choose to submit additional evidence within 90 days of filing a notice of disagreement without requesting a Board hearing. Stakeholder support is needed to provide appellants this modern, efficient appeal process that is consistent with VA's goals for the initial claims process.

History of the VA Appeal Process

The current appeals adjudication process has evolved over nearly a century from the WWI system originally managed by the Bureau of War Risk Insurance. During most of this evolution, decisions on Veterans claims were final and no court had authority to review the agency's decisions. Veterans first received the right to seek judicial review of agency decisions on their claims in the 1988 enactment of the Veterans' Judicial Review Act (VJRA) (Public Law 100–687). The VJRA established judicial review of VA decisions in a new court now known as the United States Court of Appeals for Veterans Claims (CAVC); maintained the Board as the final adjudicator within VA; abolished the $10 limit on attorneys' fees for representing Veterans in certain claims; and created additional levels of judicial review in the United States Court of Appeals for the Federal Circuit (Federal Circuit) and the United States Supreme Court.

Judicial review of VA's decisions has had both positive and negative effects for VA and claimants. Judicial review has been beneficial for Veterans by providing them with their "day in court." It has also created a forum for debating the interpretation of Veterans benefits law and the validity of VA's regulations, resulting in a significant body of case law on Veterans' benefits issues.

However, judicial review has also significantly complicated VA's administration of its benefits programs, resulting in significant delays in the initial claim and appeal processes. The processes that were developed in the decades after WWI were not designed to be compatible with judicial review. As a result, the interpretation of statutes and regulations that often date to WWI or WWII has led to many unexpected results that have been difficult to integrate into the decades of procedures that have accumulated. Specifically, the applicable law as developed primarily by precedential CAVC and Federal Circuit decisions is constantly increasing in complexity. As a result, Board decisions are lengthier, more complex, and require more time and resources to prepare than ever before. While there are a number of CAVC decisions that affect the timeliness of the claim and appeal processes, the most significant factor has been the CAVC's interpretation of VA's statutory duties to assist and notify, which have substantially increased the number of remands to the Board and VBA.

Current Statutory Framework

It is important to understand the current framework that has been built up in stages since WWI. The VA appeals process divides responsibility between VBA and the Board. In brief, it is not a closed or linear process. The appeal process provides redundant reviews of the initial decision, and the process does not move in one direction to a set conclusion. The claimant pays no fee to utilize the VA appeals process and there is no limit to the number of appeals that can be submitted. New evidence may be submitted or obtained at virtually any time and an appeal may have to go through multiple cycles of development and re-adjudication to be resolved.

VBA

A claimant may initiate VA's administrative appeal process by filing a NOD with VBA regarding a specific VBA decision. Section 7105(b)(1) of title 38, U.S.C., provides claimants with a one-year period, beginning on the date that VA issued the decision, in which to file a NOD.

Under section 7105(d)(1), when VBA receives a NOD, it initiates a fresh review and undertakes any development required for additional evidence submitted with the appeal in an attempt to resolve the disagreement. If VBA's further action regarding the appealed claim does not resolve the disagreement, it must issue a Statement of the Case (SOC), which must include a summary of the evidence, citation to pertinent laws and regulations, a discussion regarding how VBA applied the law to the facts of the claim, a decision on each issue in the appeal, and a summary

of the reasons for the decision on each issue. Claimants may then file a substantive appeal within 60 days of the date VBA issued the SOC or within one year of the date of VBA's initial decision, whichever is later, which completes the formal appeal for certification and transfer of jurisdiction to the Board.

VA has interpreted its authority under section 7105 as allowing claimants who filed an NOD to elect either a traditional appeals process or a first level of de novo review within VBA by a Decision Review Officer (DRO). If a claimant elects a DRO review, a VBA employee who processes appeals re-adjudicates the claim and issues a decision granting the benefits on appeal or an SOC confirming the prior decision. A claimant who elects a DRO review and remains dissatisfied with VA's decision may still file a substantive appeal to the Board and receive another de novo review of the claim.

A claimant may submit additional evidence to support an appealed claim at virtually any point in the process, regardless of whether the appeal is pending at VBA or the Board. If additional evidence is received after the claimant files a NOD but before VA issues the SOC, the evidence will be reviewed by VBA and incorporated into the SOC (if VBA cannot grant benefits). Evidence that an appellant identifies after VBA issues an SOC will result in VA issuing a supplemental SOC (SSOC). Each time the claimant identifies additional evidence; VBA must reconsider its decision on the appealed claim and conduct any necessary development of the claim under its duty to assist the claimant. If VBA's reconsideration of the appealed claim does not resolve the disagreement, it will issue another SSOC.

There is no limit to the number of times a claimant may identify additional evidence that may require VA to repeat this process. Accordingly, many appealed claims require several SSOCs, depending on the number of times that the claimant identifies additional evidence. Identification of additional evidence during the appeal process often results in multiple reviews and re-adjudications of an appeal before VBA is in a position to transfer it to the Board for its de novo review. In FY 2015, each additional SSOC added, on average, more than 360 days to the total appeal processing time.

THE BOARD

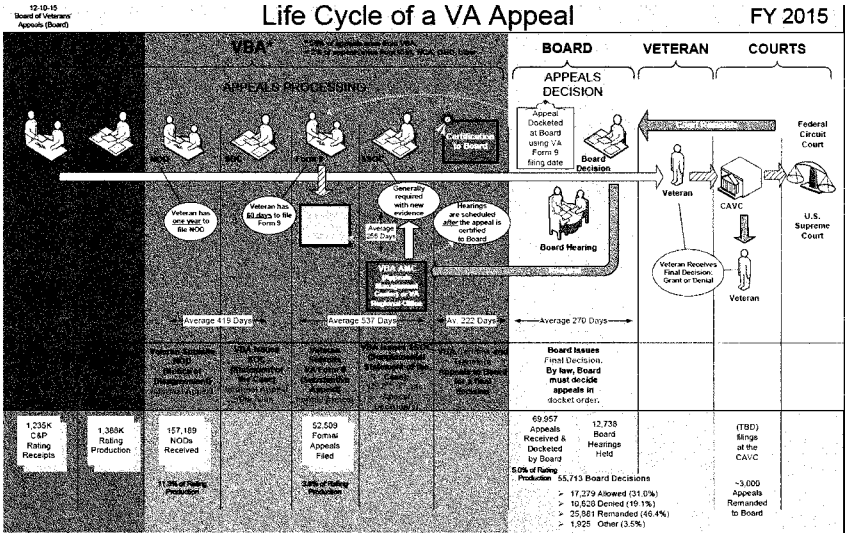
Under 38 U.S.C. § 7104(a), VBA's decisions are subject to one de novo review on appeal to the Board. In general, this right of review requires evidence to be considered by VBA in the first instance before a case can proceed to the Board. However, when the Board receives an appeal, it reviews the entire record on the claim and does not give any deference to a prior VBA decision. The Board will either issue a decision granting or denying the benefit, or will remand the claim back to VBA for additional developmental action. Approximately 60 percent of the decisions that are remanded to VBA are a result of additional evidence or information becoming available, or a change in circumstances that arose after the claim was certified to the Board. As discussed above, claimants may submit additional evidence at virtually any time during the process, regardless of whether the appeal is at VBA or the Board. This submission of additional evidence and other inherent delays in the appeal process often cause the Board to remand the claim to VBA for a new examination or a search for previously unidentified records, which causes further "churning" of the appeal. Furthermore, if the Board identifies an error in evidence gathering, the case must be returned to VBA to repeat the development and adjudication process before being returned to the Board.

In July 2003, VBA created its Appeals Management Center (AMC) for the purpose of consolidating remands from the Board at a single office for more efficient and consistent processing. The AMC has the authority to develop additional evidence regarding remanded claims and issue new decisions. If the AMC is unable to issue a full grant of benefits, it will issue a supplemental SOC and recertify the appeal to the Board for continuation of the administrative appeal process. Currently, the AMC processes approximately 65 percent of the Board's remands to VBA. VBA's regional offices process the remaining remands, including remands in claims where the appellant has asked for a hearing or a private attorney represents the claimant.

The current process (see Figures 1 and 2) provides appellants with multiple reviews in VBA and one or more at the Board depending upon the submission of new evidence or whether the Board determines that it is necessary to remand the matter to VBA. Although VA has allocated significant resources to the appeals workload, the multi-step, open-record appeal process set out in current law precludes the efficient delivery of benefits to all Veterans. Further, the longer an appeal takes, the more likely it is that the claimed disability will change, resulting in the need for additional medical and other evidence and further processing delays. As a result,

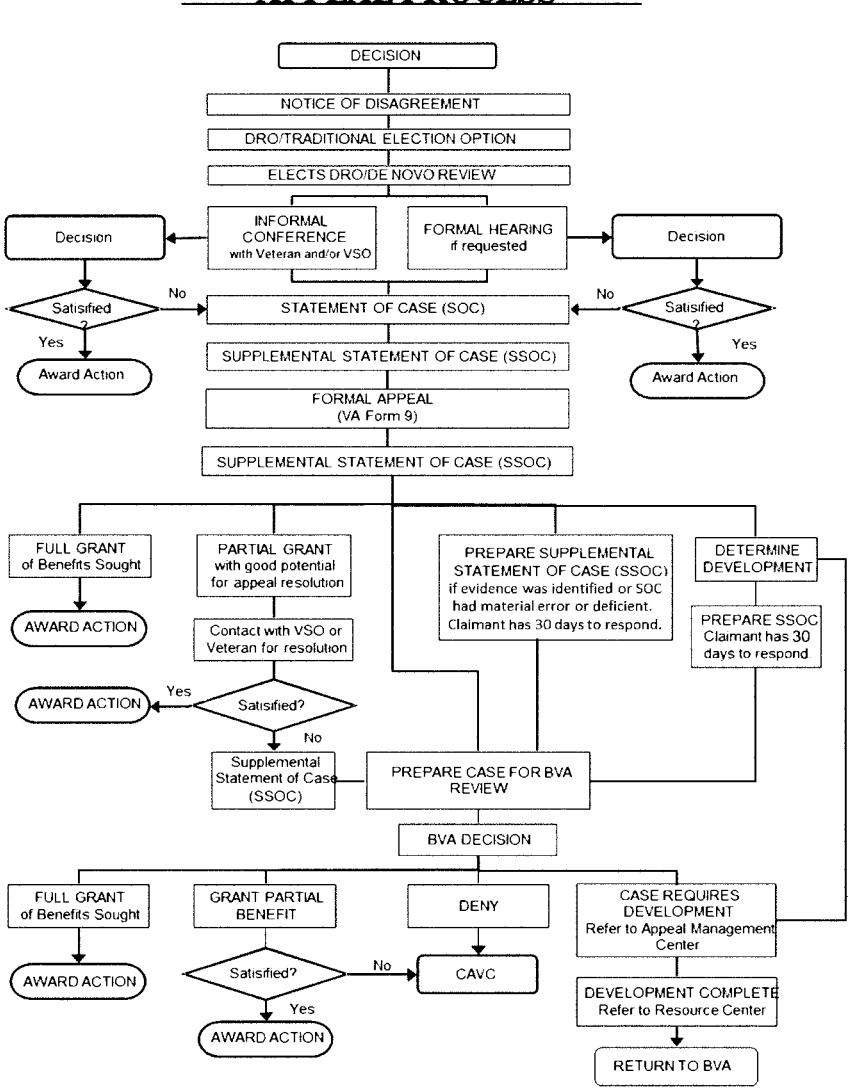
the length of the process is driven by how many cycles and re-adjudications are triggered.

FIGURE 1: Illustrating the entire appeal process, including judicial review.



** In FY 2015, each additional SSOC added, on average, more than 360 days to the total appeal processing time.

FIGURE 2:
Illustrating the complex administrative appeal process created by current law.



JUDICIAL REVIEW

As noted above, claimants have had the right to judicial review of VA's decisions on their claims since 1988. If an appellant is dissatisfied with a final Board decision on a claim, the appellant may appeal to the CAVC within 120 days of the date of the decision. Further, limited review is available in the Federal Circuit and Supreme Court. The 1988 legislation placed judicial review on top of the layers of procedures that had evolved since WWI.

If the Veteran disagrees with any or all of the final appeals decision, the Veteran always has the option of filing a claim to reopen for the same benefit once the appeal is resolved.

Proposals for a New VA Appeals Framework

There are three key elements that the new appeals framework would impact: VA's duty to assist, submission of evidence, and effective date provisions. Over the years, laws have changed to add layers of process to protect the interests of Veterans. However, those protections are no longer serving Veterans well since these laws have affected the timely and efficient resolution of appeals.

Under current statutes, Veterans have the right to submit or identify evidence and pursue new arguments of entitlement at virtually any point throughout the appeals process. Under its statutory duty to assist, VA is obligated to develop and gather the evidence for the Veteran and re-adjudicate the appeal each time. Further, current effective date statutes provide an effective date of benefits that is retroactive to the date of the filing of the initial claim, as long as a Veteran files a timely appeal that eventually results in an award. Therefore, the current process incentivizes the continual submission of new evidence. Continuous evidence-gathering and the additional duty to assist triggered by the submission of evidence delay a final decision and result in many cycles of re-adjudication. In many instances, the additional steps in the process not only add little or no value, but actually harm Veterans by delaying an otherwise favorable decision while additional process is pursued. Hence, VA's appeal system differs from other Federal agency and judicial appeal processes, which limit the appeal review to evidence included in the record at the time of the initial decision.

By modernizing and simplifying the appeals system, Veterans would be afforded a transparent appeals process with a single VA appeals owner, rather than trying to navigate a multi-step process that is too complex and too difficult to understand.

VA has brought together the Nation's leading Veteran advocacy groups for their input. They are our steadfast partners in improving the way we deliver services to Veterans.

As a result of that collaboration, VA has put forward a new proposal that would provide veterans with a simple, fair, and transparent appeals process in which, with the appropriate resources provided by Congress in future appropriations, the vast majority would receive a final appeals decision within one year of filing an appeal by 2021. This disentanglement of process is enabled by one crucial innovation—giving veterans multiple paths to adjudicate disputes on a claim, while preserving the effective date that the initial claim was filed. VA's consensus proposal was put forward as a discussion draft by Ranking Member Blumenthal and was the subject of the Committee's May 24, 2016, legislative hearing.

This legislation would modernize the Veteran appeals process, better serving veterans, taxpayers, and the Nation for years to come. And since it was layer upon layer of law that got us tangled, VA will need Congress' help to untangle it, and has been working to make this legislative change a reality, and soon. The principles of this consensus proposal are as follows:

THE NEW APPEALS FRAMEWORK PROVIDES FIVE KEY BENEFITS FOR VETERANS

I. IMPROVED COMMUNICATIONS: In order to make an informed and intelligent choice as to which review option is the most beneficial, Veterans will need a clear and detailed Decision Notice when a claim is decided. We have identified eight elements needed to draft a comprehensive notice to Veterans.

1. Issues adjudicated
2. Evidence considered
3. Statutes and regulations considered
4. Identification of findings favorable to the Veteran
5. Findings as to which element(s) were found not to have been satisfied leading to the denial of the claim including an explanation of how the evidence was weighed
6. Notice of how to obtain a copy/access to the evidence used in making the decision
7. Notice of the criteria that must be satisfied to grant the claim
8. Notice of appellate rights and all procedures available to seek further review

II. EFFECTIVE DATE PROTECTION: The new system will protect a Veteran's potential effective date while he or she considers the different options available. Choosing

one lane over another lane (See Choice below) does not prevent a Veteran from later choosing a different lane.

III. CHOICE: The new model provides Veteran's with three options (Lanes) after every VBA Decision. These Lanes are designed to allow Veterans to choose the option that best suits their particular need.

1. A Difference of Opinion Review/Higher Level Review by the AOJ (within VBA)
2. An option to submit New Evidence (within VBA)
3. The right to Appeal to the Board of Veteran Appeals (Board)

IV. EARLY RESOLUTION: The new approach is designed to facilitate early resolution of Appeals at the RO level—through options 1 and 2—rather than driving Appeals through a single process which leads to and through the Board.

V. TIMELY RESOLUTION

1. The focus on early resolution and a 125 day turn-around goal within the two VBA lanes will dramatically reduce the time to resolution for many Appeals.
2. The Board will provide 1) an Expedited Review docket for claimants who simply wish for a review on existing evidence, and 2) an Alternate Review docket which allows for hearings and the submission of new evidence.

Question 43. The American Legion's written testimony highlights the importance of the Decision Review Officers at the VA Regional Offices as one of the most efficient ways for a veteran to resolve an appeal. As VA has attempted to reduce the backlog of claims, many DROs have been assigned to focus on claims rather than appeals, reducing the number of employees available to process appeals. VA's proposal for reforming appeals seems to remove many of the functions of the Regional Office from the appeals process altogether. Under VA's proposal for a simplified appeals process, would DROs work on claims or appeals?

Response. The new appeals framework described in H.R. 5083 sets up three "lanes" or options for Veterans following an unfavorable AOJ decision. The DRO review would be eliminated in the new appeals framework; however, Veterans would have two options for further review of their claim at the AOJ, by either choosing higher level review by the AOJ or by filing a supplemental claim with new evidence.

Veterans would have up to one year from an initial claim decision to seek local review of the decision by a higher-level adjudicator. No new evidence or hearings would be permitted at this stage and the adjudicator would have the authority to grant the claim based upon a difference of opinion. However, the Veteran's representative would have the option to request an informal conference with the decisionmaker for the purpose of pointing out specific errors in the case.

If during the review, the higher-level adjudicator finds a duty to assist error, and that error occurred prior to the AOJ decision being reviewed, the adjudicator would send the case back to the lower level to correct any errors found and re-adjudicate the claim.

The level of the higher-level adjudicator would depend upon the complexity of the claim, but would be higher than that of the initial adjudicator. The Veteran could elect whether this adjudicator was from his or her local RO or from a different RO.

The effective date of the initial filing of the claim would be protected if the outcome of the review is favorable to the Veteran. If the outcome of the review is unfavorable, the Veteran would have one year from the date of the higher-level review decision to submit new evidence with a supplemental claim or file an appeal with the Board.

As an alternative to higher-level review, upon receiving a decision, Veterans would have up to one year to submit new evidence with a supplemental claim. The Veteran could also request a local hearing to submit testimony. An RO adjudicator would consider the new evidence and issue a new decision, while preserving the effective date associated with the initial claim. If Veterans remain dissatisfied with the decision, they would still have the option to appeal to the Board, seek local review by a higher-level RO adjudicator in the difference of opinion lane, or file another supplemental claim with new evidence.

This new appeals framework allows Veterans who have received an unfavorable AOJ decision to make a choice regarding the most appropriate review for their situation, and provides more options than the current legal framework.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. SHERROD BROWN TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 44. As you know a 2014 HELP Committee report revealed that eight of the top 10 recipients of Post-9/11 GI Bill benefits are large, publicly-traded compa-

nies that operate for-profit colleges who had received 23 percent of all Post-9/11 GI Bill benefits ($975 million) in 2012–13. Has this changed in the intervening time since this report was published? For the most recent year for which data is available, how many of the top 10 recipients of Post-9/11 GI Bill benefits are for-profit colleges?

Response. Based on Fiscal Year 2015 data, five of the top 10 recipients of Post-9/11 GI Bill tuition and fee payments are for-profit schools. These five schools received a total of $301,679,948 in tuition and fee payments and represent over 60 percent of the total tuition and fee payments to the top 10 recipients of the Post-9/11 GI Bill. These schools also represent 10 percent of all Post-9/11 GI Bill tuition and fee payments in 2015. Please see the table below for the top 10 highest paid schools.

Name of Institution	Profit Status	Total Tuition and Fees Paid
University of Phoenix-Online Campus	Private profit	$135,107,635.20
American Public University System	Private profit	$55,544,751.53
University of Maryland-University College	Public	$45,083,484.47
Full Sail University	Private profit	$40,276,319.58
Ashford University-On Line	Private profit	$39,886,727.16
Southern Utah University	Public	$38,084,999.78
Liberty University	Private non-profit	$37,246,788.32
Arizona State University-Tempe	Public	$34,169,659.32
University of Phoenix-Southern California Campus	Private profit	$30,864,515.37
National University-San Diego	Private non-profit	$29,959,505.74

Data Source: 2015 CBS Report

A. This same HELP Committee report also found that taxpayers are paying twice as much on average to send a veteran to a for-profit college for a year compared to the cost at a public college or university. Is this still the case?

Response. Yes, with regard to tuition and fees paid to schools, VA pays twice as much on average to send a Veteran to a for-profit college for a year compared to the cost at a public college. Please see table below for the average amount paid to schools (for tuition and fees) per student in FY 2015.

Type of School	Tuition and Fees Paid	Average per Student in a Year
For-profit schools	$2.0B	$8,254
Public schools	$1.7B	$4,362

Data Source: 2015 CBS Report

Response to Posthearing Questions Submitted by Hon. Mazie K. Hirono to U.S. Department of Veterans Affairs

VETERAN HOMELESSNESS

Question 45. Current estimates from the Department of Housing and Urban Development indicate that approximately 48,000 veterans are homeless on any given night. Meanwhile, the National Coalition for Homeless Veterans indicates that approximately 1.4 million other veterans are at risk of homelessness. Could you elaborate on how you envision the VA's transformation strategy will work to better collaborate with DOD to prevent further instances of homelessness among transitioning veterans?

Response. In collaboration with DOD and the United States Interagency Council on Homelessness, VA VHA Homeless Programs Office and Care Management and Social Work Services has developed a new initiative to prevent and end homelessness among Transitioning Servicemembers. This new holistic approach to transition preparation includes Servicemembers planning for post-separation finances, housing, transportation, employment, and family and social support. For those Servicemembers who are determined to be at risk of homelessness, a referral will be made to a VA medical facility for the coordination of health care and housing services facilitated by the Transition and Care Management (TCM) team.

Key to this initiative are the VA Liaisons for Health Care, licensed social workers or registered nurses, who are strategically placed in Military Treatment Facilities

(MTF) with high concentrations of ill and/or injured Servicemembers and those returning from combat. VA has 43 VA Liaisons for Healthcare stationed at 21 MTFs to facilitate the transfer of Servicemembers from the MTF to a VA health care facility closest to their home or most appropriate location for the specialized services their medical condition requires. VA Liaisons are co-located with DOD Case Managers at MTFs and provide onsite consultation and collaboration regarding VA resources and treatment options. VA Liaisons meet with Servicemembers directly to discuss the VA system of care and the individual's health care needs. VA Liaisons provide direct access to care for transitioning Servicemembers and ensure that VA care is personalized, proactive, and patient-driven to meet the unique needs of each new Veteran. If housing needs are identified at the time of transition, VA Liaisons communicate this information to the receiving VAMC so ongoing services can be coordinated. The goal with each referral is for the Servicemember to leave the MTF registered for VA health care with a scheduled VA appointment.

At sites without a VA Liaison for Healthcare, a VA Benefits Advisor will make a warm handoff to a Homeless Prevention point of contact at the VAMC who is an expert at identifying and accessing VA and community homeless resources.

Question 46. It is encouraging to see that the President's FY 2017 budget includes $1.6 billion for programs that will continue VA's efforts to end veterans' homelessness. I also appreciate the work that VA has done to reduce veterans' homelessness in the last several years, whereas Veteran homelessness has declined by 36% between 2010 and 2015. What kind of impact does VA project toward lowering the rate of homeless veterans throughout the Nation with the requested funding level?

Response. The kind of progress reflected in the declining Point-in-Time estimates affirms that the strategies and systems that VA, together with the Department of Housing and Urban Development and community partners, has implemented are working. The requested increase in the FY 2017 VA homeless-services budget request is needed to sustain its continuum of care for not only homeless and at-risk Veterans but for those Veterans who have obtained permanent housing yet still require supportive services in order to maintain housing stability. VA has made unprecedented efforts to promote the services available to Veterans who are homeless or might become homeless. As a result of the success of the effort and targeted resources, more Veterans than ever before are seeking out VA. Since 2010, demand for VA homeless-related services has increased by 136 percent (FY 2010: 127,070—FY 2015: 300,108 Unique Veterans accessing VHA homeless services). There has been a 7.8 percent increase in demand for homeless services since this time last year (January 2015: 164,224 to January 2016: 178,139).

Communities that have reached the goal or are close to effectively ending homelessness rely heavily on VA targeted homeless resources. Communities that have developed a sustainment plan are dependent on those resources to remain available as they continue to tackle homelessness. The systems we have in place will make sure that the experience is measured not in months or years, but in days if sustained. Therefore, VA remains focused on ensuring adequate resources that address the needs of Veterans who may become or are at-risk of homelessness and sustain the supports for Veterans who have moved into permanent housing so that they maintain housing stability and do not fall back into homelessness.

DOD/VA HEALTH RECORD INTEROPERABILITY

Question 47. Secretary McDonald, in your testimony you indicate that one of VA's breakthrough outcomes for 2016 is to finalize congressionally mandated DOD/VA interoperability requirements at the Office of Information and Technology. Could you comment on the specific metrics that VA is using to measure interoperability? What is the 2016 timeline for when these requirements will be fulfilled?

Response. Our key measure of interoperability between VA and DOD is a clinician's ability to access all health information required to provide optimal care for Veterans and Servicemembers. To ensure we are exchanging this information effectively, the DOD/VA Joint Interoperability Plan (JIP) includes details regarding the Departments' efforts to standardize terminology, content, exchange methods, and access to shared health information. The JIP also addresses the Departments' efforts to exchange health information securely, flexibly, and in compliance with national standards and relevant privacy laws. Currently, JLV is used by both VA and DOD for a complete view of a Veteran or Servicemember's longitudinal record. Later this year, JLV will also provide direct access to radiographs and other images. Imaging study reports are already included in JLV today. As VA continues improving our point-of-care health record interface with the enterprise Health Management Platform, all current capabilities of JLV will be included in the new system.

The Departments certified that we have achieved the interoperable capability required in Section 713 (b)(1) of the 2014 National Defense Authorization Act on April 8, 2016,—approximately 8 months ahead of the deadline.

The summary of Interoperability Metrics and Milestones, extracted from the JIP, is embedded below for additional detail.

Office of Information & Technology (OI&T)

Architecture, Strategy and Design (ASD)

Product Platform Management (PPM)

Interoperability Metrics & Milestones

March 21, 2016

Table of Contents

List of Tables

Appendices

1. Introduction

The Department of Veterans Affairs (VA) has/will meet/met the requirements of Public Law 113-66 (P.L. 113-66), SECTION 713 – "ELECTRONIC HEALTH RECORDS OF THE DEPARTMENT OF DEFENSE AND THE DEPARTMENT OF VETERANS AFFAIRS," of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2014. by December 31, 2016, by achieving an interoperable Electronic Health Record (EHR) with an integrated display of data with the Department of Defense (DoD) and private providers. Section 713 requires an integrated display of data complying with national standards and the deployment of a modernized electronic health record that continnes to snpport standards based interoperability adhering to several design principles including adherence to national standards. The law's interoperability section required all relevant data for clinical encounters be mapped and available for use in for both departments. This is being accomplished through JLV or successor applications.

VA has/will meet/met the interoperability requirement in Section 713 with the deployment of the Joint Legacy Viewer (JLV). Through JLV, all relevant data for clinical encounters will be mapped and available for use at the point of care in both departments. VA has met the requirements of the law with the deployment of JLV utilizing mapped data, but the JLV is the beginning, not an end state. Interoperability is a path of continual improvement that evolves over time. VA will remain focused on improving and enhancing interoperability with DoD and the private sector as national data standards advance over time.

VA will achieve Generation 3 requirements stipulated in Section 713 by deployment of VistA Evolution. When deployed, eHMP (the replacement for VA's current display, CPRS) will bring evidence based medicine to the point of care. It will provide end user clinical encounter and care coordination transaction capabilities, data visualization, and decision support integration between Provider, Patient, and System facing components and devices.

VistA Evolution is intended to go beyond the requirements of the law and achieve the intent of tbe law: improved care for Veterans, Servicemembers and all eligible beneficiaries.

Interoperability capabilities will be achieved within the overarching VistA Evolution product delivery schedule. The path to interoperability evolves and builds upon existing progress year by year until achievement of the FY 2014 NDAA directive to provide "seamless electronic sharing of medical health data" between the Departments by December 31, 2016. Interoperability is a path of continual improvement and a permanent commitment, and is not an end-state. VA will remain focused on continued interoperability as health discoveries and data standards evolve over time, in close coordination with DoD DHMS Program Executive Office, DoD DMIX Program Office, DoD DHMSM Program Office, the DoD/VA IPO, and ONC.

The targeted DoD/VA EHR interoperability framework is intended to enable the secure, reliable, context-sensitive management and delivery of requested health information among health care delivery partners supporting access to a comprebensive and well-integrated virtual patient record. This framework provides a standards-based foundation of data, terminologies, information structures, and data interchange services, which together constitute the candidate clinical terminology services. Through the establishment of this framework, enterprise-wide exchange of clinically relevant health information, including essential semantically interoperable data, can be ensured.

2. Purpose

The purpose of this document is to respond to provide VA metrics and timeline for achieving interoperability. This document describes VA's metrics related to the VistA Modernization program that are traceable to the FY14 NDAA requirements through the Joint Executive Committee (JEC) strategy, and in alignment with goals and technical interoperability objectives set forth in the Joint Interoperability Plan (JIP).

3. Joint Interoperability Plan (JIP)

The Joint Interoperability Plan (JIP) is published as a guide for interoperability technical vision of VA and DoD. Coordinated care and communication between patients and their providers, as well as across public health entities, using seamless data integration is designed into this plan. The plan has two major components, the foremost being the seven technical interoperability objectives. The Departments' technical objectives for interoperability are focused on data availability, standardization, utility, and security.

Interoperability shall ensure that all data shared between the DoD, VA, and our private sector partners is secure, available for providers at the right time and right place, and usable in the appropriate context to support decision making for timely and effective patient care. To achieve the seven technical objectives the Departments are addressing two critical characteristics of interoperability:

1. The ability of two or more systems to exchange information.
2. The ability of those systems to use the information that has been exchanged.

Effective and efficient interaction of patients and providers with the Departments' health IT systems is critical; user-centered design is therefore a necessity. Both data consumers and data producers will be involved in the engineering processes for achieving technical objectives, since shared data is ultimately used by people, not computers. The seven technical objectives for interoperability include:

1. Standardize Terminology
2. Standardize Content
3. Standardize Exchange Methods
4. Standardize Access
5. Design Flexibility and Modularity
6. Protect Privacy and Security
7. Compliance with National Standards Organizations

3.1 JIP Objective 1 - Standardize Terminology

The semantic alignment of terms within VA requires a comprehensive, non-trivial, perpetual lifecycle approach. VistA legacy services are not fully compatible with, nor supported by existing National Standards. Therefore, direct mapping is required while newer approaches are being sought. These standards must evolve as the interoperability design matures. Successful execution of terminology standardization requires a centralized maintenance process to keep data current with applications and emerging national standards. The metrics needed to track these evolving standard will also need adaptive expansion.

Table 1a: JIP Objective 1 Metrics

Critical Success Factor	JIP Key Technical Performance Indicator	Recommended Indicator	Product/Service Affected
(I) Implement integrated computable data mapped to National Standards.	2.1 Assess semantic language consistency through validation and verification of shared data elements mapped to national standards throughout implementation testing.	2.1.1 - Percentage of elements in twenty-one useable domains mapped to National Standards in CY 2015 compared to total ICIB domain elements approved.	VistA Exchange, Bidirectional Health Information Exchange (BHIE)
		2.1.2 - Percentage of the ICEB clinical data elements that are shared from DoD to VA in a Transition of Care	

Table 1b: JIP Objective 1 Milestones

Milestones	Scheduled Delivery
Mapping of group 1 (first 12 domains)	May 27, 2015
Mapping of group 2 (6 domains)	October 16, 2015
JLV provides all (relevant) VA data domains	September 30, 2015
JLV provides all (relevant) VA data domains with data including	September 30, 2015
Mapping of group 3 (3 domains)	November 13, 2015
Complete set of domains mapped (21)	November 13, 2015
Native Terminology standardization	December 31, 2016

3.2 JIP Objective 2 - Standardize Content

Content structure standards address the syntax or the way data is formatted. Syntax is at the core of the most commonly known health information standards, such as Health Level Seven (HL7) v2.x and Consolidated-Clinical Document Architecture (C-CDA). Metrics for this objective highlight both the content structure and the accompanying syntactic model to affirm necessary and sufficient operation of the design. Development of applicable standards for the Departments' information sharing systems is still evolving and will eventually include the emerging HL7 Fast Healthcare Interoperability Resources (FHIR) standard. These content structures will support transitions of care, patient care summaries as well as other data sharing requirements for benefits adjudication.

Table 2a: JIP Objective 2 Metrics

Critical Success Factor	JIP Key Technical Performance Indicator	Recommended Indicator	Product/Service Affected
(II) Implement integrated computable data mapped to National Standards.	2.2 Track implementation of consistent syntactic language for interoperability terminology by the number of shared data messages validated and verified during implementation period.	2.2.1 Percentage of data messages properly processed by the message structure compared to number sent during the period of implementation testing.	Data Access Service (DAS), Electronic Health Exchange (eHX), Enterprise Message Infrastructure (eMI), Clinical Data Repository/ Health Data Repository (CHDR), Virtual Lifetime Electronic Record (VLER) Health Information Exchange (HIE)
		2.2.2 Clinical Data Repository/ Health Data Repository (CHDR) Clinical Update Success Rate (DoD to VA)	
		2.2.3 Percentage of C-CDA messages successfully provided by VLER HIE compared to number requested by the external partners	

Table 2b: JIP Objective 2 Milestones

Milestones	Scheduled Delivery
Purpose of Use emergency requirement implemented in VistAWeb - CCD Service Interface	February 2016
Patient Discovery requirement met with VistAWeb - CCD Service Interface	October 2015

3.3 JIP Objective 3 - Standardize Exchange Methods

Development of applicable standards for the Departments' information sharing systems is still evolving. Consistent and standardized data exchange between the Departments' including network services, transaction protocols, regulatory compliance, information management and security is being accomplished via the BHIE and FHIE. As an essential part of the interoperability implementation, Q4 FY16 will retire both these exchanges as newer, replacement systems are in place. VLER Health Information Exchange will continue to be the primary query-based method by which VA exchanges data with external partners.

Table 3a: JIP Objective 3 Metrics

Critical Success Factor	JIP Key Technical Performance Indicator	Recommended Key Results Capture	Recommended Indicator[1]	Product/Service Affected
(I) Implement interoperable, real time medical data sharing with a single integrated display. (III) Deploy a modernized electronic health record supporting clinical decision making.	2.3 Implement content structure enabling meaningful data exchange for clinical decision support.	2.3.1 Increase in monthly data sharing transactions (xx TBD) percent for each interoperability component during FY16.	2.3.1.1 Increasing number messages sent over (interval TBD) by VA and received by DoD.	BHIE Framework (Sustainment)
			2.3.1.2 Trend for increasing number messages sent by DoD and received by VA monthly.	BHIE Framework (Sustainment)
			2.3.1.3 Number Direct messages sent & received weekly.	Direct Secure Messaging
			2.3.1.4 Number VA providers accessing system.	Direct Secure Messaging
			2.3.1.5 Increasing average monthly JLV users (number TBD) compared to number consolidated uses of BHIE, CPRS RDV, and VistAWeb.	JLV, BHIE Framework, CPRS RDV, VistA RDV
			2.3.1.6 Average Transaction Response Time Performance	JLV, BHIE, VLER
			2.3.1.7 Trend for increasing VA clinicians viewing community Health Summaries	VLER VHIE
		2.3.2 Increase in number of eHealth Exchange users by (xx TBD) percent per month.	2.3.2.1 Number of authorized veterans accessing system monthly.	VLER VHIE
			2.3.2.2 Trend of the increase in exchange partners in production monthly.	VLER VHIE
		2.3.3 Cumulative variance from development plan for cut over from JLV use to eHMP production operation.	2.3.3.1 Increase in number of eHMP users by month compared to FY16 target.	eHMP

[1] This column added as an example of a KPI expanded into additional PIs and links performance to major components or services. These PIs (normally tracked at the project level in PMAS) support KPI accomplishment and expand upon the KRI results. For example, there is potential for further sub-division into topics such as: a) number queries by providers, b) number consultation reports and, c) other items of clinical interest. This process could expand to include performance monitoring such as a ratio of successful (requires definition of success) or failed transactions, thereby providing linkage to VistA Evolution technical metrics evolving during IOC and then following FOC.

7

Table 3b: JIP Objective 3 Milestones

Milestones	Scheduled Delivery
Pre-Fetch implemented for eHealth Exchange	February 2016
VAP Enhancements - VA Social Security Administration (SSA) enhancements to enable the exchange of veteran records with SSA for the purpose of disability adjudication.	February 2016
eMI increment 4 complete	December 2016
JLV (within VA) transitioned to getting DoD data from the Data Exchange Service (DES) via eMI (rather than via BHIE Relay Service)	January 2016
eHMP transitioned to getting DoD data from DES	November 2015
Shutoff CAPRI's DoD data tab (currently, the CAPRI DoD data tab receives data via the BHIE Framework/BHIE AHLTA)	FY16Q4

3.4 JIP Objective 4 - Standardize Access

Users and systems must share data in a manner making it available, reliable and accessible to the enterprise. Data access will be available to any user or application except as limited by policy, regulation or security. Data should be easily accessible to veterans and empower them to become partners in their healthcare.

Table 4a: JIP Objective 4 Metrics

Critical Success Factor	JIP Key Technical Performance Indicator	Recommended Indicator	Product/Service Affected
(V) Provide timely, and continuously improve access to health care and services. (VI) A patient portal to personal medical records assessable to authorized providers.	2.4. Provide reliable and easily assessable data that enables a steady increase in number of authorized users along with increasing individual frequency of use during FY16.	2.4.1 – Number of users connecting through MEDCOI VPN to VA Medical Treatment Facilities monthly.	Med-COI DAS
		2.4.2 Number trouble tickets open for failure to connect compared to satisfactorily number resolved (a Corrective action metric).	DAS, GTDB, BHIE Framework, DoD/VA Gateways, JLV, eHealth Exchange
		2.4.3 Increase in number records retrieved via Blue Button per month.	Blue Button[2]
		2.4.4 Monthly increase in number new users accessing Blue Button[3].	Blue Button
		2.4.5 Monthly increase in number of records viewed in JLV	JLV
		2.4.6 Rate of message flow migration from Vitria Interface Engine (VIE) to eMI monthly.	eMI
		2.4.7 Number of queries by approved VA personnel successfully accomplished.	eMI
		2.4.8 Cumulative variance in days from plan for production cut over from VIE to eMI FOC.	VIE eMI
		2.4.9 Frequency use of VAP and workload impact in restricting sharing a veteran's VA health information to Community Health Partners.	VAPE

Table 4b: JIP Objective 4 Milestones

Milestones	Forecast Delivery
eHealth Exchange deployment inflow	FOC TBD

[2] The direct connection of the veteran to the system and by design, with the provider has significant effect on perception of care coordination, therefore the technical data will only indicate the system is working "per design". Client satisfaction with the system operation and perception of provider or Patient Aligned Care Teams is better captured through end user feedback via Consumer Assessment of Healthcare Providers and Systems (CAHPS) or (SHEP).

[3] Approximately 14% of veterans enrolled in the VA health care system (~8.92M) are using Blue Button as of July 2015. No known goal.

3.5 JIP Objective 5 - Design for Flexibility and Modularity

The VA is modernizing VistA, called VistA 4, and the DoD is implementing the Defense Health Management System Modernization (DHMSM) system to enable technical insertion and innovation flexibility. An essential element of VistA Evolution will be implementation of service-oriented architecture (SOA). Incorporating loosely coupled, independent services allows independent operation of these services, service reuse and quick adaption to changing business requirements without starting from scratch when upgrades or enhancements are needed. VistA 4 will also consolidate current systems, and incorporated roust interfaces to support modular design of products and services. Some of these design goals are a work in progress so metrics are still being defined to synchronize with the JIP Objectives.

Table 5a: JIP Objective 5 Metrics

Critical Success Factor	JIP Key Technical Performance Indicator	Recommended Indicator	Product/Service Affected
(VI). A modernized EHR design embodying proven technology insertion strategies and product upgrade techniques.	2.5 Reduce VistA 4 complexity, promote reuse, and improve business agility (with SOA design).	2.5.1 Trend showing number of enterprise services registered in the SOA platform monthly.	DAS (VLER), VIE & STA 200 to eMI (ESB), VistA Services Assembler (VSA)
		2.5.2 Number of Patient Registration messages successfully transmitted through the SOA Platform	

Table 5b: JIP Objective 5 Milestones

Milestones	Scheduled Delivery
VSA IOC complete and FOC completion	April 2016, November 2017 respectively
VSA Phase 2 FOC	December 2016
eMI connects with DMIX DES	FY16Q3
Vitria Interface Engine migration to eMI	April 2016 (Paused)

3.6 JIP Objective 6 - Protect Privacy and Security

VistA 4 will provide data security for data, both in transit and archived in storage through data encryption. The use of SOA addressed in JIP Objective 5 will have an authentication component. Confidentially and security of Personally Identifiable Identification Information (PII) and Protected Health Information (PHI) across enterprise boundaries and will meet National Institute of Standards and Technology (NIST) SP 800-137 guidance. JIP Objective 4 addresses control of access, a key element, as well. Secure interoperability access to health record information across the Departments is also being implemented to address emergency care situations.

Table 6a: JIP Objective 6 Metrics

Critical Success Factor	JIP Key Technical Performance Indicator	Recommended Indicator	Product/Service Affected
(II) Provide secure, interoperable medical data sharing in real time to a single integrated display.	2.6 Implement interoperable security software with controlled access to protect sensitive health information in transit and in storage.	2.6.1 Number of times system security breached compared to total number access attempts.	IAM, DSM, JLV, cHMP
		2.6.2 Number of failed authorized access attempts made compared to total attempts made.	
		2.6.3 System reliability weekly trend.	
		2.6.4 Data availability and integrity monthly trend.	

Table 6b: JIP Objective 6 Milestones

Milestones	Scheduled Delivery
VistA Access Enhancements milestone one approved	November 12, 2015
Veterans Authorizations Preferences Enhancements	Increment 1 Development - November 20, 2015
Direct Secure Messaging Increment 2 start; Regression test and UAT start.	November 16, 2015 and December 7, 2015 respectively

3.7 JIP Objective 7 - Compliance with National Standards Organization

The IPO Healthcare Information Interoperability Technical Package (I2TP) identifies the required national health data interoperability standards as agreed to by the Departments for acquisition programs and technical solution design specifications. Where progressive data interoperability deployment initially implements a new or evolving standard, alignment of that standard to the demands of interoperability requirements and specific content will be made. The VEIP addresses a process for initial standards selection accommodating interoperability development plans.

Table 7a: JIP Objective 7 Metrics

Critical Success Factor	JIP Key Technical Performance Indicator	Recommended Indicator	Product/Service Affected
(VII) Adapt national health data interoperability standards as available or as they evolve per IPO guidance.	2.7 Adapt and implement national health data standards incrementally to accommodate phases of interoperability deployment per IPO guidance.	2.7.1 National standards incorporated in system design compared to total number of existing standards approved in IPO guidance.	VistA Exchange, DAS,VistA,CHDR, VETS, JMeadows
		2.7.2 Number of new standards approved monthly compared to number of required data standards identified but without an approved Standards determination.	CTS, TTS
		2.7.3 Percentage of data domains with mapped standards or common format	CTS, TTS
		2.7.4 Progressive implementation of new standards to accommodate interoperability requirements within (XX days-TBD) of approval success	VistA Exchange, DAS,VistA,CHDR, VETS, JMeadows
		2.7.5 Monthly trend of increase in number data elements recorded natively or included in common format in approved data domains.	CTS, TTS
		2.7.6 Verify number of standards identified per Domain correlating with I2TP monthly.	CTS, TTS
		2.7.7 Number of active terms mapped monthly to the standards verified as correlated to I2TP standards.	CTS, TTS

Table 7b: JIP Objective 7 Milestones

Milestones	Delivery Date
First maintenance release for data domain groups 1, 2, and 3	Begin FY16Q4 and complete FY16Q1
Second maintenance release for data domain groups 1, 2, and 3	Begin FY16Q1 and complete FY16Q3
Third maintenance release for data domain groups 1, 2, and 3	Begin FY16Q2 and complete FY17Q1
Fourth maintenance release for data domain groups 1, 2, and 3	Begin FY16Q4 and complete FY17Q2
Fifth maintenance release for data domain groups 1, 2, and 3	Begin FY17Q2 and complete FY17Q2

Appendix A: Comparison of NDAA Strategic Objectives, JIP Technical Objectives and Critical Success Factors

NDAA Interoperability Strategic Objectives[4] (w/NDAA Section 713 reference)	JIP Technical Objectives (with JIP section reference)	Recommended Critical Success Factors
Deploy a national healthcare system with interoperable data exchanges providing seamless, near real time data sharing to a single integrated display between VA and DoD and with private sector providers by December 31, 2016. Section 713 (b)1	2.1 Standardize Terminology - Implement consistent semantic language for interoperability. 2.2 Standardize Content Structure - Implement consistent syntactical data formats and content structures enabling meaningful data exchange for clinical decision support. 2.3 Standardize Exchange Methods – Provide consistent and standardized method(s) to exchange data.	I. Incorporate integrated, computable data mapped to National Standards. II. Provide secure, interoperable medical data sharing in real time to a single integrated display III. Provide targeted, well-designed care coordination (i.e. transition of care, benefits determination and patient care summaries).
Deploy a modernized electronic health record using integrated, computable data mapped to national data standards with continued support and compatibility of interoperability goals. Section 713 (b)2, (c)2	2.1 Standardize Terminology - Implement consistent semantic language for interoperability. 2.7 Compliance with National Standards Organizations – Adapt and implement national health data interoperability standards incrementally to accommodate phases of interoperability deployment per DoD/VA IPO guidance.	I. Incorporate integrated, computable data mapped to national standards. VII. Adopt national health data interoperability standards as available or as they evolve per IPO guidance.
Provide a secure, remote network-accessible health data storage system enabling veterans to electronically upload or download their personal medical records and make that information accessible to medical providers delivering care to the patient by CY15. Section 713 (c)5(C)	2.4 Standardize Access – Reliable and accessible data for authorized users that has properly controlled access to health record data. 2.6 Protect Privacy and Security – Interoperable security software to protect sensitive health information in transit and in storage with controlled access.	V. Provide timely and continuously improve access to health care and services. VI. Provide a patient portal personal medical records assessable to authorized providers.
Establish a health data authoritarian source assessable by multiple providers and standardize the input of new medical data. Section (c)5(A)	2.1 Standardize Terminology - Implement consistent semantic language for interoperability. 2.2 Standardize Access – Reliable and accessible data for authorized users that has properly controlled access to health record data.	V. Provide timely and continuously improve access to health care and services.

[4] The list of objectives is subjectively consolidated to abbreviate the redundant nature of Section 713 subsection(s) wording.

Deploy a national healthcare system by December 31, 2016 to provide consistently effective and efficient operations for patient access to care, care coordination, and timely adjudicated benefits delivery to veterans and veteran's beneficiaries. Section (c)1 and JEC Goal 2	2.4 Standardize Access – Reliable and accessible data for authorized users that has properly controlled access to health record data. 2.6 Protect Privacy and Security – Interoperable security software to protect sensitive health information in transit and in storage with controlled access.	V. Provide timely and continuously improving access to health care and services. V. Provide a patient portal personal medical records assessable to authorized providers. IV. Deploy a modernized EHR supporting clinical decision making.
Integrate open architecture standards in design of a modernized EHR that includes lifecycle sustainment planning using proven technology insertion strategies and product upgrade techniques. Section 713 (c)3c	2.5 Design for Flexibility and Modularity – An interoperable architecture to reduce complexity and promote component reuse.	VII. Deploy a modernized EHR design embodying proven technology insertion strategies and product upgrade techniques.
Deploy a patient-centered, integrated and interoperable healthcare system conforming to a Generation 3 EHR which will provide a patient's comprehensive health record, and promote continued improvement in clinician operations by FY18. (c)4	2.2 Standardize Content Structure - Implement consistent syntactical data formats and content structures enabling meaningful data exchange for clinical decision support. 2.6 Privacy and Security – Interoperable security software to protect sensitive health information in transit and in storage with controlled access.	VIII. Deploy a Generation 3 Electronic Medical Record by FY18.

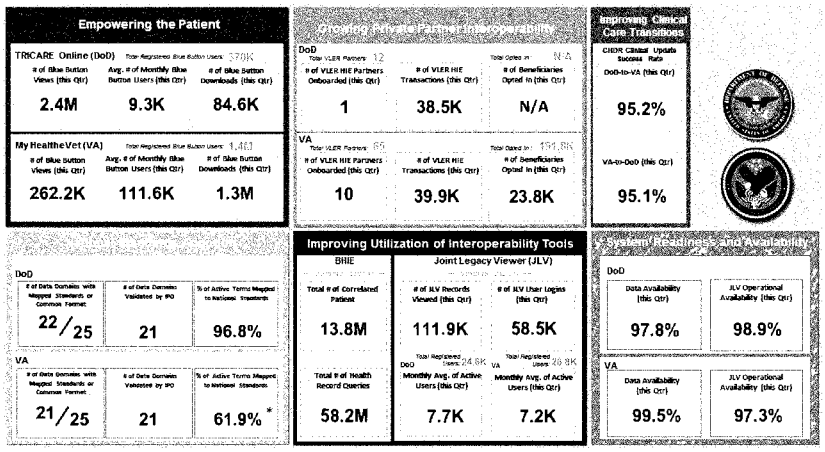
Appendix B: Approved Data Domains[5]

	Data Domain	National Standard Terminology
1.	Allergies (Multiple Types)	Initial: UMLS Target: Drug-RxNorm
2.	Medications	RxNorm
3.	Immunizations	CVX – Vaccines Administered
4.	Problem Lists	SNOMED CT
5.	Vital Signs	LOINC Vitals Subset
6.	Documents (Multiple Types)	LOINC Document Types
7.	Results – Lab Chemistry & Hematology	LOINC
8.	Results – Lab Anatomic Pathology	LOINC
9.	Results – Lab Microbiology	LOINC
10.	Results – Radiology Reports	LOINC
11.	Encounter Data – Appointments	Encounter DXs – SNOMED CT
12.	Encounter Data – Admissions	Encounter DXs – SNOMED CT
13.	Procedures	CPT4/HPCS
14.	Demographics	Ethnicity & Race ISO 639-2 alpha-3
15.	Social History	SNOMED CT
16.	Family History	SNOMED CT
17.	Scanned & Imported Paper Records & Non-Radiology Images	LOINC (For Document Type) PDF-A, Text, JPEG, etc. (For File Type)
18.	Plan of Care – Pending Orders, Med Orders	RxNorm
18.a	Plan of Care – Pending Orders, Lab Orders	LOINC
18.b	Plan of Care – Pending Orders, Rad Orders	LOINC
18.c	Plan of Care – Pending Orders, Consult Orders	NONE
19.	Radiology Images	DICOM (Format not Terminology)
20.	Payers	ASC X12N Health Insurance Types
21.	Questionnaires (General & Standard Instruments)	LOINC (Document Type)

[5] Approved by the Health Executive Board subgroup the Interagency Clinical Informatics Board

22.	Functional Status	SNOMED CT (Emerging)
23.	Providers	Provider Type: NUCC Taxonomy
24.	Advance Directives (Metadata Only)	Advanced Directive Type: SNOMED CT
25.	Medical Equipment	Device Type: UMDNS (Emerging)

HDI Metrics Dashboard FY16Q1



N/A denotes data is not available yet

** denotes percentage may not be precise due to lack of frequency data; domains recorded natively are not included; revision expected in FY16Q2*

Healthcare Information Interoperability Technical Package

Version 5.0

DoD/VA INTERAGENCY PROGRAM OFFICE
November 2015

THIS PAGE INTENTIONALLY LEFT BLANK.

Approved by

Lauren C. Thompson, Ph.D. Director DoD/VA Interagency Program Office	Date	Brian P. Burns Deputy Director DoD/VA Interagency Program Office	Date

THIS PAGE INTENTIONALLY LEFT BLANK.

Executive Summary

One of our Nation's highest priorities is high-quality health care for active duty and retired Service members, their families, and our Veterans. The Department of Defense (DoD) and Department of Veterans Affairs (VA) seek to seamlessly integrate DoD and VA electronic health record data to improve health status for all beneficiaries. A key element in this vision is transforming the care delivery system to achieve health information technology (IT) interoperability, which will allow for better care, smarter spending, and healthier people. Over the past 15 years, DoD and VA have transitioned from a paper-based sharing of information to a digital exchange of information. Today, more than 6.3 million correlated patient records are jointly accessible and more than 1.5 million pieces of health data are shared daily; however, the Departments currently share only a limited amount of standardized, computable data partly due to complex and evolving health data interoperability standards.

Successful health data interoperability requires common agreement and appropriate implementation of multiple components, including:

- Vocabulary/Terminology: vocabulary and code sets used within the content/structure mapped to national standards (semantic interoperability).
- Content/Structure: the way data is formatted (syntactic interoperability).
- Transport and Security: a means of electronically transferring data using agreed upon common network services, security standards, and standardized transaction protocols for data exchange. Transport and security standards are not unique to the health care industry.

This Healthcare Information Interoperability Technical Package (I2TP) focuses on the Vocabulary/Terminology and Content/Structure standards as they represent the most immediate opportunities for improved interoperability between the Departments. While transport and security standards are key building blocks in achieving interoperability, several existing health exchange frameworks address the immediate interoperability needs of the Departments with regard to these standards.

During the past year, Departments and the DoD/VA Interagency Program Office (IPO) have expanded the functionality of the Joint Legacy Viewer (JLV) by applying the I2TP identified national standards. The IPO will continue working closely with the Departments to monitor and advance the quality of clinical data mappings to enhance interoperability between the Departments, other government entities, and private sector providers. In addition, the IPO will also leverage, as applicable, the relevant assets from Office of the National Coordinator (ONC) for Health IT via the Standards and Interoperability (S&I) Framework or Federal Health Architecture (FHA) initiatives.

Revision History

Release/ Revision No.	Date	Author	A=Add M=Modify D=Delete	Description of Change
1.0	April 11, 2014	IPO	A	Version 1.0 (initial baseline)
2.0	August 5, 2014	IPO	M	Incorporated comments received after the April 11, 2014 Version 1.0 Release, including feedback from May 2014 stakeholder engagement meetings. Incorporated comments from Veterans Affairs Intranet Quorum (VAIQ)/Staff Action Control and Coordination Program (SACCP) process.
3.0	November 18, 2014	IPO	M	• Medical Equipment was Universal Medical Device Nomenclature System (UMDNS), a footnote was added to note Department discussions occurring on an update to Global Medical Device Nomenclature (GMDN) • Refined Near-Term (FY2014-16) Data Interoperability Architecture - Exchange Methods figure • Aligned I2TP V3.0 Section 1.4 Technical Objectives with the latest version of the Joint Interoperability Plan (JIP) • Adjustment of the Clinical Data Domains to reflect the ICIB decision going from 28 to 25 domains • IPO-recognized as a status for a standard caused too much confusion, so IPO updated standard status to either be approved, emerging, or interim • Edits through-out document based on comments to clarify or improve wording • New appendix "Narrative of Near-Term (FY 2014-16) Data Interoperability Architecture-Exchange Methods" • New appendix "Links to Standards" that lists all standards and a reference link to the standard or more information for that standard • New appendix "Terminology Standard Traceability Table" that provides traceability between V2.0 and V3.0 Standards Terminology matrix

Release/ Revision No.	Date	Author	A=Add M=Modify D=Delete	Description of Change
4.0	May 2015	IPO	M	• Established a tighter connection with HDIMP and JIP by: added paragraph describing relationship with amongst I2TP, JIP, and HDIMP; removed redundancy to de-conflict with HDIMP and added reference to it; removed Emerging Standards section and added relevant contents to Section 2; removed the consolidated CDA section. • Aligned components to ONC's "A Shared Nationwide Interoperability Roadmap" by changing: Content to Vocabulary/Terminology; Content Structure to Content/Structure; and Exchange Method to Transport throughout the document. • Corrected Virtual Lifetime Electronic Record (VLER) Health exchange in the Near-Term Data Interoperability Diagram. • Removed relationships between Health Level Seven International (HL7) and security. • Consolidated vocabulary/terminology into single reference table. • Updated Architecture Diagram based on Department system updates. • Added section describing the Clinical Interoperability Scenario development effort planned by IPO • Added section describing the ONC 2015 Standards Advisory • Removed column -"current health exchange framework and content/structure "from the Clinical Data Domain and Terminology Summary table. • Updated Table 1: Clinical Data Domain and Terminology Summary • Additional language regarding HDS BL Subgroups and CIS
5.0	August 2015	IPO	M	• Added HL7 C-CDA 2.1, FHCC Orders Portability, and HL7 PIX/PDQv3 as required standards in Section 2.2 • Added HL7 2.2 and HL7 2.3 (LDSI) as interim standards in Section 2.2 • Table 1 - Added HL7 2.5.1, LDSI and FHCC. • Modified Figure 1 Health Interoperability Enterprise Architecture chart: VA eMI added; changed to Data Exchange Service (DES). • Updated Appendix E

THIS PAGE INTENTIONALLY LEFT BLANK

Table of Contents

List of Appendices

List of Tables

List of Figures

1 Introduction

The IPO's mission is to lead the Departments' efforts in implementing national health data standards for interoperability[1] as well as responsible for establishing, monitoring, and approving the clinical and technical standards profile and processes to ensure seamless integration of health data between the two Departments and private health care providers. This document identifies applicable interoperability standards that support data exchange for the clinically relevant data domains, which were prioritized by the DoD/VA Health Executive Committee's (HEC) Interagency Clinical Informatics Board (ICIB) and correspond with guidance from the ONC.

For each standard identified, this document clarifies implementation expectations for the standard by classifying it as required (supported indefinitely), interim (supported until Department-identified sunset date), or emerging (future standards under development supported as needed). The IPO will continue to work with DoD, VA, and ONC to select and mature healthcare standards in order to improve the functional state of interoperability and monitor the Departments' progress toward data standards compliance. The IPO will maintain, update, and refine applicable standards as they mature and as Department implementations are identified and realized.

1.1 Intended Audience

The intended audience of this document are individuals working on Departmental acquisition programs, system/software engineers, functional analysts, enterprise architects, information assurance engineers, and developers implementing interoperability solutions for sharing health data among the Departments, other government entities (e.g., Department of State (DoS), Social Security Administration (SSA), local governments), and private sector providers. Private sector health care providers and external partners include clinicians who have direct contact with and responsibility for patients who receive medical care, patients who reimburse or pay for healthcare services, or any entity in the healthcare continuum.

1.2 Objective

The objective of this document is to identify applicable data interoperability standards that support data exchange for the domains prioritized by the ICIB and align with recommendations published by ONC. These data standards shall inform technical exchange standards for DoD and VA where healthcare information is exchanged among Departments, other government entities, and private sector providers.

1.3 Scope

The focus of this document is the required domain and messaging standards that the DoD and VA are expected to implement to achieve interoperability. This document

[1] The Institute of Electrical and Electronics Engineers (IEEE) Standard Computer Dictionary defines "interoperability" as "the ability of two or more systems or components to exchange information and to use the information that has been exchanged." IEEE Standard Computer Dictionary: A Compilation of IEEE Standard Computer Glossaries (New York, NY: 1990).

identifies standards for near-term (FY16-17) system implementations. Future releases will address standards for mid-term (FY18-22) and long-term (FY2022+) solutions for the "to-be" system environment.

This document is intended to:

- Identify the required national health data interoperability standards for the Departments' use in defining requirements for acquisition programs and technical solution developers in the DoD and VA.
- Provide a list of required standards to facilitate consistency in vocabulary/terminology, content/structure, transport, and security. If additional requirements and guidance beyond the referenced specifications are needed, it will be included in future I2TP releases. Technical requirements and guidance are agnostic to system infrastructures used in implementation.
- Define the IPO-required standards for data domains, vocabulary/terminology, content/structure, transport, and security. These requirements and guidance take the form of simple lists and references to implementation guides and specifications. Future versions may provide detailed implementation profiles to address shortcomings in the standards or unique needs of the Departments.

This document does not address:

- Intradepartmental (i.e., within a Department) transport and security standards or additional infrastructure services that may be used to support the exchange of shared data (e.g., directory services).
- Department data capture or storage.
- Department infrastructures for implementing national standards. Departments are responsible for their tooling and processes for implementing standards as guided by this document.

The I2TP maintains coordination with IPO's two other key deliverables: Health Data Interoperability Management Plan (HDIMP)[2]: high-level process and management framework for the IPO and outlines the management structures and processes necessary to support Departmental implementation of the agreed-upon standards managed in this document and

- Joint Interoperability Plan (JIP)[3]: guide for the Departments' technical vision for interoperability to include plans for achieving seamless data integration and the approach to continuous improvement.

[2] IPO HDIMP (https://intelshare.intelink.gov/sites/ipo/IPOHome/HITStandardsImplementationIntLib/Final_DoDVA_IPO_HDIMP20150708_v2_0%20(Signed).pdf)

[3] IPO JIP (https://intelshare.intelink.gov/sites/ipo/IPOHome/StandardsIdentificationIntLib/IPO_JIP%20MASTERv3_FINAL_20150731.pdf)

1.4 Document Updates

The proper application of the health data interoperability standards specified by the IPO will be guided by the technical decisions and specification products that will be identified in progressive versions of this document. This document will be updated to reflect maturing standards for vocabulary/terminology, content/structure, transport, and security, in order to show the current state of data architecture implementation.

2 IPO Standards Alignment

The IPO adopts and approves standards using its Standards Guidance Establishment Process as documented in the HDIMP. As part of establishing this guidance, the IPO considers functional and technical interoperability needs as verified by the Departments and follows standards selection prioritization criteria documented in the HDIMP. The output from this activity is the selection of technical standards required for development and implementation of electronic health records systems or capabilities that allow for full interoperability of health care information between the Departments.

The IPO classifies selected standards as required, interim or emerging:

- Required standard - A standard designated by the IPO that the Departments must support (e.g., Continuity of Care Document (CCD)).

- Interim standard - A standard currently deployed by the DoD or VA that the Department will replace with a new approved standard. The future approved standard is noted whenever an interim standard is referenced in this introduction. An interim standard must be supported until the Departments agreed-upon sunset date (e.g., HL7 2.2 and HL7 2.3 for Laboratory Data Sharing Initiative).

- Emerging standard - A new standard under development, draft publication, or pilot use. This status may apply to a new Standards Development Organization (SDO) standard or pilot Department project. Departments are not required to support emerging standard. Department may only use an emerging standard where a specific need is not support in currently available standards. An emerging standard has garnered enough interest that it may become a future approved standard and is provided for informational purposes (e.g., Fast Healthcare Interoperability Resources (FHIR)). The IPO's Technical Analyses Process supports emerging standards by investigating and contributing to emerging healthcare interoperability standards. For additional information about this process see HDIMP.

Both Departments are responsible for ensuring their data exchanges with external healthcare partners are implemented in compliance with IPO-required health data interoperability standards. The IPO provides technical support to the Departments' implementation efforts through its Interoperability Implementation Support Process as documented in the HDIMP.

2.1 Clinical Data Domains and Vocabulary/Terminology Standards

The Departments and IPO have designated the clinical data domains, determined the appropriate national standard terminology for the primary data elements in each domain, and mapped local terms to those national standard terminologies.

2.1.1 Approved Clinical Data Domains

Clinical data domains represent functional groupings of data to be shared. Table 1 shows the list of patient clinical data domains approved initially by the Health Executive Committee (HEC) on March 28, 2014 and updated on October 29, 2014. They are prioritized according to their importance for clinical care. The list is based upon two sources:

1. Clinical data domains as described by ONC-endorsed standards (i.e., Consolidated Clinical Document Architecture[4] (C-CDA) sections).[5]
2. Clinical data domains currently used by DOD and VA legacy data sharing capabilities (including some not obviously associated with C-CDA sections).[6]

2.1.2 Vocabulary/Terminology Standards

Table 1 lists the national standard terminology for each primary data element in each clinical domain and the reference for that selection, including entries in the Federal Register, where applicable. While each domain includes multiple discrete data elements, for the purposes of this document, the "primary data element" is the data element in each clinical domain prioritized by the Departments for exchange.

The IPO Status column indicates whether the standard is IPO-required, interim, or emerging. Links to all of these standards can be found in Appendix E - Links to Standards. In addition to the clinical domain primary data element, each domain contains one or more discrete additional (i.e., secondary) data elements. For example, while the primary data element for the Provider domain is "provider type" and the terminology standard is "NUCC Taxonomy," the clinical domain may also include data elements such as name (first, last, middle), office address, contact information (phone, email, etc.), specialty (pediatrician, internist, etc.), identification number, etc. None, some, or all of the additional data elements in each clinical domain may require semantic interoperability when being shared between the Departments and thus require an associated terminology standard/value set. Some of these secondary data elements are critical to achieving semantic interoperability, such as the "units" field for both lab

[4] Formally titled, HL7 Implementation Guide for CDA® Release 2: IHE Health Story Consolidation, DSTU Release 1.1.

[5] It is important to note that some C-CDA section content is divided into multiple subdomains to account for important subcategories. For example, C-CDA "Results" include both radiology reports and lab results that are further subdivided into chemistry/hematology, microbiology, and anatomic pathology, and the "Documents" domain (aka "notes") includes many different document types (e.g., consults, visit notes, discharge summaries, history and physicals). In addition, some clinical data domains may be broad enough that they could be further subdivided. For example, Allergies includes medication allergies, food allergies, and environmental allergies. However, the allergy domain (i.e., "Allergies (multiple types)") is currently addressed only at a high-level.

[6] These legacy data sharing capabilities include the Bidirectional Health Information Exchange (BHIE), the Virtual Lifetime Electronic Record (VLER) Health program, and the Clinical Data Repository/Health Data Repository (CHDR).

results and vital signs; without these elements, a receiving system cannot properly interpret and compare result sets.

Table 1: Clinical Data Domain and Terminology Summary

HEC Approved Priority (29 October 2014)	Clinical Data Domain	Reference/or Standard for Clinical Data Domain[7]	Data Element	National Standard Terminology	IPO Status	Reference for National Standard[8]
1	Allergies (multiple types)	C-CDA 1.1, BHIE, VLER Health, CHDR	Drug Allergen	RxNorm	**Required**	MU2 §170.207(d)(2), C-CDA 1.1
			Drug Allergen	UMLS	Interim	DoD/VA Current Usage
			Drug Class Allergen	NDF RT	Emerging	C-CDA 1.1
			Food Allergen	SNOMED CT	Emerging	C-CDA 1.1
			Ingredient	UNII	Emerging	C-CDA 1.1
2	Medications	C-CDA 1.1, BHIE, VLER Health, CHDR	Medication	RxNorm	**Required**	MU2 §170.207(d)(2), C-CDA 1.1
3	Immunizations	C-CDA 1.1, BHIE, VLER Health	Vaccine Administered	CVX	**Required**	MU2 §170.207(e)(2)
4	Problem Lists	C-CDA 1.1, BHIE, VLER Health	Problem	SNOMED CT	**Required**	MU2 §170.207(a)(3), §170.314(a)(5), C-CDA 1.1

[7] The references to "BHIE" in the Reference for Clinical Data Domain column includes clinical data domains used in the Bidirectional Health Information Exchange (BHIE) Framework and BHIE DoD Adaptor. Standards for BHIE exchange are contained in the relevant ICDs.

[8] Indicates the base source from which the National Standard Terminology was derived and should be referenced directly to gain a better understanding of the full scope of these domains.

HEC Approved Priority (29 October 2014)	Clinical Data Domain	Reference/or Standard for Clinical Data Domain[7]	Data Element	National Standard Terminology	IPO Status	Reference for National Standard[8]
5	Vital Signs	C-CDA 1.1, BHIE, VLER Health	Vitals Type	LOINC (Vitals Subset)	**Required**	C-CDA 1.1
6	Documents (many types)	C-CDA 1.1, BHIE, VLER Health	Document Type	LOINC (Document Types)	**Required**	C-CDA 1.1
7	Results - Lab Chemistry & Hematology	C-CDA 1.1, BHIE, VLER Health, LDSI, FHCC	Result Type	LOINC	**Required**	MU2 §170.207(c)(2), C-CDA 1.1, HL7 2.5.1
8	Results - Lab Anatomic Pathology	C-CDA 1.1, BHIE, VLER Health, LDSI, FHCC	Result Type	LOINC	**Required**	MU2 §170.207(c)(2), C-CDA 1.1, HL7 2.5.1
9	Results - Lab Microbiology	C-CDA 1.1, BHIE, VLER Health, LDSI, FHCC	Result Type	LOINC	**Required**	MU2 §170.207(c)(2), C-CDA 1.1, HL7 2.5.1
10	Results - Radiology Reports	C-CDA 1.1, BHIE, VLER Health, FHCC	Result Type	LOINC[9]	**Required**	C-CDA 1.1
				CPT4	Interim	
11	Encounter Data -- Appointments	C-CDA 1.1, BHIE, VLER Health	Encounter Type	CPT4	**Required**	C-CDA 1.1
			Encounter Diagnosis (Dx)	SNOMED-CT	**Required**	C-CDA 1.1

[9] Beyond 2015 – the Results – Radiology Reports Clinical Domain Squad believes LOINC will be used upon completion of the merger of RadLex with LOINC.

HEC Approved Priority (29 October 2014)	Clinical Data Domain	Reference/or Standard for Clinical Data Domain[7]	Data Element	National Standard Terminology	IPO Status	Reference for National Standard[8]
12	Encounter Data – Admissions	C-CDA 1.1, VLER Health	Encounter Type	CPT4	**Required**	C-CDA 1.1
			Encounter Diagnosis (Dx)	SNOMED CT	**Required**	C-CDA 1.1
13	Procedures	C-CDA 1.1, BHIE, VLER Health (VLER is currently radiology and surgery)	Procedure Type-Outpatient/Clinician	CPT4/HCPCS	**Required**	MU2 §170.207(b)(2)
			Procedure Type-Hospital	ICD-10 PCS[10]	Emerging	MU2 §170.207(b)(4), C-CDA 1.1
				ICD-9 CM	**Required**	MU2 §170.207(b)(1), C-CDA 1.1
14	Demographics	C-CDA 1.1, VLER Health (no known Department source for preferred language)	Ethnicity & Race	OMB/CDC Race codes	**Required**	MU2 §170.207(f), C-CDA 1.1
			Preferred Language	ISO 639-2 alpha-3 codes	**Required**	MU2 §170.207(g), C-CDA 1.1
15	Social History	C-CDA 1.1, BHIE, VLER Health	Social History Entry	SNOMED CT (including smoking status subset)	**Required**	MU2§170.207(h) (1-8), C-CDA 1.1
16	Family History	C-CDA 1.1, BHIE	Family History Entry	SNOMED CT	**Required**	MU2 §170.207(a)(3), §170.314(a)(13), C-CDA 1.1
17	Scanned & Imported Paper Records & Non-Radiology Images	C-CDA 1.1 (unstructured documents), HAIMS	Document Type	LOINC	**Required**	C-CDA 1.1

[10] ICD-10 PCS is required by Oct 1 2015.

HEC Approved Priority (29 October 2014)	Clinical Data Domain	Reference/or Standard for Clinical Data Domain[7]	Data Element	National Standard Terminology	IPO Status	Reference for National Standard[8]
18	Plan of Care- Pending Orders (multiple types)	C-CDA 1.1, VLER Health (lab and radiology orders), Care Management (not currently shared) FHCC	Med Order Item	RxNorm (Med Orders)	**Required**	C-CDA 1.1 HL7 2.5.1
			Lab Order Item	LOINC	**Required**	C-CDA 1.1 HL7 2.5.1
			Rad Order Item	LOINC	**Required**	C-CDA 1.1 HL7 2.5.1
				CPT4	Interim	C-CDA 1.1
			Consult Item	None	No National Standard	None/ C-CDA 1.1 Unstructured Document HL7 2.5.1
19	Radiology Images	HAIMS	Image Format	DICOM (a format, not a terminology)	No National Standard	DICOM
20	Payers	C-CDA 1.1, VLER Health	Insurance Type	ASC X12N (Health Insurance Type)	**Required**	C-CDA 1.1
21	Functional Status	C-CDA 1.1 (no known Dept. source), VLER Health	Functional Status Entry	SNOMED CT	Emerging	C-CDA 1.1
22	Providers	VLER Health, FHCC	Provider Types	NUCC Taxonomy	**Required**	VLER Health C-CDA1.1 HL7 2.5.1
23	Advance Directives (metadata only)	C-CDA 1.1, VLER Health	Advanced Directives Type	SNOMED CT	**Required**	C-CDA 1.1
24	Medical Equipment	C-CDA 1.1 (no known Dept. source)	Medical Equipment Type	UMLS-SNOMED CT[11]	Emerging	Departments' Recommendation

[11] Note this is under discussion with the Departments for potentially being updated to Global Medical Device Nomenclature (GMDN).

HEC Approved Priority (29 October 2014)	Clinical Data Domain	Reference/or Standard for Clinical Data Domain[7]	Data Element	National Standard Terminology	IPO Status	Reference for National Standard[8]
25	Questionnaires (general & standard instruments)	BHIE, VHA (standard instruments)	Document	Unstructured Document with LOINC Document Type	Interim	None/ C-CDA 1.1 Unstructured Document

2.1.3 Clinical Data Domains and Vocabulary/Terminology Planned Activities

The IPO is transitioning focus to documenting secondary data elements by leveraging Clinical Interoperability Scenarios (CIS). A CIS provides a framework for evaluating data exchange needs by describing how clinicians use shared data to diagnose and treat patients. Based on an appropriate context of clinical use, primary and secondary data elements for each clinical domain will be classified with applicable terminology standards and desired level of interoperability (e.g., technical, semantic). The expected outcome of the CIS team effort is a clarification of the Department interoperability needs and corresponding standards selections.

In October 2014, the HEC Co-Chairs approved reorganization into four high level business lines, led by co-leads from each Department, to drive strategic direction, communication and coordination among work groups and between business lines, and to oversee development of milestone-driven deliverables. The Health Data Sharing (HDS) Business Line oversees four use-case subgroups, with the mission to drive continued progress in health data sharing among DoD, VA, and private sector partners to enable health care continuity, active engagement in care, timely and accurate benefits decisions, and continuous improvements in the health and care of Veterans, Service members and other DoD and VA beneficiaries.

The IPO CIS team will collaborate with the HDS use case subgroup's effort. Given the recent realignment of the use case subgroups, future iterations of the I2TP and JIP will reflect updates as the subgroup's efforts progress.

2.2 Content/Structure Standards

Content/structure standards provide the structure that, when used with standard terminology, support semantic interoperability. Semantic interoperability occurs when a data exchange "takes advantage of both the structuring of the data exchange and the codification of the data including vocabulary so that the receiving information technology systems can interpret the data."[12]

Table 2 captures the content/structure standards and associated IPO status.[13]

Table 2: Content/Structure Standards

Content/Structure Standard	IPO Status
HL7 C-CDA 1.1 CCD	Required[14]
HL7 C-CDA 1.1 Unstructured Document	Required
HL7 C-CDA 2.1 CCD	Required[15]

[12] [+ MSS Interoperability definition (http://www.himss.org/library/interoperability-standards/what-is-interoperability)]
[13] IPO-approved standard is a standard designated by the IPO that the Departments must support. See Section 2.1.2.
[14] C-CDA and eHealth exchange is required for external data sharing whenever structured document exchange is appropriate, whether by query or push.
[15] HL7 C-CDA 2.1 Product Brief, (http://www.hl7.org/implement/standards/product_brief.cfm?product_id=408)

Content/Structure Standard	IPO Status
HL7 2.5.1 1. S&I Framework Lab Results Interface 2. Implementation Guide: Electronic Laboratory Reporting to Public Health[16] 3. Implementation Guide for Immunization Messaging, Release 1.4 4. PHIN Messaging Guide for Syndromic Surveillance[17] 5. FHCC Orders Portability	**Required**
HL7 2.4 (CHDR only)	**Required**
HITSP C32	Interim
VDS XML / DES JSON	Interim
HL7 2.2 and HL7 2.3 (LDS!)	Interim
Patient Identifier Cross-Reference HL7 V3(PIXV3) and Patient Demographic Query HL7 V3 15(PDQV3)	**Required**

2.3 Health Exchange Frameworks

Transport and security standards are key building blocks in achieving interoperability. Several existing health exchange frameworks address the interoperability needs of the Departments with regard to transport and security. The IPO recommends alignment with transport and security standards through continued participation with these health exchange frameworks. Future iterations of this document may expand on the standards necessary for transport and security alignment.

These frameworks enable the secure transmission of content complying with the standard vocabulary/terminology and content/structure identified in this document. Each health exchange framework may have multiple health exchange capabilities, each of which is supported by specific transport and security standards. The IPO identifies these health exchange frameworks; the Departments are solely responsible for their implementation. Health exchange frameworks include:

1. **eHealth Exchange** (formerly called Nationwide Health Information Network) – eHealth Exchange is one of the two primary health exchange frameworks promoted by the ONC. It includes the VA Virtual Lifetime Electronic Record (VLER) partnership. The network supports query/response, publish/subscribe, and push-based methods for exchanging health information. Reference The Sequoia Project[18] for a list of current specifications associated with this health exchange framework.

2. **Direct Project** – The Direct Protocol[19] is the other primary health exchange framework promoted by the ONC. It is a push method that is being used to support certain use cases (e.g., referrals), and was designed to be a lightweight

[16] HL7 Version 2.5.1 Implementation Guide: Electronic Laboratory Reporting to Public Health, Release 1 (US Realm) with Errata and Clarifications, and ELR 2.5.1 Clarification Document for EHR Technology Certification.

[17] HL7 2.5.1 Implementation specifications: Public Health Information Network (PHIN) Messaging Guide for Syndromic Surveillance and Conformance Clarification for EHR Certification of Electronic Syndromic Surveillance, Addendum to PHIN Messaging Guide for Syndromic Surveillance.

[18] The Sequoia Project eHealth Exchange (http://sequoiaproject.org/ehealth-exchange/)

[19] The Direct Project (http://directproject.org/)

health exchange framework that could be supported by even the smallest provider organizations. DirectTrust is a collaborative non-profit association of health IT and health care provider organizations to support secure, interoperable health information exchange via the Direct message protocols.

3. **Department-specific Web-Services** (including the VistA Data Services and VistA Exchange) – A collection of exchanges currently occur via custom Department-developed web services, using either Simple Object Access Protocol (SOAP) or Representational State Transfer (RESTful) frameworks.

Table 3 identifies health exchange frameworks in use today by the Departments and their IPO status.

Table 3: Currently Identified Health Exchange Frameworks

Health Exchange Frameworks	IPO Status
eHealth Exchange (VLER Health Exchange)	**Required**
Direct Protocol (MU requirement)	**Required**
Department-specific Web-Services (including the VistA Data Services and VistA Exchange)	Interim

2.3.1 IPO Health Interoperability Enterprise Architecture

Figure 1 depicts the FY2016 data interoperability architecture which shows the secure health exchange frameworks between the DoD and VA.[20]

A common integrated viewer can provide clinician's access to a patient's combined clinical information from both DoD and VA systems and corresponding clinicians, as the ultimate result of data sharing between the Departments' systems.

The figure shows a high-level view of systems for the VA on the left, in yellow, and a high-level view of systems for the DoD on the right, in purple. Large bidirectional blue arrows show the data exchanges between external partners and denote the health exchange framework for each of these data exchanges. For more detailed descriptions of each item in the data interoperability architecture, refer to Appendix C.

[20] Refer to Appendix D – Narrative of FY2016 Health Interoperability Enterprise Architecture – Health Exchange Frameworks for acronyms spelled out and short descriptions of the components.

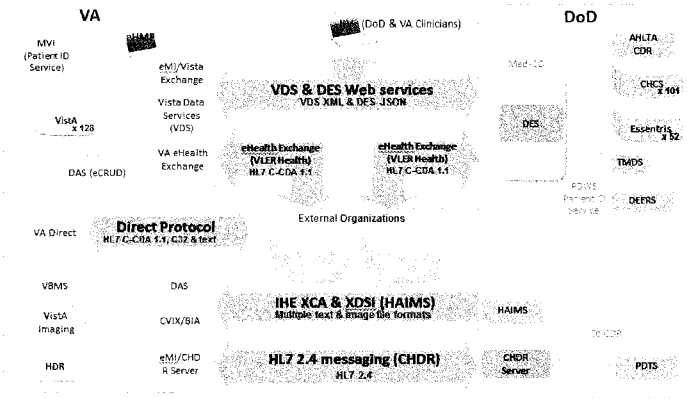


Figure 1 - FY2016 Health Interoperability Enterprise Architecture[21]

2.3.2 Evolution of Health Exchange Frameworks

The current state of data exchange includes multiple redundant health exchange frameworks. For example, the HL7 v2.x push methods include vocabulary/terminology that may be available in eHealth Exchange or the Direct Protocol. Different interoperability use cases and workflows (e.g., query/response vs. push) require the use of different health exchange frameworks.

The IPO generally recommends using a single health exchange framework for a given workflow within an interoperability use case to enable interoperability between the Departments, other government entities, and private sector providers. Each interoperability use case may have multiple workflows, and thus may use multiple health exchange frameworks. The IPO recommends the use of standardized health exchange frameworks built upon discreet data web services (either RESTful services or SOAP web services) for query-response exchanges between the Departments, and is monitoring the evolution of FHIR-based RESTful services for future interdepartmental exchange. The Direct Protocol and the eHealth Exchange are required for push and query-response exchanges, respectively, with private sector partners.

In particular, Joint Legacy Viewer (JLV) may receive the same Private Sector information twice if the same private sector organization is connected to both VA and DoD VLER programs (e.g. Kaiser Permanente).

[21] DoD will have Direct Protocol capabilities upon the acquisition of a new EHR system.

2.4 Other Considerations

The IPO engages with the Departments, other government entities, private sector providers, and multiple SDOs while approving interoperability standards for Departmental use. The following subsections address initiatives that either strongly influenced the IPO's development of this document or need to be addressed in order to clarify the IPO position on the initiative for implementers.

2.4.1 ONC 2015 Standards Advisory [22]

The IPO is aligned with the ONC's 2015 Draft Standards Advisory, which was published to serve two purposes:

1. To provide the industry with a single, public list of the standards and implementation specifications that can best be used to achieve a specific clinical health information interoperability purpose.
2. To prompt dialogue, debate, and consensus among industry stakeholders when more than one standard or implementation specification could be listed as the best available.

Many of the standards noted in the standards advisory directly correlate to selections in this document. In a few instances - such as Radiology - this document and the standards advisory provide different recommendations. In those instances, the IPO will submit comments to ONC to consider for their next release. The 2015 release is considered an "open draft"; I2TP will maintain the alignment and reflect the updates with the Standards Advisory progress.

2.4.2 Federal Health Information Model

The Federal Health Information Model (FHIM)[23] is a project under a larger program called Federal Health Interoperability Modeling and Standards (FHIMS), which is an initiative of the FHA[24] that is managed by the ONC. The FHIM is a logical data model. This document recommends system data exchange standards under the heading of Content/Structure Standards. These standards are most closely aligned with physical data models for exchange, rather than data storage. It is not within the scope of this document either to recommend a logical data model to the Departments or to create mappings to them.

2.4.3 National Information Exchange Model

The National Information Exchange Model (NIEM) is "a community-driven, standards-based approach to exchanging information."[25] The IPO and this document align with

[22] ONC Interoperability Standards Advisory http://www.healthit.gov/standards-advisory

[23] More FHIM information is available at: http://www.fhims.org/.

[24] Information on the Federal Health Architecture (FHA) is available at Healthit.gov (http://www.healthit.gov/policy-researchers-implementers/federal-health-architecture-fha)

[25] National Information Exchange Model (NIEM) is available at NEIM.gov (https://www.niem.gov/aboutniem/Pages/niem.aspx)

ONC-endorsed National Healthcare Standards as the priority. Currently NIEM is not an ONC-endorsed information exchange approach.

3 Summary

While the Departments share a tremendous amount of technically interoperable health data, semantically interoperable data sharing has been limited. By implementing the standardization initiatives outlined in this document and led by the IPO, the level of semantically interoperable data sharing can be greatly expanded. Agreement on standardized health exchange frameworks and incorporation of the same vocabulary/terminology and content/structure standards promotes interoperability between systems and will move the Departments toward an environment where sharing computable data will become a reality.

This document has provided IPO-required standards for near-term (FY16-17) system implementations taking into account the reality of current architectures. This near-term architecture moves the Departments in the appropriate direction; however it is at the discretion of the Departments to implement IPO-required standards in a timeframe that is suitable for the Departments. Future releases of the I2TP will address transport and security in more detail for near-term, as well as standards for mid-term (FY2018-22) and long-term (FY2022+) solutions for the "to-be" system environment.

The I2TP is a living document and will continue to evolve as applicable health data interoperability standards mature and Department implementations are realized. Updates of this document will be released with less frequency as the health data interoperability standards environment stabilizes.

Appendix A – Glossary

Below is a list of IPO Key Terms with the corresponding definitions.

Term	Definition
All Health Care Data	Clinically relevant and available data to support clinical decision making and improve health care outcomes.
Content	Descriptive information encoded as data, subject to being shared among systems and users. Data may be represented using specific types of data, vocabulary terms, code lists, etc. to express the semantics of the information content.
Content/Structure	The syntax or way data is formatted.
Clinical Data domain	Clinical data domains represent functional groupings of data to be shared. Clinical data domains may be organized into subdomains. For example, allergies are differentiated as medication allergies, food allergies, and environmental allergies. Departmental data are expected to be mapped to the clinical data domains specified by the HEC.
Computable Data	Data that exists in a format useable in computational routines by one or more computer systems.
Draft Standard for Trial Use (DSTU)	An interoperability standard published by Health Level 7 (HL7) as a preliminary specification, expected to become normative, to "provide timely compliance with regulatory or other governmental mandate and/or timely response to industry or market demand."[26]
Emerging Standard	An emerging standard is a new standard under development, draft publication, or pilot use. The standard is being considered as a recommendation or normalization for health data interoperability at a national or international level.
External Partner	An entity outside of Department of Defense (DoD) and Department of Veterans Affairs (VA) that exchanges health information with DoD and/or VA. This may include clinicians, patients, payers, or any entity in the healthcare continuum.
Full Standards-based Interoperability	Ability of different electronic health records systems or software to meaningfully exchange relevant data, coded or mapped to national standards when such standards exist, in near real time between one or more systems or users.
Health Exchange Framework	A means of transferring data using specific protocols, standards, and approaches to electronically move data in a way that preserves syntax, semantics, and/or security of the data.
Integrated Display of Data	Ability to display health data from multiple sources in a format that can be used to support clinical decision-making.
Interoperability	The ability of two or more systems or components to exchange information and to use the information that has been exchanged.
IPO-required Standard	A standard designated by the IPO that the Departments must support.
Primary Data Element	A data element identified as most important for the domain for the purposes of semantic interoperability.
Semantic Interoperability	The ability to exchange data between systems with unambiguous shared meaning.

[26] Draft Standard for Trial Use (Revised), HL7 Policy and Procedure, POL 14.00.01, June 2004.

Appendix B – Acronym List

The table below provides a list of all acronyms in this document with the corresponding definition.

Acronym	Definition
A&I	Artifacts and Images
ADC	Active Dual Consumer
ADT	Admission, Discharge, Transfer
AHLTA	Armed Forces Health Longitudinal Technology Application
ASC X12	Accredited Standards Committee X12
BHIE	Bidirectional Health Information Exchange
BIA	BHIE Image Adapter
C32	Healthcare Information Technology Standards Panel Summary Documents Using Health Level 7 Continuity of Care Document Component
CCD	Continuity of Care Document
CATMS	Correspondence and Task Management System
C-CDA	Consolidated Clinical Document Architecture
CDA	Clinical Document Architecture
CDC	Centers for Disease Control and Prevention
CDR	Clinical Data Repository
CHCS	Composite Health Care System
CHDR	Clinical Data Repository/Health Data Repository
CIS	Clinical Interoperability Scenarios
CPR	Computer-based Patient Record
CPT4	Current Procedural Terminology Codes, Fourth Edition
CTS	Correspondence Tracking System
CVX	Vaccines Administered
DAS	Data Access Service
DEERS	Defense Enrollment Eligibility Reporting System
DICOM	Digital Imaging and Communication in Medicine
DMIX	Defense Medical Information Exchange
DoD	Department of Defense
DSTU	Draft Standard for Trial Usage
EHR	Electronic Health Record
FHA	Federal Health Architecture
FHCC	Federal Health Care Center
FHIM	Federal Health Information Model
FHIMS	Federal Health Interoperability Modeling and Standards
FHIR	Fast Healthcare Interoperability Resources

Acronym	Definition
FY	Fiscal Year
GMDN	Global Medical Device Nomenclature
HAIMS	Health Artifact and Image Management Solution
HCPCS	Healthcare Common Procedure Coding System
HDIMP	Health Data Interoperability Management Plan
HDR	Health Data Repository
HDS BL	Health Data Sharing Business Line
HEC	Health Executive Committee
HITSP	Healthcare Information Technology Standards Panel
HL7	Health Level Seven International
HTTP	Hypertext Transfer Protocol
I2TP	Information Interoperability Technical Package
ICD	Interface Control Document
ICIB	Interagency Clinical Informatics Board
ICN	Integration Control Number
IEEE	Institute of Electrical and Electronics Engineers
IHE	Integrating the Healthcare Enterprise
IHE XCA	Integrating the Healthcare Enterprise Cross Community Access
IPO	DoD/VA Interagency Program Office
ISO	International Organization for Standardization
IT	Information Technology
JEC	Joint Executive Committee
JIP	Joint Interoperability Plan
JLV	Joint Legacy Viewer
JSON	Java Script Object Notation
LDSI	Laboratory Data Sharing Initiative
LOINC	Logical Observation Identifiers Names and Codes
MHS	Military Health System
MLLP	Minimum Lower Level Protocol
MTF	Military Treatment Facility
MU2	Meaningful Use Stage 2
MVI	Master Veteran Index
NDAA	National Defense Authorization Act
NDF RT	National Drug File Reference Terminology
NIEM	National Information Exchange Model
NUCC	National Uniform Claim Committee
OMB	Office of Management and Budget
ONC	Office of the National Coordinator for Health Information Technology
PDTS	Pharmacy Data Transaction Service

Acronym	Definition
RDF	Resource Description Framework
RDV	Remote Data View
PHIN	Public Health Information Network
REST/RESTful	Representational State Transfer
RxNorm	Normalized Names for Clinical Drugs
S&I	Standards and Interoperability
SDC	Structured Data Capture
SDO	Standards Development Organization
SDWG	Structured Documents Working Group
SNOMED CT	Systematized Nomenclature of Medicine - Clinical Terms
SOAP	Simple Object Access Portal
STR	Service Treatment Record
TMDS	Theater Medical Data Store
U.S.	United States
UD	Unstructured Document
UMDNS	Universal Medical Device Nomenclature System
UMLS	Unified Medical Language System
UNII	Unique Ingredient Identifier
VA	Department of Veterans Affairs
VAIQ	Veterans Administration Intranet Quorum
VBA	Veterans Benefits Administration
VBMS	Veterans Benefits Management System
VDS	VistA Data Services
VE	VistA Evolution
VHA	Veterans Health Administration
VistA	Veterans Health Information Systems and Technology Architecture
VLER	Virtual Lifetime Electronic Record
XDS-I	Cross-enterprise Document Sharing for Imaging
XML	Extensible Markup Language

Appendix C - Interface Control Document (ICD) Summaries

This Appendix summarizes the Interface Control Documents (ICDs) for existing data sharing capabilities between the DoD and VA. Please contact the Departments directly to obtain the latest ICD version.

ICD Name	Summary
BHIE DoD Adaptor Interface Control Document (ICD)	This ICD defines the external and internal interfaces to be added or altered to meet the requirements of the BHIE DoD Adaptor (BDA).
Updated Interface Control Document Clinical Data Repository/Health Data Repository (CHDR) Program Support	This ICD specifies the interface between the DoD's Clinical Data Repository (CDR) and the Veterans Administration's Health Data Repository (HDR). The document describes the concept of operations and interface design, specifies the data exchange requirements, defines the message structure and protocols that govern the interchange of data, and identifies the communication paths along which the data is expected to flow. The interface described in the ICD will be developed to support exchange of patient data for the military's Active Dual Consumer (ADC) population as services are rendered at Joint Venture Sites. Joint Venture Sites are VA Medical Centers (VAMCs) and DoD Military Treatment Facilities that provide services to both VA and DoD beneficiaries under locally negotiated partnership arrangements.
jMeadows Data Service Interface Control Document	This ICD describes the relationship between two components of the Joint Legacy Viewer (JLV) system: the jMeadows Data Service and the JLV Web Application. This ICD presents the software interface requirements between the JLV Web Application and the jMeadows Data Service. The purpose of the ICD is to specify interface requirements to be met by the participating systems. It describes the concept of operations for the interface, defines the message structure and protocols that govern the interchange of data, and identifies the communication paths along which the data is expected to flow.
Relay Service Interface Control Document	This ICD describes the relationship between two components of the Joint Legacy Viewer (JLV) Presentation Layer in terms of data items and messages passed, protocols observed, and the timing and sequencing of events. Specifically, this ICD presents the software interface requirements between the jMeadows Data Service and the Relay Service, which are located in the JLV Presentation Layer solution. The purpose of the ICD is to specify interface requirements to be met by the participating systems. It describes the concept of operations for the interface, defines the message structure and protocols that govern the interchange of data, and identifies the communication paths along which the data is expected to flow.
VistA Data Service Interface Control Document	This ICD describes the relationship between two components of the Joint Legacy Viewer (JLV) solution: the Veterans Health Information Systems and Technology Architecture (VistA) Data Service and the jMeadows Data Service. The document describes the concept of operations for the interface, defines the message structure and protocols that govern the interchange of data, and identifies the communication paths along which the data is expected to flow. This ICD presents the software interface requirements between the VistA Data Service and the jMeadows Data Service. This document also provides data items and messages passed, protocols observed, and the timing and sequencing of events between the two web services.

Appendix D – Narrative of FY2016 Health Interoperability Enterprise Architecture

The near-term health interoperability enterprise architecture portraying the secure health exchange frameworks is shown in Figure 1. The figure illustrates how a common integrated viewer can provide clinician's access to a patient's combined clinical information from both the DoD and VA. Further descriptions of the entities shown in Figure 1 can be found below.

VA Systems	
Term	**Description**
BHIE Image Adapter (BIA)	An enterprise service which allows users of a local VistA Imaging system to retrieve images from remote VistA Imaging systems and DoD's Health Artifact and Image Management Solution (HAIMS).
CVIX	A special implementation of the VistA Imaging Exchange that resides in the Philadelphia Sungard Spring Garden data center. The CVIX facilitates data sharing and exchange across organizational and functional boundaries. DoD HAIMS content is now connected as a node on the CVIX via the BHIE framework.
Data Access Service (DAS)	A set of enterprise data services that retrieves data from a variety of sources. It also includes an enterprise persistence service.
Enterprise Messaging Infrastructure (eMI)	The VA's instantiation of the IBM WebSphere SOA suite of products, is being utilized to improve the speed, reliability, security, and capabilities of data services, and allows programs and products to consume and publish information integral to the complete virtual health record in VA.
Enterprise Health Management Platform (eHMP)	The name of VA's overarching system which includes both the front end application called the eHMP Clinical Practice Environment (eHMP CPE), and the middle tier components, called eHMP Services. eHMP is the VA's target clinical application under the VistA Evolution program that currently enables a comprehensive view of the "virtual patient record" provided by VistA Exchange. This holistic view of detailed patient information will support team-based care to the Veteran from a consistent set of information, regardless of where in the VA system the Veteran receives that care. Clinical information captured at the point of care is by design made available to all authorized providers across the enterprise.
Health Data Repository (HDR)	Collect VistA data from 130 VistA systems in "real-time." Data can be stored as HL7 messages and made available to view by clinicians through Remote Data Views (RDV).
Master Veteran Index (MVI)	An enterprise wide master patient index at the VA. VA uses the MVI to maintain patient identities, with the VA primary patient identifier being the Integration Control Number (ICN). To access VA patient data, systems must query the MVI to determine which local VistA systems have data for that patient along with the patient's identifiers in those local systems, which can then be used to retrieve the patient's data.
VA CHDR Server	This VA interoperability system synchronizes medications and allergies between the VA and the DoD (interacting with the DoD's CHDR server) for patients shared by both departments. It does so in a semantically interoperable way for the primary purpose of drug-drug and drug-allergy checking.

VA Direct	Enables VA providers and other staff to send or receive information about a Veteran's healthcare (such as a referral or an authorization for purchased care) to or from a non-VA provider using the secure messaging capability of the DIRECT Project (a secure email protocol for healthcare).
VA eHealth Exchange	A component of the VLER Health, developed to ensure that appropriate medical information is shared through secure and interoperable information management systems, using national standards, with external partners of the VA. VA eHealth Exchange connects VA with approved healthcare providers, consumers, and other partners, such as Kaiser Permanente, who are involved in supporting Veterans. External partner data is now available in the VistAWeb, JLV and as part of the VistA Exchange eVPR (displayed in eHMP). VA eHealth Exchange is a member of the eHealth Exchange (formerly known as the Nationwide Health Information Network or NwHIN) network managed by the Sequoia Project.
Veterans Benefit Management System (VBMS)	The VA's enterprise system to collect and manage Veterans benefit information, within Veterans Benefits Administration.
VistA	With 130 instances--VistA is the VA's health information system that is implemented at each VA Medical Center (VAMC). Each VistA system contains data specific to a single site. Some of this data, including prescribed medications, lab (chemistry and hematology) results, and allergies, will be sent to the HDR for inclusion in the patient's longitudinal record.
VistA Data Services (VDS)	A set of read-only data services that retrieve patient record data from all the VistA hosts in which a patient is registered.
VistA Exchange	The new data management that services most data needs of the new eHMP application (and often is included in discussions and documents under the eHMP umbrella). The VistA Exchange and eHMP, together with VistA serve as the core of the VistA Evolution program. VistA Exchange creates a "virtual patient record" called the "eVPR" that is an aggregated and normalized patient record from DoD, VA, and external partner sources, along with a data cache that will significantly enhance performance and reduce redundant network traffic.
VistA Imaging	A VA application for reviewing digital images.
DoD Systems	
Term	**Description**
AHLTA	AHLTA, a major component of the military's electronic health record, is the primary clinical information system used by the military's medical community to help generate, maintain, store and securely access data for 9.5 million beneficiaries.
CDR	The DoD's AHLTA EHR database. The term CDR Database includes the 3M Clinical Data Repository, as well as the AHLTA-specific extended CDR Plus.
Composite Health Care System (CHCS)	CHCS allows clinicians to electronically perform patient appointment processes and scheduling, order laboratory tests, authorize radiology procedures and prescribe medications. It serves as the foundation for AHLTA, the DoD's current electronic health record.
Defense Enrollment Eligibility Reporting System (DEERS)	A worldwide, computerized database of uniformed services members (sponsors), their family members, and others who are eligible for military benefits.

Data Exchange Service (DES)	It is managed by Defense Medical information Exchange (DMIX) office and serves as the core of the new data sharing services for the DoD. It provides RESTful query/response services for nearly all DoD patient data for an identified patient. It is the conduit for DoD data for the target VA applications – eHMP and JLV.
DoD CHDR Server	This DoD interoperability system synchronizes medications and allergies between the VA and the DoD (interacting with the VA's CHDR server) for patients shared by both departments. It does so in a semantically interoperable way for the primary purpose of drug-drug and drug-allergy checking.
Essentris	The military's inpatient electronic health record is used in acute hospital environments, providing point-of-care data capture at the patient's bedside for physiological devices, fetal/uterine devices, ventilators and other patient care machines. Essentris® allows worldwide documentation of inpatient care for all service members and their beneficiaries.
Health Artifact and Image Management Solution (HAIMS)	HAIMS provides the DoD and VA health care providers global visibility and access to artifacts and images generated during the health care delivery process. HAIMS is a Wounded Warrior strategic project that provides a single enterprise-wide data sharing capability for all types of artifacts and images (also known as A&I), including radiographs, clinical photographs, electrocardiograph, waveforms, audio files, video and scanned documents.
Pharmacy Data Transaction Service (PDTS)	PDTS is currently being used by the DoD to coordinate the medications across all DoD MTFs, retail pharmacies accepting Tricare insurance, and mail-order pharmacies. PDTS input is also used to trigger non-MTF pharmacy data from retail and mail order pharmacies to be sent to the CDR and forwarded to the VA for ADC patients via DoD CHDR Server. PDTS is also used in interaction checking by CHCS Order Entry. Since it is currently being used for drug/drug interaction testing, all VA medications received via the CHDR services are sent to PDTS. PDTS receives VA data from the CHDR Application Server.
Patient Discovery Web Service (PDWS)	A technical solution provided by Defense Manpower Data System (DMDC) that offers new matching criteria and additional methods for identifying and matching patients.
Theater Medical Data Store (TMDS)	A web-based application used to view Service members' medical treatment information recorded in the combat zone. TMDS views and tracks ill or injured patients as they move through theater levels of care, sustaining base MTFs and those shared with the VA. TMDS updates the CDR, where all Service members' EHRs reside. This information is also available via the TMDS to DoD Adapter interface.

FY16 Health Exchange Frameworks

Term	Description

Joint Legacy Viewer (JLV)	A web application that provides a read-only interface for patient data aggregated from DoD, VA, and external partners. JLV provides an integrated view of both DoD and VA health information on a single screen for providers of both Departments. It obtains its data from the DoD's newer data services (currently called the DoD Adaptor, by way of the "BHIE Relay Service" component – not a part of the BHIE Framework), from all of VA's VistA systems (currently via it's "VistA Data Services" component), and from external partners through the VLER Adaptor.
VDS & DES Web Services	Exchange between DES and VDS using DES JSON and VDS Extensible Markup Language (XML).
eHealth Exchange (VLER Health)	Exchange between VA VLER Adaptor & Gateway and the DoD VLER Adaptor & Gateway using HL7 C-CDA 1.1
Direct Protocol	Part of the VLER Health program. It is a secure email exchange between VA and External Organizations using ONC Direct Project standards. Email attachments can be HL7 C-CDA 1.1 & text and other documents.
Integrating the Healthcare Enterprise (IHE) Cross Community Access and Cross-enterprise Document Sharing for Imaging (IHE XCA & XDS-I) (HAIMS)	Exchange between VA's DAS/BIA and the DoD HAIMS using multiple text and image file formats
HL7 2.4 messaging (CHDR)	Exchange between HDR and CHDR using HL7 2.4
External Organizations[27]	
Term	**Description**
Private Sector Providers	External partners, typically clinicians, outside of DoD and VA that exchange health information with DoD and/or VA
Other Government Agencies	Examples of other government agencies may include Social Security Administration for benefits adjudication, Indian Health Service, Department of State and Coast Guard for treatment purposes in cases of shared patients, Centers for Disease Control for required reporting and for medical surveillance, and Health and Human Services for payment. Other government agencies are not limited to the federal government and may include states or local governments.

[27] Although not explicitly listed on the diagram, other external partners may also include patients, payers, or any entity in the healthcare continuum.

Appendix E - Links to Standards

Table below provides the links to each standard terminology and structure standard referenced in this document.

Standards Terminology	Link
ASC X12N (Health Insurance Type)	http://www.x12.org/x12org/docs/EDITransactions.pdf http://www.hitsp.org/ConstructSet_Details.aspx?&PrefixAlpha=4&PrefixNumeric=80
CPT4	http://www.amacodingonline.com/
CVX	http://www2a.cdc.gov/vaccines/iis/iisstandards/vaccines.asp?rpt=cvx
DICOM (a format, not a terminology)	http://dicom.nema.org/
HCPCS	http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/index.html
ICD-10 PCS	http://www.cms.gov/Medicare/Coding/ICD10/index.html
ISO 639-2 alpha-3 codes	http://www.loc.gov/standards/iso639-2/php/code_list.php
LOINC	http://loinc.org/downloads
NDF RT	http://www.nlm.nih.gov/research/umls/sourcereleasedocs/current/NDFRT/
NUCC Taxonomy	http://www.nucc.org/index.php?option=com_content&view=article&id=107&Itemid=132
OMB/CDC Race codes	http://www.whitehouse.gov/omb/fedreg_1997standards
RxNorm Files	http://www.nlm.nih.gov/research/umls/rxnorm/docs/rxnormfiles.html
SNOMED CT	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
UMLS	http://www.nlm.nih.gov/research/umls/
UNII	http://www.fda.gov/ForIndustry/DataStandards/SubstanceRegistrationSystem-UniqueIngredientIdentifierUNII/default.htm
Structure Standards	
HITSP C32	http://www.hitsp.org/ConstructSet_Details.aspx?&PrefixAlpha=4&PrefixNumeric=32
HL7 C-CDA 1.1 CCD	http://www.hl7.org/implement/standards/product_brief.cfm?product_id=258
HL7 C-CDA 2.1 CCD	http://www.hl7.org/implement/standards/product_brief.cfm?product_id=408
HL7 2.5.1	http://www.hl7.org/implement/standards/product_brief.cfm?product_id=144
HL7 2.x	http://www.hl7.org/implement/standards/product_brief.cfm?product_id=185
HL7 PIX/PDQv3	http://www.hl7.org/implement/standards/product_brief.cfm?product_id=186
Implementation Guide: Electronic Laboratory Reporting to Public Health	http://www.hl7.org/implement/standards/product_brief.cfm?product_id=98
Implementation Guide for Immunization Messaging, Release 1.4	http://www.cdc.gov/vaccines/programs/iis/technical-guidance/downloads/hl7guide-1-4-2012-08.pdf
PHIN Messaging Guide for Syndromic Surveillance	http://www.hl7.org/implement/standards/product_brief.cfm?product_id=98
S&I Framework Lab Results Interface	http://www.hl7.org/implement/standards/product_brief.cfm?product_id=279

AUTOMATION OF BENEFITS

Question 48. In your testimony, you highlight the need to simplify the VA appeals process. As a result of automating burial benefits, you state that the Department was able to reduce the time spent processing these benefits from 190 days to 6. This Congress, in collaboration with VA, I introduced the Veteran Survivors' Claims Processing Automation Act which passed out of this Committee last month. The bill would provide the Department with the authority to automate the claims process for dependency and indemnity compensation, survivors' pensions, and payments of accrued benefits. In the context of your 2016 Breakthrough Outcomes for Appeals, would you be able to comment on the impact that automating these benefits would have on decreasing processing time, and assisting the VA in meeting its goal of completing 90 percent of appeals within one year of filing by 2021? Can you comment

on the budgetary impact you anticipate that streamlining programs in this manner would have on the VA, and the positive impacts that it would have on veterans' services by improving the timeliness and quality of benefits delivery?

Response. The overall intent of automating survivors' benefits is to grant the benefit without the need for the survivor to submit an application. Because of the unique adjudication process of appeals, VBA cannot implement automation at the time a survivor files an appeal. Many of these appeals require a detailed analysis of multiple types of evidence before a decision is reached. Automation does not lend itself well to this type of review. Additionally, since nearly 98 percent of all pending VA appeals involve disability compensation benefits, the impact from automating survivor appeals would be minimal.

BOARD OF VETERANS' APPEALS CHAIRMAN NOMINATION

Question 49. Making significant progress on the veteran claims backlog is a key part of your 2016 breakthrough outcomes however the Board of Veterans' Appeals has not had a Senate-confirmed Chairman since the departure of the late James Terry in 2011. Laura Eskenazi was designated by Secretary Eric Shinseki as Executive in Charge and Vice Chairman of the Board of Veterans' Appeals (BVA), on June 30, 2013. Since the beginning of the 114th Congress, the Senate has not received a nomination for BVA Chairman. Are there plans to submit to the Senate a nominee for BVA Chairman in 2016?

Response. VA acknowledges that leadership for the Board of Veterans' Appeals is important as we move critical initiatives forward. Nomination of the Chair, Board of Veterans' Appeals is a process executed by the White House, and we therefore defer to the White House on this matter.

TELEHEALTH/HEPATITIS C TREATMENT

Question 50. Secretary McDonald, you note in your testimony that with its $1.5 billion request in FY 2017, VA expects to treat 35,000 patients with Hepatitis C and that VA will focus resources on the sickest patients and most complex cases and continue to build capacity for treatment through clinician training and use of telehealth platforms. Could you elaborate on how telehealth will be expanded and how it will impact treatment?

Response. VHA currently operates multiple Hepatitis C and liver Telehealth programs, both within and across VISNs. These include traditional provider-patient Telehealth visits, in which the patient is seen through a video link at one VAMC by a Hepatitis C provider at another VAMC. They also include Tele-consultation models using VHA's highly successful SCAN-ECHO program, in which primary care physicians at a VAMC or CBOC present Hepatitis C cases to an expert team at another VAMC and receive didactic training, enabling them to become experienced Hepatitis C treaters. Preliminary data from VHA's Hepatitis C SCAN-ECHO program show significant increases in patient access, decreases in travel time, and most importantly, cure rates similar to those achieved by experienced VHA Hepatitis C providers.

VHA is planning and executing expansion of these programs as rapidly as possible. Expansion will use geomapping to target sites that report patient access difficulties due to geographic constraints or limitations in provider resources as well as relatively low proportions of Veterans treated. Expansion will involve meetings between the VHA National Viral Hepatitis Program Office and National Telehealth Program Office with clinical staff at such sites to guide deployment and implementation of Telehealth resources, recruitment of experienced Hepatitis C providers to deliver Hepatitis C Telehealth care, use of peer support groups for remote treatment of Veterans, and updating the existing national liver/Hepatitis C Telehealth guide. VHA will also leverage its existing provider to provider training programs, including its Hepatitis C SCAN-ECHO program, to buildupon existing provider capacity to treat Hepatitis C; the National Viral Hepatitis and Primary Care Programs are collaborating to refine a Hepatitis C curriculum for VHA primary care providers. Based on the data from existing programs, we anticipate that this expansion will improve access to Hepatitis C and liver care, particularly among Veterans residing in rural and highly rural areas.

Chairman ISAKSON. We have a second panel that will come forward. If the second panel will move forward?

I appreciate your time this morning. [Pause.]

I would like to welcome our second panel, and, again, I appreciate the Secretary staying for the second panel. We have our veterans service organizations, which are critically important to us on the VA Committee. We have The American Legion in town today. I was with them earlier this morning, and I appreciate their support for the Veterans Administration and for this Committee.

We have: Mr. Carl Blake, the Associate Executive Director of Government Relations, Paralyzed Veterans of America; Paul Varela, Assistant National Legislative Director, Disabled American Veterans; Ray Kelley, the Director of the National Legislative Service, Veterans of Foreign Wars; and Mr. Louis Celli, Jr., National Director of Veterans Affairs and Rehabilitation, The American Legion.

Mr. Blake, we will begin with you.

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

Mr. BLAKE. Thank you, Mr. Chairman. On behalf of the co-authors of *The Independent Budget*—DAV, PVA, and VFW—I would like to thank you for the opportunity to testify today. You have a copy of our joint statement that we submitted for the record, so I will limit my comments primarily to the medical care section of the VA's budget and to the recommendations of the *IB*.

Let me say first and foremost that overall we believe that the VA's budget is a good one. I think in many ways it mirrors the recommendations of the independent budget for this year, particularly when you take into account the amount of money that the VA projects to spend from Section 801 and Section 802 of the Choice Act as well. It brings the numbers up pretty close. The one exception to that would certainly be the infrastructure portion. I will leave the comments on that to my colleague with the VFW.

Let me say, though, that we do have some real concerns about this continued escalated growth in funding in community care. This year, the VA introduced its new medical community care account. When coupled with the Choice Act, they project to spend nearly $12.2 billion on care in the community this year.

It is fair to say that we understand the need to leverage community care as best as possible to expand access. The independent budget framework that we have already discussed with the Committee staff outlines some of our ideas in that same way, much as the VA's new Veterans Choice Plan also addresses the issue.

However, we are concerned about what is the potential for uncontrolled growth in this area. While the Congress and the Administration seem to be keenly focused on expanding access in the community, I do not think we can emphasize enough the need to devote critical resources and focus also on expanding the existing capacity of the VA and the staffing levels of the VA health care system, particularly in the areas of specialized services like spinal cord injury or disease. Just outsourcing the care into the community, while it might seemingly improve access, runs the risk of un-

dermining the larger health care system, which many veterans, particularly those with catastrophic disabilities, rely upon.

One interesting note that I'd like to point out is in the VA's budget this year, they project for fiscal year 2016 to spend about $1.7 billion in Section 802 Choice funding. That is the community care portion of Choice. When we asked them about it during their budget briefing, they admitted that they actually project to spend $2.3 billion or more in Choice Act funding for community care this year. But, their budget does not seemingly square those two facts, which begs the question: where will the additional money come from? The obvious easy answer would be the remaining balance of the Choice Act. Then, that would call into question, how does that impact the $4.8 billion in Choice funding that they are projected to spend in fiscal year 2017 for community care?

We have real concerns about how the Choice Act funding is going to be broken up. Certainly last year, with the massive budget shortfall, that caused some significant difficulties when figuring out how to manage the Choice Act funding line. We will be keeping a close eye on how that impacts care going forward.

With these thoughts in mind, we also have some real concerns about the funding level for fiscal year 2017 that was approved in the advance appropriation in December of last year. While the *IB* recommends approximately $72.8 billion for medical care for 2017, that advance appropriation only included about $66.6 billion. That is a lot of money no matter how you look at it. But, the fact is the VA revised its estimate for 2017, necessarily so, we believe, to a much higher and much more significant level, we believe reflective of the actual need that they project to have for 2017. Unfortunately, we believe that we are setting up the scenario where the very same shortfall problems that we experienced last summer may rear their head again in this fiscal year, 2016, and potentially again in 2017 this advance appropriation level is not appropriately addressed. We hope this Committee will take a serious look at that and consider that as you put together your views and estimates.

Last, we are concerned about the 2018 advance appropriation level. When we questioned the VA on what we felt like was clearly an insufficient level for 2018 for all of medical care, they sort of half-heartedly admitted that they do not believe it is going to be sufficient either, which is kind of befuddling to us. If you took the historical perspective that that is OK because it will be corrected, that is not a fair way to look at this. While the last 2 years Congress has adjusted the advance appropriation in many appropriate ways, the four previous years to that Congress did not adjust by a single dollar the advance appropriation for health care, particularly in medical services. The track record does not lend itself to underestimating now to get it corrected later. So, I certainly hope that the Committee will take a real look at the 2018 advance appropriation and address it so that funding is not left short when we get to that point 2 years from now.

Mr. Chairman, I would like to thank you again for the opportunity to testify. I would be happy to answer any questions that you may have.

Chairman ISAKSON. Thank you, Mr. Blake.

Mr. Varela?

STATEMENT OF PAUL VARELA, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. VARELA. Good morning, Chairman Isakson and Members of this Committee. On behalf of the IBVSOs, we thank you for providing us with the opportunity to discuss our fiscal year 2017 budget recommendations and those proposed within VA's budget request. Today I will focus my oral remarks on four elements: compensation (comp service); vocational rehabilitation and employment service (voc rehab); the Board of Veterans Appeals (the Board); and the simplified appeals process recommendations.

For comp service, we recommended an increase of 1,700 full-time employee equivalents (FTEEs). The administration requests authorization for just 400. Given the significant backlog and workload affecting appeals, we believe that 1,000 of the 1,700 FTEE requested by the IBVSOs should be dedicated solely to appeals processing. Without adequate resources, appellants seeking redress of their VA determinations will continue to endure significant delays in the adjudication of their appeals. We have also recommended 100 additional FTEE for the fiduciary program, 300 FTEE for non-disability rating activities, and 300 FTEE for call centers. VBA must be resourced properly to meet the needs and expectations of veterans, survivors, and dependents seeking VA benefits and services.

Second, voc rehab. The IBVSOs have again recommended a staffing increase for fiscal year 2017; 158 new FTEEs are required, but for a second consecutive year, the administration has not requested a staffing level increase. Mr. Chairman, voc rehab program participation has increased steadily over the past few fiscal years to include receipt of new applications for entitlement determinations, which has also increased at roughly the same rate. Vocational rehabilitation counselors (VRCs), perform myriad tasks ranging from their daily caseload responsibilities to integrated disability evaluation system and veteran success on campus activities. VRCs have one of the most critical roles within VA. They ensure that ill and injured veterans have all the help, guidance, and resources they need to overcome their employment obstacles to lead to more independent and economically fulfilling lives. The IBVSOs recommended a staffing increase that would support a more appropriate client-to-counselor ratio throughout voc rehab so VRCs can devote the appropriate amount of time to each veteran in the program to ensure they are on a path to success.

Third, the Board. We are pleased to see the administration's request for 242 FTEEs. The IBVSOs fully support this request. The additional personnel are certainly needed given the exceedingly large inventory of appeals now estimated at roughly 440,000 appeals pending review at various stages in the appeals process. It is important to note that even if the Board is provided with this staffing increase and VA's budget is appropriated on time, the impact of these new employees would not be fully realized until some time in 2018. Regardless of the time it will take to hire, train, and orient these new hires to the Board, they are desperately needed now. In fiscal year 2015, the Board was able to produce over 57,000 decisions with 646 FTEEs. This averages out to be 88 decisions per FTEE. If the Board were to receive their staffing increase, thus in-

creasing their staff size to 922, they could conceivably complete 81,000 appeals each year. However, to end the backlog and keep up with incoming appeals, future staffing increases will likely be needed.

Last, Mr. Chairman, the proposal regarding a simplified appeals process. The IBVSOs strongly object to closing the evidentiary record at the point of initial decision, transferring jurisdiction of an appeal to the Board upon receipt of a notice of disagreement, and eliminating an appellant's option for a personal hearing before the Board. However, the IBVSOs are pleased that VA has engaged with us regarding their proposals, and we hope to find reasonable and tangible solutions to address the appeals process.

I would like to highlight that we have put forth several recommendations to address the appeals issues, such as eliminating or amending the new and material evidence standard, fencing off decision review officers, and enacting fully-developed appeals legislation that passed in the House and was introduced here in the Senate. We would like to thank Senators Sullivan, Casey, Heller, and Tester for their support on this legislation.

We cannot emphasize enough how important it is to move FDA legislation forward. FDA has the potential to provide tangible relief to both appellants and VA. FDA differs from VA's proposed simplified appeals process because while it has sped up appeals processing, it is a voluntary option, tempered with critical due process protections currently afforded to veterans.

Chairman Isakson and Members of this Committee, thank you for allowing us the opportunity to testify today, and I look forward to your questions.

Chairman ISAKSON. Thank you, Mr. Varela.

Mr. Kelley?

STATEMENT OF RAY KELLEY, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS

Mr. KELLEY. Mr. Chairman, on behalf of the 1.7 million members of the Veterans of Foreign Wars and our Auxiliary, thank you for the opportunity to testify today. As a partner of the *IB*, the VFW is responsible primarily for capital infrastructure and the National Cemetery Administration (NCA), so I will limit my remarks to those two areas.

For more than 100 years, the Government solution to provide health care to our military veterans has been to build, manage, and maintain a network of Federal hospitals around the country. Many of these facilities need to be replaced, others need to be expanded, and all of them need to be maintained. VA uses what is known as the "Strategic Capital Infrastructure Plan," or SCIP, to manage and identify VA's current and projected gaps in building access, utilization, condition, and safety.

Major and minor construction, leasing, and non-recurring maintenance make up the four cornerstones of VA's capital infrastructure, and each work together to ensure veterans have access to their earned health care.

While Congress and VA need to realign the SCIP process to allow VA to enter into public-private partnerships, both publicly and federally, to right-size VA's footprint, it must continue to fund the

projects that are partially funded today and begin advance planning and design on those projects that we know VA needs to fund in the near future.

Currently, there are 30 major construction projects that are partially funded. To completely fund these 30 projects, VA is going to have to invest more than $3 billion to complete them. These projects need to be put on a clear path to completion.

Out of the next five major projects on the VA's priority list, two of them are seismic in nature, two of them are specialty clinics—one is a mental health care clinic, the other is a spinal cord injury center—and one is in addition to an existing facility to eliminate access barriers. The *IB* recommends that Congress appropriate $1.5 billion for fiscal year 2017 to help close these gaps.

Approximately 600 minor construction projects need funding. Congress provided additional funding through the Choice Act, and VA developed a spending plan that will obligate over $500 million to 64 minor construction projects over the next 2 years. It is important to remember these funds are supplemental to and not a replacement for the annual appropriations for minor construction. With that in mind, the *IB* is requesting $749 million for VA's minor construction accounts for fiscal year 2017.

This year, VA is requesting $52 million for fiscal year 2017 leasing needs. While VA's request is adequate, Congress needs to authorize these leases and the leases that were brought forward last year in their appropriation cycle. Even though non-recurring maintenance (NRM) is not found in the construction account, NRM is very critical to VA's capital infrastructure. VA is investing more than $800 million in NRM projects that was funded from the Choice Act. But, to maintain the status quo, VA's NRM account needs to be funded at $1.35 billion a year.

The administration request is just over $1 billion for fiscal year 2017. The *IB* requests that the full $135 billion baseline for appropriations for this line item be appropriated so NRM backlog does not grow any larger.

NCA historically asks for and properly spends what it needs, and the *IB* recommends that NCA be funded at the requested level of $286 million.

VA also provides construction grants for State extended care facilities and State veterans' cemeteries. The *IB* requests $200 million for extended care facility grants and $51 million for cemetery grants.

Thank you again for allowing the VFW to testify before you today, and I look forward to any questions you or the Committee may have.

Chairman ISAKSON. Thank you, Mr. Kelley.

[The prepared joint statement of PVA, DAV, and VFW for the *Independent Budget* follows:]

PREPARED JOINT STATEMENT OF *THE INDEPENDENT BUDGET* REPRESENTATIVES

JOINT STATEMENT

OF

THE CO-AUTHORS OF THE INDEPENDENT BUDGET

DISABLED AMERICAN VETERANS

PARALYZED VETERANS OF AMERICA

VETERANS OF FOREIGN WARS

FOR THE

SENATE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

THE INDEPENDENT BUDGET

AND THE DEPARTMENT OF VETERANS AFFAIRS BUDGET

FOR FISCAL YEAR 2017

FEBRUARY 23, 2015

Chairman Isakson, Ranking Member Blumenthal, and members of the Committee, on behalf of the co-authors of *The Independent Budget* (IB)—DAV (Disabled American Veterans), Paralyzed Veterans of America (PVA), and Veterans of Foreign Wars (VFW), we are pleased to present the views of the IB organizations regarding the funding requirements for the Department of Veterans Affairs (VA) for FY 2017, including health care advance appropriations for FY 2018.

The IB veterans' service organizations (IBVSO) believe that the FY 2017 VA budget request is generally a good budget to begin the debate. The Administration's budget request is $78.7 billion in total discretionary spending for FY 2017. When considering the additional $5.7 billion that the Administration projects spending from the Choice Act funds appropriated in 2014, the total projected expenditure from VA in FY 2017 is approximately $84.2 billion. The IBVSOs recommend $84.4 billion in total funding for the VA.

The IBVSOs share growing concerns about the massive growth in expenditures in community care spending in FY 2017 totaling $12.2 billion. We understand the need for leveraging community care to expand access to health care for many veterans, as discussed in *The Independent Budget* framework, but we are troubled by the virtually uncontrolled growth in this area of VA health care spending. Congress and the Administration must ensure that it devotes critical resources to expand capacity and increase staffing of the existing health care system, particularly for specialized services such as spinal cord injury or disease, and not simply punt this responsibility into the private sector. Simply outsourcing more care to the community will ultimately undermine the larger health care system on which so many veterans with the most catastrophic disabilities must rely.

Also, as we have previously announced, we believe the advance appropriation amount for FY 2017 provided for by Congress in the "FY 2016 Consolidated and Further Continuing Appropriations Act," approved in December 2015, is insufficient to meet the full demand for services veterans are placing on the system. For FY 2017, the *IB* recommends $72.8 billion for total Medical Care. Congress recently approved only $66.6 billion for total Medical Care (based on an assumption that VA will collect approximately $3.3 billion in 1st and 3rd party payments to the Medical Care Collections Fund).

Medical Services

The IBVSOs believe that significant attention must be placed on ensuring adequate resources are provided through the Medical Services account to ensure timely delivery of high quality health care. We are generally pleased with the Administration's revised overall medical care funding request for FY 2017, as well as the resources that would be directed specifically to Medical Services. Unfortunately, the budget shortfall from last year shined a bright light on the insufficient funding that has plagued, and may continue to plague, the VA health care system going forward. In FY 2017 (and subsequent fiscal years), the problem will be compounded as the VA will be shedding funds from its traditional Medical Services account to push more care into the community. With these thoughts in mind, for FY 2017, *The Independent Budget* recommends $60.9 billion for Medical Services.

Additionally, we believe the Administration's advance appropriation request for Medical Services in FY 2018, $54.3 billion, is woefully inadequate to meet continually growing demand for VA health care services. The Administration appears to have ignored its responsibility to properly address the funding question for VA medical care, and intends to pass it to a new Administration following this fall's election. This is an unacceptable proposition. For FY 2018, the IBVSOs recommend Congress appropriate $64 billion as an advance appropriation for Medical Services.

Our recommendations for Medical Services reflect the estimated impact of uncontrollable inflation on the cost to provide services to veterans currently using the system. We also assume a 1.2 percent increase for pay and benefits across the board for all VA employees in FY 2017, as well as 1.3 percent in the advance appropriation recommendation for FY 2018. The significant increase in our recommendations for FY 2017 also reflects an adjustment in the baseline for funding within the Medical Services account of $2.85 billion. *The Independent Budget* believes this adjustment is necessary in light of the nearly $3 billion shortfall that the VA health care system experienced last summer. The fact that VA provided 7 million more appointments last year—both inside VA facilities and in the community—is further evidence of the dramatic increase in demand VA faces today. If the baseline from FY 2016 is not adjusted to better reflect the true demand for services, we believe the VA will once again face a severe shortfall this fiscal year and next.

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

Long Term Services and Supports

The Independent Budget recommends $285 million for FY 2017, as well as $285 million for FY 2018. This recommendation reflects the fact that VA has experienced a significant increase in the number of veterans receiving long term services and supports (LTSS) in 2015. Unfortunately, due to loss of authorities—specifically fee-care no longer being authorized, provider agreement authority not yet enacted, and the inability to use Choice funds for all but skilled nursing care, to purchase appropriate LTSS, and particularly for home- and community-based care, we estimate an unfortunate increase in the number of veterans using more costly long-stay and short-stay nursing home care placements. This funding is particularly important to veterans with spinal cord injury/disease (SCI/D), because these veterans tend to rely on inpatient LTSS for services that are far more complex than the average veteran. Unfortunately, SCI/D veterans are significantly underserved by VA LTSS. We believe the Administration must demonstrate serious commitment to expanding capacity for long-term care for veterans with SCI/D, and that Congress should support this need with adequate appropriations.

Hepatitis C

We also recommend $1.7 billion dedicated specifically to the goal of expanding treatment for veterans diagnosed with Hepatitis C. The VA previously projected a goal to treat 120,000 veterans with Hepatitis C between FY 2016 and FY 2018. In FY 2017, VA is expected to treat as many as 50,000 veterans with a projected cost of approximately $1.7 billion. This estimate also includes the assumption of a 10 percent cost reduction per veteran, which we believe the VA

will can achieve through the introduction of newer and cheaper Hepatitis C medications, and if the VA renegotiates the price of currently available medications. In FY 2018, the VA is expected to treat as many as 30,000 veterans with a projected cost of approximately $1.0 billion.

Prosthetics and Sensory Aids

In order to meet the increase in demand for prosthetics, the *IB* recommends an additional $150 million in FY 2017 and $160 million for FY 2018. These increases in prosthetics funding reflect a similar increase in expenditures from FY 2015 to FY 2016, and the expected continued growth in expenditures for FY 2017.

Caregiver Support Program

Our additional program cost recommendation also includes $120 million (above the projected baseline of $605 million) for the Comprehensive Family Caregiver Program in FY 2017. The additional $120 million for VA's caregiver program will provide for the steady growth in the number of participating caregivers, currently averaging between 350 and 400 new caregivers per month. The amount recommended will also provide for a more robust number of VA Caregiver Support Coordinators to address issues regarding the program administration at local facilities. This will directly benefit an aging and severely disabled veteran population whose lives are significantly impacted by the availability of VA caregiver support services. For FY 2018, the IBVSOs recommend $125 million to address the continually increasing demands on the caregiver program. Moreover, if Congress approves legislation to finally expand access to this program to veterans of all eras, beyond post-9/11 veterans, then consideration must be given to providing additional resources to meet the substantial new demand expected.

Women Veterans

Finally, the Medical Services appropriation should be supplemented with $90 million designated for women's health care programs, in addition to amounts already included in the FY 2017 baseline. For FY 2018, this amount should be increased by an additional $100 million. These funds would be used to help the Veterans Health Administration deal with the continuing growth in ensuring coverage for gynecological, prenatal, and obstetric care, other gender-specific services, and for maintenance and repair of facilities hosting women's care to improve privacy and safety of VA facilities where women seek their care. The new funds would also aid the VHA in making its cultural transformation to embrace women veterans and welcome them to VA health care, and provide the means for VA to improve specialized mental health and readjustment services for women.

Medical Support and Compliance

For Medical Support and Compliance, *The Independent Budget* recommends $6.2 billion in FY 2017. Our projected increase reflects growth in current services based on the impact of inflation on the FY 2016 appropriated level. Additionally, for FY 2018 *The Independent Budget* recommends $6.3 billion for Medical Support and Compliance. This amount also reflects an increase in current services from the FY 2017 advance appropriation level.

Medical Facilities

For Medical Facilities, the IBVSOs recommend $5.7 billion for FY 2017, nearly $700 million more than the enacted advance appropriation from December 2015. Our Medical Facilities recommendation includes $1.35 billion for Non-Recurring Maintenance (NRM). The Administration's request over the past two cycles represents a wholly inadequate request for NRM funding, particularly in light of the actual expenditures that are outlined in the budget justification. While VA has actually spent approximately $1.3 billion on average yearly for NRM, the Administration has requested only $460 million. This is clearly insufficient. If Congress follows suit, VA would be forced to divert funds designated for other purposes to meet NRM needs.

Last year the Administration's recommendation for NRM reflected a projection that would place the long-term viability of the health care system in serious jeopardy. Unfortunately, it appears that the Administration will once again reduce critically needed funded in the Medical Facilities account for the advance year of FY 2018. *The Independent Budget* recommends $6.7 billion for Medical Facilities for FY 2018. Our FY 2018 advance appropriation recommendation includes $1.35 billion for NRM.

Medical and Prosthetic Research

The IBVSOs are pleased that the Administration has committed significant new resources to the Medical and Prosthetic Research account. The IB recommends $665 million in direct appropriations for the Medical and Prosthetic Research account; the Administration recommends $663 million. The VA research program is a jewel within the VA that we support without hesitation or reservation. Research is a vital part of VA health care, and fulfills an essential mission for our national health care system. This sustained investment in research has been long needed, and we applaud the Administration for taking this step. We ask the Committee to also give consideration to making an additional investment specifically in the Million Veteran Program (MVP). The IBVSOs recommend $75 million in directed funding for the MVP, independent of and supplemental to, the funds proposed for the Medical and Prosthetic Research account. Unfortunately, the Administration's budget request proposes to siphon funds from the research appropriation to support the expansion of MVP, rather than requesting dedicated funding to continue this important genetic research. Shifting research funds from the appropriated amount to MVP will weaken VA's ability to make awards for new and promising research proposals. We believe MVP should be funded outside these levels.

General Operating Expenses (GOE)

For FY 2017 the *Independent Budget* recommends increasing funding for General Operating Expenses (GOE) – which includes the Veterans Benefits Administration (VBA), General Administration and the Board of Veterans Appeals (Board) – to approximately $3.056 billion, more than $380 million over the FY 2016 level, and $156 million more than the Administration's budget request of approximately $2.8 billion. Both the VBA and the BVA have significant financial needs to properly adjudicate claimed benefits by veterans, and the Administration's

budget proposal is a reasonably good start toward maintaining the functionality of these two crucial areas, particularly the substantial increase proposed for the Board.

Disability Claims Processing and Appeals of Denied Claims

The VBA account is comprised of several primary divisions. These include Compensation, Pension, Education, Vocational Rehabilitation and Employment (VR&E), Housing, and Insurance. The increases the IBVSOs are recommending for these accounts primarily reflect current service estimates with inflation. However, three of the VBA subaccounts—Compensation, VR&E, and the Board—also reflect substantial increases in requested staffing.

As you know, after several years of concentrated effort to reduce the backlog of disability compensation claims the VBA can point to a dramatic transformation of the claims processing system and significant measurable progress. Consider that at its peak in 2013 almost 611,000 disability claims were backlogged; today VBA reports roughly 75,000 claims are backlogged, defined as claims pending over 125 days. In FY 2015 VBA reported completing nearly 1.4 million claims, a laudable accomplishment, but more work remains to be done.

VBA owes much of this success to implementing new work processing models for the regional offices (RO) and efficiencies gained through the expansion of the Fully Developed Claims (FDC) process to speed up simpler claims for disability compensation. In fact, almost half of all disability claims filed with the VA are FDCs, proving the success and viability of this alternative claims-filing process. However, much of the productivity increase is the result of simply putting more resources into processing claims by shifting personnel from appeals processing, along with the use of mandatory overtime. What remains unknown is whether VBA will be able to manage its current claims inventory of just over 350,000 claims without relying on mandatory overtime.

Disability Benefits Questionnaires (DBQ) have streamlined the claims process, although some veterans still encounter obstacles within the Veterans Health Administration (VHA) when attempting to get DBQs completed by VA clinicians; however, efforts to simply this process continue. VBA also continues to enhance information technology systems, including the Veterans Benefits Management System (VBMS), the Stakeholder Enterprise Portal (SEP) and e-Benefits, which are revolutionizing the filing of claims through electronic means.

Please consider that in 2010, no claims were processed electronically in the VA; today almost all of VBA's more than 350,000 pending disability claims are fully electronic; less than 30,000 paper claims remain in the system. More than one billion record images have been scanned into VBMS and are associated with claimants' new e-Folders, allowing them to be read simultaneously at all VBA offices, 148 VHA facilities and by veterans service organizations (VSO) that represent veterans in their claims.

As a consequence of this concentrated effort to reduce the disability claims backlog, the backlogs for other activities, including appeals, have grown. As of February 2016, 440,000 appeals were pending, 360,000 within the jurisdiction of the VBA, and the remainder within the jurisdiction of the Board. This growing appeals backlog is a result of VBA's shift in focus and resources to process disability claims, as evidenced by the fact that, until recently, Decision Review Officers

(DROs) and Quality Review Specialists (QRSs) were performing development and rating duties during both regular and overtime working hours at many VA regional offices (VARO). Considering the enormous growth in appeals, non-rating-activities and other services, the IBVSOs believe that more accurate staffing and production models are required to determine future resources for VBA.

Compensation Service Personnel: 1,700 New FTEE—$171 million

For FY 2017, the IBVSOs have focused resource recommendations on VBA's non-rating related work, appeals processing and call center needs. We recommend an additional 1,000 FTEE for FY 2017 that would be dedicated to processing appeals at VBA in an effort to eliminate the backlog of an assumed 360,000 appeals within the next three years. We are concerned that the Administration request for an additional 300 FTEE will be far below resources needed to address the backlog of appeals pending at VBA.

To address the growing backlog of non-rating related work such as dependency claims, the IBVSOs recommend an additional 300 FTEE. In order to address the delays experienced by callers contacting VBA call centers, the IBVSOs recommend an additional 300 FTEE.

In addition, the IBVSOs recommend an increase of 100 FTEE for the Fiduciary program to meet the growing needs of veterans participating in VA's Family Caregiver Support programs. This recommendation is also based on a July 2015 VA Inspector General report on the Fiduciary program that found, "...Field Examiner staffing did not keep pace with the growth in the beneficiary population, [and] VBA did not staff the hubs according to their staffing plan...."

Since VA may achieve future technological and organizational productivity gains, we recommend that VBA hire a blend of permanent and two-year temporary FTEE for these new positions. At the end of the two years, the best of those hired on a temporary basis could be transitioned into permanent positions made available through attrition. The IBVSOs believe this approach to staffing would offer a temporary surge capacity, while also developing a group of experienced and trained employees to fill positions that occur through attrition.

VR&E Service Personnel: 158 New FTEE—$17.6 million

For FY 2017, the Administration has again failed to request an increase in staffing for this program despite the fact that demand for services and workload continue to rise. VR&E is one of the most significant programs within the VA, enabling wounded, injured and ill veterans able to lead more fulfilling lives by providing them with significant employment, education, and training opportunities.

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

An extension for the delivery of VR&E assistance at a key transition point for veterans is the VetSuccess on Campus (VSOC) program deployed at 94 college campuses. Additional VR&E services are provided at 71 military installations for active duty service members undergoing medical separations through the Department of Defense and VA's joint Integrated Disability Evaluation System (IDES). These additional functions of VR&E personnel are undoubtedly beneficial to injured and ill veterans; however, staffing levels throughout VR&E services must be commensurate with current and future demands and its global responsibilities.

At the end of FY 2014, VR&E reported a total of 1,416 FTEE dedicated to direct VR&E services. VR&E projected an increase of 7.3 percent in program participation for FY 2015, and for FY 2016 an additional 3.8 percent increase in participation was expected. Over the previous two fiscal years, program participation was expected to increase by 11.1 percent; however, the Administration failed to request adequate staffing levels to keep pace with anticipated demand.

For FY 2015 and FY 2016, only 1,442 direct personnel were requested, with no increase for FY 2016, the same pattern holds true for the FY 2017 budget request, with no request to increase staffing. Over the past five years, program participation has increased by an average of 7.1 percent each year, and the IBVSOs project that total program participation for FY 2017 will grow by at least 7.1 percent for a total caseload of approximately 147,000.

In July 2015, VR&E reported that its average Vocational Rehabilitation Counselor (VRC)-to-client ratio was 1:139, which represented an increase from its previous 1:135 ratio. A more reasonable VRC-to-client ratio would consist of 1:125; however, this benchmark may even be too high when taking into consideration the overall responsibilities of VRCs, such as VSOC and IDES.

In order to achieve and sustain a 1:125 counselor–to-client ratio in FY 2017, we estimate that VR&E would need 158 new FTEE, for a total workforce of 1,600 FTEE, to manage an active caseload of 147,000 VR&E participants. At a minimum, three-quarters of the new hires should be VRCs dedicated to providing direct services to veterans.

Board of Veterans' Appeals Personnel: 166 New FTEE—$23.1 million

The IBVSOs fully support our FY 2017 budget recommendation to hire an additional 242 FTEE for the Board, which is a larger number than the IBVSOs had estimated could be absorbed over the next year.

Faced with a growing number of claims and resultant appeals, the Board's staff grew from 510 FTEE in FY 2012 to 676 FTEE in FY 2015. However, for 2016, the Administration did not request funding for increased staffing, despite an ever-increasing workload; instead the FY 2016 budget request actually proposed a reduction from of 669 FTEE to 662 FTEE.

Over the past few years, the Board has averaged approximately 90 appeal dispositions per FTEE, producing a record 55,532 decisions in FY 2014. For FY 2015, the Board reached another milestone by issuing just over 57,000 dispositions. Although most of the 440,000 pending appeals are in various stages of processing at VBA, the Board currently has nearly 80,000

appeals in its jurisdiction. In order to process these 80,000 appeals in one year, based on 90 appeals per Board FTEE per year, the Board would need approximately 890 FTEE; however, it did not receive any increase in FY 2016, and will likely only be able to dispose of approximately 60,000 appeals.

Furthermore, as the number of claims processed annually continues to rise as a result of the increased capacity of VBA, and the number of appeals is expected to continue rising. Even with increased accuracy in rating board decisions, on average 10 to 12 percent of claims decisions are appealed. Thus, assuming VBA processes 1.5 million claims next year—a reasonable estimate considering VBA processed over 1.4 million claims in both FY 2014 and FY 2015–roughly 150,000 appeals would enter the system, with roughly half of them continuing on to the Board for review.

In order for the Board to keep pace with only new incoming workload and not appeals already in the system, a total FTEE level of 833 would be required. Furthermore, a significant number of Board remands return to the Board for a second round of appellate review, as many as 20,000 per year, requiring an additional 217 FTEE to manage this workload.

About 360,000 appeals are backlogged at VBA, of which approximately 180,000 are expected eventually to reach the Board. If the goal were to eliminate the backlog in three years, while simultaneously disposing of both new incoming appeals and returning remanded appeals, then an additional 666 FTEE would be required. In total, without any increases in productivity, the Board would require 1,716 FTEE, almost tripling its current workforce. Even if the Board could increase its productivity by one-third to 120 appeals per FTEE per annum, approximately 1,291 FTEE, almost double the current workforce, would be needed.

To meet current and future workload requirements, the Board would need to continue adding new attorneys and veteran law judges, as well as sufficient support staff; however, the Board could not absorb that level of staffing growth while simultaneously managing its overall workload. Approximately 18 months of training and orientation are required for a new Board attorney to reach full productivity. Given the time taken away from existing staff to train and mentor new staff, the Board must strike a balance in its hiring strategy.

For FY 2017, the IBVSOs recommended an increase of 166 FTEE, based upon the assumption that the Board could not absorb more than a 25 percent increase in personnel in one year. However, the Board seems convinced it can bring onboard 242 FTEE next year without disrupting ongoing appeals work; thus, the IBVSOs fully support that requested increase. Further, the Board must continue to increase its personnel over the next couple of years to grow its capacity to handle the rising number of appeals that will come from VBA's increased productivity.

The Board may also want to consider in future years authorizing a mix of full-time and temporary hires to meet rising workload, utilizing the temporary workforce in a surge capacity role to help reduce the appeals backlog.

However, even with this sizeable increase for FY 2017, the effect on the appeals inventory may not be realized until sometime in 2018. Moreover, Congress has delayed VA's appropriation beyond October 1 every year for the past decade; a delayed budget will mean delayed hiring, delayed training, and delayed production.

Proposed "Simplified Appeals Process"

One concern within the Administration's budget identified by the IBVSOs is a provision calling for developing a "simplified appeals process" to expedite adjudication of veterans' appeals, which if not done properly eliminates due process rights for appellants. The recommendations outlined within the budget proposal regarding the "simplified VA appeals process" – particularly eliminating hearings and closing the evidentiary record – raise many due process concerns and call for deeper discussions. The IBVSOs strongly disagree with the recommendations as currently proposed. It is essential that we protect the rights of every veteran who seeks and receives the benefits he or she deserves while contemplating changes to simplify and streamline the appeals process. We have proposed several concepts to reform appeals, and look forward to participating in the discussion on the best ways to improve the process while protecting the rights of veterans to seek redress. As currently proposed, the IBVSOs oppose the Administrations "simplified appeals process" because it could severely harm many veterans. Rather than focusing only on reducing the elapsed time of a BVA decision from the filing of a Notice of Disagreement to an arbitrary one year, we must work together to develop a plan that ensures veterans receive proper decisions within reasonable time frames while fully protecting their due process rights.

Standardized Forms for Claims and Appeals

On September 25, 2014, VA issued a Final Rule in the Federal Register requiring that all claims and appeals for benefits must be filed on standard forms issued by VBA, and that VA would only accept NODs on standardized forms provided by the agency. The rule was fully implemented March 24, 2015. VBA also eliminated the informal claims process and replaced it with a new intent-to-file process. Under the new rule, if a claimant files a written claim or appeal using anything other than a VA standard form for the purpose, VBA does not recognize this filing as a claim or an appeal; instead, VBA sends the claimant notice as to which form is required to properly complete the claim or appeal filing. Please note that VA does not send the claimant the form, but simply tells him or her where and how to obtain one.

We understand the need to use standard forms whenever possible in order to create a more efficient claims processing system to benefit all claimants, and we support the principle involved in that decision, but VA's hardened rule changes have failed the test of reasonableness. These changes provide for no exceptions or extensions for the small number of claimants who might require accommodation. Considering the fact that claimants often have physical or psychological limitations from service-connected disabilities, may lack the degree of sophistication required to understand, are poor, have no access to the internet, have educational deficits, and are subject to other circumstances that may hinder their ability to fulfill these new requirements, these rules need to be amended to allow limited but commonsense exceptions and extensions to the standard form restriction.

The IBVSOs and other stakeholders were deeply troubled by VA's decision to change the rules for filing claims and appeals without providing for such exceptions. In response, concerned stakeholders filed suit against the VA. Five separate challenges on behalf of 10 veterans' service organizations are currently pending before the United States Court of Appeals for the Federal Circuit. All parties have challenged the March 2015 rule change because we consider VA's dramatic changes to the claims and appeals process to be extremely harmful to ill and injured veterans and their dependents and survivors in their efforts to secure earned benefits related to service performed in our nation's armed forces.

Congress should closely monitor the progress of the Federal Circuit action, and if the Court does not protect the interests of all veterans and their dependents, we will work with Congress to enact legislation that provides necessary protections.

Appeals Reform

While the claims backlog has fallen significantly, as indicated above, the backlog of pending appeals has risen. Over the past several years, the IBVSOs have voiced our concerns that appeals were being neglected as VA concentrated on the inward-facing 2015 claims processing goals, but a backlog is a backlog, whether it is a claim or an appeal, and each claim in a backlog is a veteran waiting for an important VA decision that may affect his or her life.

Despite the fact that the Board decided more than 55,000 appeals in FY 2014, an increase of 10 percent over the highest previous total and just over 57,000 decisions for FY 2015, the number of appeals at various stages working their way through VBA toward the Board now exceeds 320,000, not counting over 80,000 appeals already within the Board's jurisdiction. As VA continues to complete more claims each year (at the end of FY 2015, roughly 1.4 million), the rate of appeals also coming into VA increases; these two trends are inversely related.

In order to seek new solutions that could improve the appeals process for veterans, the IBVSOs along with other key VSO stakeholders, VBA and the Board developed a new appeals approach that entitled "Fully Developed Appeals" (FDA). Each of our organizations testified at hearings before the House Veterans Affairs Committee during this Congress in support of H.R. 800, the "Express Appeals Act," a bill that would create a new pilot program modeled after the FDC program. The premise of the FDA program is that some appellants could opt into the streamlined FDA process and contribute to development by gathering new private evidence necessary to support their appeals. These appellants would agree to waive some current appeal processing options and technical work currently performed by VBA and the Board, such as issuance of a Statement of the Case, Supplemental Statement of the Case, and conduct of hearings. In return the appellant would receive a significantly faster decision from the Board.

The elimination of these steps could save some veterans two to three years of processing time at the RO compared to the traditional appeals approach. While the FDA proposal is not a magic bullet that would eliminate the backlog of pending appeals, it would create another option that could save some veterans up to a thousand days waiting for their appeals to go to the Board, while also reducing the workload on both VBA and the Board.

With bipartisan support in the House from Representative O'Rourke and Chairman Miller, FDA language similar to H.R. 800 was recently included as an amendment to H.R. 677, the "American Heroes COLA Act of 2015." This bill was reported by the House VA Committee and approved favorably by the House. We hope that the Senate VA Committee will give favorable consideration to these provisions.

Of note, H.R. 677 also contains language that would round-down cost-of-living adjustments (COLA) for VA beneficiaries over a nine year period, a legislative proposal that we oppose because it would dilute benefits for ill and injured veterans, their dependents and survivors. The IBVSOs call on Congress to strike the round-down provision contained within H.R. 677.

Regarding a companion Senate bill, we are pleased to report that members and staff of the Senate Veterans' Affairs Committee considered the merits of the FDA concept. In response, Senator Sullivan, along with Senators Casey, Heller and Tester, introduced a similar FDA bill, S. 2473, the "Express Appeals Act of 2016." We hope the passage of this concept in the House and its introduction in the Senate eventually illustrate that Congress is willing to reach across party lines to provide wounded, injured and ill veterans, their dependents, and their survivors with a reasonable and viable solution to address the backlog of pending appeals. The IBVSOs intend to continue to work diligently to achieve compromise legislation on appeals reform.

We have identified some additional reforms to the appeals process that we urge VBA, with encouragement from the Committee, to adopt, or for the Congress to mandate:

- Strengthening VBA's DRO post-determination review program;
- Simplifying the "new and material evidence" standard , or eliminating it altogether;
- Commissioning a feasibility study on pre-screening appeals to identify cases that should require development prior to review by the Board;
- Engaging an outside entity to conduct a Six Sigma management study of the best performing ROs in terms of quality and timeliness, to identify best practices for processing claims and appeals work that would be transportable to other ROs;
- Engaging an outside entity to conduct a time-and-motion study of claims and appeals processing in order to determine accurate and effective human resources requirements for ROs and the Board; and
- Requiring the Secretary to report to Congress within 90 days on progress in modernizing the Board's IT systems along with a plan, including required funding, to complete all necessary IT improvements within one year from the date of a required report.

Adoption of these ideas would go a long way toward significantly and substantially reducing VA's appeals backlog, and we urge the Committee to support them.

The IBVSOs also call on Congress to support the following legislative proposals to enhance the benefits and services provided by our nation to veterans who have sacrificed as a consequence of their military service:

- Complete the ongoing reform of VA's benefits claims processing system, with the focus on quality, accuracy, accountability and timeliness;

- Eliminate inequitable policies that prohibit the concurrent receipt of VA disability compensation and military retired pay, and that require Dependency and Indemnity Compensation and military Survivor Benefit Plan payments to be offset;
- Exclude veterans' disability compensation from countable income for purposes of eligibility for benefits and services under other government programs;
- Enact legislation that would allow veterans to transfer their military skills and credentials to the civilian sector to enhance their employment opportunities;
- Strengthen veterans' vocational rehabilitation and employment programs by ensuring adequate funding for increased staffing and IT enhancements to meet increases in VR&E demand;
- Remove the 12-year delimitating date imposed on vocational rehabilitation entitlement under Chapter 31, title 38, United States Code;
- Improve delivery of transition services to all separating service members;
- Reduce premiums for Service Disabled Veterans' Life Insurance, consistent with current life expectancies.

VA's budget request for FY 2017 includes some necessary increases; however, we believe more must be done to adequately provide both VBA and the Board with the resources needed to accomplish their critical missions. We look forward to working with this Committee and others to ensure that every veteran is able to receive the benefits earned through military service.

Construction Programs

For more than 100 years, the government's solution to provide health care for our military veterans has been to build, manage and maintain a network of federal hospitals across the nation. This model allows VA to deliver care at 1,753 facilities, but has left it with more than 5,600 buildings, many of which are well past their building lifecycles. Many of these facilities need to be replaced, others need to be expanded, and all of them need to be maintained. The process to manage this network of facilities is the Strategic Capital Infrastructure Plan (SCIP). The SCIP effort identifies VA's current and projected gaps in building access, utilization, and condition. Then it lists them in order based on a gaps priority. In VA's FY 2017 budget submission, the 10-year full implementation plan to close these gaps is estimated to cost from $52-$63 billion, including $11-$13 billion in activation costs for new facilities.

Four cornerstones guide VA capital infrastructure: major construction, minor construction, leasing, and non-recurring maintenance. Major construction projects construct, alter, extend and improve a facility, and cost over $10 million each. Minor projects preform the same tasks as major construction projects but cost less than $10 million each. Leases generally reserved for small stand-alone projects such as community-based outpatient clinics (CBOC) or mental health facilities. Non-Recurring Maintenance funds the cost to equip new facilities and ensures existing facilities are functional through their lifecycle.

Major Construction

While Congress and VA needs to realign the SCIP process to allow VA to enter into public-private partnerships and sharing agreements – both federal and private – to right-size VA's

footprint, it must continue to fund the projects it had partially funded, and begin the advance planning and design of those projects it knows VA will need to fund through the traditional appropriations process.

Currently, VA is managing 30 major construction projects that are partially funded, some of which were originally authorized by Congress in FY 2004. These projects need to be put on a clear path to completion. Outside of the partially funded major projects list are major construction projects at the top of the FY 2017 priority list that are seismic in nature. These projects cannot take a strategic pause while Congress and VA decide how to manage capital infrastructure in long term.

VA will need to invest more than $3 billion to complete the 30 partially funded projects. Of the top five projects on the priority list, two of them are seismic deficiencies, two are the in VA's core mission: a mental health clinic, and a spinal cord injury center – and one is an addition to an existing facility. The total cost of these five projects is $1.2 billion.

The IB recommends that Congress appropriate $1.5 billion for FY 2017. This amount will fund either the next phase, or fund through completion all existing projects, and begin advance planning and design development on six major construction projects that are the highest ranked on VA's priority list.

Minor Construction

In FY 2016, Congress appropriated $406 million for minor construction. Currently, approximately 600 minor construction projects need funding to close all current and future year gaps within ten years. To complete all of these current and projected projects, VA will need to invest between $6.7 and $8.2 billion over the next decade.

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

VA planned to invest $383 million of these funds in FY 2015, leaving $128 million for minor projects in FY 2016. It is important to remember that these funds are a supplement to, not a replacement for, annual appropriations for minor construction. To ensure that VA funding keeps pace to complete identified current and future minor construction projects, the IBVSOs recommend that Congress appropriate an additional $749 million in FY 2017.

Additionally, the IBVSOs recommend $175 million in non-recurring maintenance and minor construction funding to address needs identified in the Congressionally-mandated report on the status of VA research laboratories and related facilities.

Leasing

Historically VA has submitted capital leasing requests that meet the growing and changing needs of veterans. VA has again requested an adequate amount, $52 million for its FY 2017 leasing needs. While VA has requested adequate resources, Congress must find a way to authorize and appropriate leasing projects in a way that precludes the full cost of these leases being accounted for in the first year. This will be especially important as VA includes public-private partnerships for major medical facilities in the future.

Non-Recurring Maintenance

Even though non-recurring maintenance (NRM) is funded through VA's Medical Facilities account, and not through a construction account, NRM is critical to VA's capital infrastructure. NRM embodies the many small projects that together provide for the long-term sustainability and usability of VA facilities. NRM projects are one-time repairs, such as modernizing mechanical or electrical systems, replacing windows and equipment, and preserving roofs and flooring. Nonrecurring maintenance is a necessary component of the care and stewardship of a facility. When managed responsibly, these relatively small, periodic investments ensure that the more substantial investments of major and minor construction provide real value to taxpayers and to veterans as well.

To maintain in the status quo, VA's NRM account must be funded at $1.35 billion per year, based on estimated plant replacement value (PRV). The Administration is requesting $1.057 billion for NRM in FY 2017. While this amount falls short of the PRV guideline, it is much closer to the actual need than VA has requested over the past several years. While more than the baseline $1.35 billion per year will be required to reduce the more than $20 billion of identified gaps within NRM, VA is investing more than $800 million from funds that were made available through the Veterans Access, Choice, and Accountability Act in NRM in FY 2016 and FY 2017.

The IB partners believe VA should develop a PRV metric and publish its results. Adding the PRV to the SCIP will allow VA to more accurately determine the appropriate amount to request for NRM and objectively decide when a facility becomes more costly to maintain than to replace. Using the PRV as a tool, VA can more accurately determine the annual funding levels needed for NRM by facility, allowing for a reduction in the NRM backlog and fully funding future needs in a way that would be the more cost effective. The industry goal for NRM is approximately two percent of the PRV. At that rate, a facility could operate for 50 years or more without outspending its replacement cost. Knowing what percentage of the PRV is being spent and taking a long-term view of capital planning could allow Congress and VA to rationally assess when a facility would need to be replaced.

National Cemeteries

In a strategic effort to meet the burial and access needs of our veterans and eligible family members, the NCA continues to expand and improve the national cemetery system, by adding new and/or expanded national cemeteries. Not surprising, due to the opening of additional national cemeteries, the NCA is expecting an increase in the number of annual veteran

interments through 2017 to roughly 130,000, up from 125,180 in 2014; this number is expected to slowly decrease to 126,000 by 2020. This much needed expansion of the national cemetery system will help to facilitate the projected increase in annual veteran interments and will simultaneously increase the overall number of graves being maintained by NCA to 3.7 million in 2018 and 3.9 million by 2020.

Even as the NCA continues to add veteran burial space to its expanding system, many existing cemeteries are exhausting their capacity and will no longer be able to inter casketed or cremated remains. In fact, as of 2016, the NCA expects four national cemeteries—Baltimore, Maryland; Nashville, Tennessee; Danville, Virginia; and Alexandria, Virginia—to reach their maximum capacities and will be closed to first interments, although they will continue to accept second interments.

With the above considerations in mind, the IB recommends $275 million for FY 2017 for the Operations & Maintenance of the NCA. The IBVSOs believe that this should include a minimum of $20 million for the National Shrine Initiative. Since FY 2013, national shrine funding has declined each year. We believe the NCA must continue to invest sufficient resources in the National Shrine initiative to ensure that this important work is completed, and that our veterans of the past will be memorialized in properly maintained fields of honor.

State Veterans Home Construction Grants

Grants for state extend-care facilities, commonly known as state home construction grants, are a critical element of federal support for the state veterans' homes. The state home program is a very successful federal-state partnership in which VA and states share the cost of constructing and operating nursing homes and domiciliaries for America's veterans. State homes provide over 30,000 nursing home and domiciliary beds for veterans, their spouses, and gold-star parents of deceased veterans. Overall, state homes provide more than half of VA's long-term-care workload, but receive less than 15 percent of VA's long-term-care budget. States construction grants help build, renovate, repair, and expand both nursing homes and domiciliaries, with states required to provide 35 percent of the cost for these projects in matching funding.

VA maintains a prioritized list of construction projects proposed by state homes based on specific criteria, with life and safety threats in the highest priority group. Only those projects that already have state matching funds are included in VA's Priority List Group 1 projects, which are eligible for funding. In FY 2016, the estimated federal share for the 109 state home construction grants requests that had been submitted by states was over $1 billion. Of that amount, the states had already secured their state matching funds required to put them in the Priority Group List 1 for 69 projects that will require $550 million in federal matching funds. Last year, VA requested only $80 million whereas the IBVSOs had recommended $200 million; Congress ultimately appropriated $120 million funding for FY 2016, which will fund only the first 13 projects on the FY 2016 Priority Group 1 List. Unfortunately, this year VA recommended only $80 million for FY 2017, a 33 percent reduction from the FY 2016 appropriated level. With almost $1 billion in state home projects still in the pipeline, the IBVSOs again recommend $200 million for the state home construction grant program, which we estimate would provide funding for approximately

40 percent of the projects expected to be on the FY 2017 VA Priority Group 1 List when it is released at the end of this year.

We encourage the Committee to scrutinize the VA's budget with vigor. The IBVSOs thank you once again for the opportunity to submit this joint statement for the record. We would be pleased to provide the Committee additional information concerning any of the issues raised in our testimony.

17

Mr. Celli?

STATEMENT OF LOUIS J. CELLI, JR., DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION, THE AMERICAN LEGION

Mr. CELLI. $103 billion in mandatory spending, money that goes directly to veterans based on laws passed by Congress for the sole purpose of attempting to make them whole again. $79 billion in discretionary spending for things like doctors, claims processors, administrative staff, IT infrastructure, hospital maintenance, and out of that, $65 billion will be spent for health care alone.

Chairman Isakson, Ranking Member Blumenthal, Members of this Committee, on behalf of National Commander Dale Barnett and the 10 percent of all U.S. American veterans that make up The American Legion, we welcome this opportunity to comment on the Department of Veterans Affairs' budget.

In 2014, Kaiser Permanente had an operating revenue of $56.4 billion and a staff of 177,000 employees. Meanwhile, for about the same amount of money, VA ran 150 hospitals, 819 CBOCs, 300 Vet Centers, 131 national cemeteries, and 56 regional offices, and they do it with a staff of 350,000. That is double Kaiser's staff. And unlike private-sector physicians, VA providers are not eligible for overtime pay, so this weekend, when VA is conducting its second access stand-down in an attempt to zero out backlogged appointments, VA will incur very little additional expense while serving veterans. I am not sure we can expect the same level of dedication from private-level doctors ever.

By law, VA facilitates the largest teaching hospital in the country, conducts statutorily mandated medical research, maintains emergency backup infrastructure in support of our national defense and national emergencies, processes millions of compensation claims, the appeals that result from those claims, cemeteries, processes GI bill payments, VA home loan applications, and insurance programs, all the while providing health care to millions of veterans in 50 States and the Caribbean. This is a massive budget that is broken down into hundreds of accounts and thousands of line items. Does VA have enough money? They have too much money. Is it wisely spent? Are there areas where VA can save money? All valid questions, but the bottom line is someone has got to do it, and to date, no one has come up with a cheaper solution.

In the meantime, The American Legion recognizes that VA will need sufficient budget authority and flexibility in order to serve our members and the veterans of the United States of America, and

there are certainly areas where VA can save money. As highlighted in the written portion of my testimony, The American Legion would like to draw this Committee's attention to three areas: consolidation of outside care; ensuring adequate VA staffing; and the growing number of pending appeals.

With the enactment of the Choice Act, Congress added yet one more layer to an already complicated system of eligibility and payment structures. The time is now to fix it by organizing all of these programs under one umbrella, with a single point of entry and a logical physician reimbursement system that is streamlined and easy for primary care teams to use. This would not only save VA money, but it would provide better and faster health care for veteran patients.

VA is a service-based industry. As in all service-based industries, the most expensive line item is employee burden. The fastest way to start saving money today is to reduce employee turnover. VA has a terrible problem filling vacancies in their mid- and upper-level leadership positions and an even worse record of succession planning. If VA is to successfully keep their positions filled, they must do a better job with succession planning. It is rare, if it happens at all, that a deputy is promoted to the position of a departing director. This practice leaves little incentive for the deputy to remain loyal to the organization and breeds resentment once the new director is instilled. VA has 50 percent of leadership positions filled by temporary fill-ins or vacant. Fifty percent. Employee turnover is expensive and a waste of money when it can be avoided.

Finally, claims. Every time a claim goes into the appeals process, it costs money. Adjudicate the claim correctly the first time, and the rate of appeals will be reduced to a trickle. We address the appeals today because VA has included a request to revamp the appeals process in their budget submission. As submitted, The American Legion does not support this plan. That said, VA has been working closely with The American Legion and our VSO partners to look at ways VA can improve the timeliness and quality of the appeals process, and we are excited and encouraged by the progress that we have made early on in this discussion and with the openness VA has shown in seeking detailed input from VSOs by treating them as valued partners.

Senators, my time before you is short today, so I will be happy to try to address any questions you may have following my opening statement. But, more importantly, we look forward to our continued work with you and your very dedicated professional staff.

[The prepared statement of Mr. Celli follows:]

PREPARED STATEMENT OF LOUIS J. CELLI, JR., DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION DIVISION, THE AMERICAN LEGION

"What we have done historically is that we have managed to a budget number as opposed to managing to requirements . . . as a result we've muddled along and not met the needs veterans deserve."

~VA Acting Secretary Sloan Gibson before the House Committee on Veterans Affairs July 24, 2014 [1]

When now Deputy Secretary of the Department of Veterans Affairs (VA) Sloan Gibson addressed this Committee nearly two years ago, he was not advocating the

[1] HVAC Hearing "Restoring Trust: The View of the Acting Secretary and the Veterans Community"—July 24, 2014

budgetary planning approach he described, but speaking to the problems that long standing approach could cause. Drawing contrasts with the planning models he was familiar with in the private sector, Deputy Secretary Gibson noted the historical approach was about managing to requirements. For VA to succeed and be great, they need to be able to move beyond managing requirements and move toward building planning based on need.

Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee: On behalf of National Commander Dale Barnett and the over two million members of The American Legion, we welcome this opportunity to comment on the Federal budget, and programs of the Department of Veterans Affairs (VA).

The American Legion is a resolution based organization; we are directed and driven by the millions of active legionnaires who have dedicated their money, time, and resources to the continued service of veterans and their families. Our positions are guided by nearly 100 years of consistent advocacy and resolutions that originate at the grassroots level of the organization—the local American Legion posts and veterans in every congressional district of America. The Headquarters staff of the Legion works daily on behalf of veterans, military personnel and our communities through roughly 20 national programs, and hundreds of outreach programs led by our posts across the country.

What we present here is an attempt to focus on a few particular issues and projected needs, rather than what has been the historical and problematic approach of presenting a budget based on a number. While the budget numbers have gone up for VA, indicative of the commitment that Congress has shown even in tight fiscal times, there has still been the tendency to set a number and manage to that limit, rather than projecting the need and divining numbers from that need.

In terms of future planning, and ensuring that VA's budget meets needs in critical areas, The American Legion directs the Committee's focus to three critical areas: the consolidation of outside care, ensuring VA's medical hiring needs are met, and addressing the rising backlog of appeals.

CONSOLIDATION OF OUTSIDE CARE

When the Choice Card program was added as a temporary emergency measure as part of the Veterans Access, Choice and Accountability Act (VACAA) of 2014[2], The American Legion supported the program because we had seen firsthand the need across the country. During 2014 The American Legion set up a dozen Veterans Crisis Command Centers (VCCCs) in affected areas from Phoenix to Fayetteville and spoke to hundreds of veterans personally affected by the scheduling problems within VA. The Choice Card program provided an immediate short term option, but also provided an opportunity to learn how veterans utilized the program. At the time, The American Legion advised gathering as much data as possible from veterans' use of the program to make all of VA's other existing authorities for care in the community[3] better in their ability to serve veterans.

Ultimately that has led to the current transformation in VA's community care programs. As directed by the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 (VA Budget and Choice Improvement Act) in July 2015, VA has developed a plan to consolidate all existing programs into a single community care program, the New Veterans Choice Program (New VCP). Generally, The American Legion supports the plan to consolidate VA's multiple and disparate purchased care programs into one New VCP. We believe it has the potential to improve and expand veterans' access to health care. Much depends, however, on the department's success in working with its employees, Congress, VSOs, private providers, academic affiliates, and other stakeholders as the agency moves forward in developing and implementing the plan.

With an eye toward budgetary matters, there are two important considerations revolving around this new transformation that must be implemented in future budgets: (1) VA must have the ability to spend all community care monies under the new framework; and (2) the additional funding required to provide for the Choice Card program needs to be factored into future budgets.

During 2015, VA ran into problems with budgetary shortfalls because of the separation in funding between Choice Card care and other community care authorities. Because of the strong push to ensure veterans were seen as quickly as possible, VA quickly exhausted care in the community funding, while emergency funding for the Choice Card program was still available. VA was forced to seek, and was granted,

[2] Public Law Public Law 113–146

[3] Such as Project Access Received Closer to Home (ARCH), the Patient Centered Community Care (PCs) program and others

authority to move some of the $10 billion allocated to fund the Choice Card program over the three year pilot to cover care in the community costs.

By now, as the transformation of care in the community moves forward to a plan with a single, overarching authority for this care (New VCP) the distinctions between the VACAA Choice funds and community care funding should be academic. While The American Legion understands there are reasons certain funding and accounts have limitations, and is not advocating for a wholesale removal of barriers for VA to move funding, in this instance is makes sense. Care in the community is care in the community, and VA must have a single stream of funding for this.

It is important to recognize that the need for the extra funding was and is real. The VACAA provided $10 billion for treating veterans in the community through Choice because the need to fund that care was real. Those needs are not going away. As of last month, VA had over 6.1 million appointments scheduled nationwide, and more than 8.5% of those appointments are still waiting over 30 days for treatment.[4] VA has seen their number of completed appointments jump by over 2.6 million last year, and throughout this they still need to authorize millions of appointments for outside care.

The $10 billion from VACAA was provided as emergency funding, but in the future, we must plan for the tremendous demand on the VA system. This is a direct illustration of the managing to numbers versus managing to need contrast mentioned above. For future budgets, we must ensure that VA is receiving funding for care that adequately reflects how they must deliver that care. A robust budget for VA medical care is necessary, but as the past few years have shown, VA has been dependent on care in the community as well to provide timely care to veterans where they are overburdened by scheduling, staffing, or lack of adequate resources. This needs to be reflected in the community care budgets, not as an emergency measure when the problem boils over and out of control.

ENSURING PROPER VA STAFFING

One reason VA may sometimes struggle to provide care within the Veterans Health Administration (VHA) is directly related to staffing. The staffing figures can be ugly. One in six positions nationally for some critical jobs remain vacant, and critical needs like psychiatric workers can see vacancy rates of 40–64%.[5]

To be fair, the VACAA already provided funding for 10,000 new healthcare positions, however funding new positions alone may not be the solution and there may be budgetary means to address some of the vacancies. Even when VA is hiring an additional 9% of their workforce they are losing a similar amount to attrition.[6] Some of this could be improved with better hiring incentives and more competitive wages, particularly in key fields of need such as psychiatric care, physician's assistants, nurses and physical therapists.

As the Office of the Inspector General recommended, VA also bears additional responsibility in the form of the development of better staffing models and examining the red tape and bureaucratic burdens that stretch hiring out into a process that can take nine months or longer.[7] Additional examination of where VA can better incentivize prospective applicants to decide on a career serving veterans would be helpful. We need to ensure VA has proper funding to get the best and brightest team members on their medical and psychological staffs serving veterans.

The VA can further help improve their staffing, especially in leadership positions, with better succession planning for VA employees to rise to leadership levels within the organization. As an organization of advocates that has worked hand in hand with VA for decades, The American Legion notes the training programs VA had in place during the 1990's were better suited to creating the next generation of leadership than the current programs in place. The VHA training programs of the 1990's were specifically built to prepare administrative employees to assume mid-level management programs at the department level. This could include personnel, fiscal, medical administration, associate director training and other leadership training. The programs were replaced, over time, with VA's current Leadership Development Programs, but feedback The American Legion has garnered from interacting with VHA personnel during visits from our System Worth Saving Task Force has indicated these programs are not providing the tools the employees need to be the next generation leaders of VA and to lead from within. Additional consideration to revamping this portion of training, and ensuring this training is properly funded,

[4] VA Pending Appointments—January 15, 2016
[5] *USA Today*—September 2015
[6] VA Office of the Inspector General (VAOIG) Report No. 15–03063–511 "OIG Determination of Veterans Health Administration's Occupational Staffing Shortages"—September 2015
[7] Ibid

could be a key component to reducing VA's reliance on the complicated process of hiring from outside VA and ultimately reduce the number of unfilled leadership positions.

THE LOOMING APPEALS CRISIS

Last year, 2015, was the year VA was supposed to "break the back of the backlog" of veterans' claims for disability benefits. While VA has made substantial progress according to their public figures in reducing the number of initial claims—the "claims backlog" sits at around 77,000 claims today[8] down from a peak of over 600,000 claims in early 2013—those numbers do not reflect the waiting period for many veterans who have been waiting for three or more years for their appeals to be decided. Over that same period the number of appeals has soared to over 325,000 from their level of 250,000 in 2013.[9] VA defines "backlog" as any case pending over 125 days. Every single appeal represents a veteran who has been waiting for much, much longer than 125 days, but those 325,000 appeals are not counted as part of the "backlog."

Often the fastest way to resolve an appeal is with a Decision Review Officer (DRO) in a Regional Office (VARO). The DROs are among the most experienced employees, and can discern aspects of a claim that a newer employee might miss, furthermore after an initial denial the veteran can be better equipped to provide information the VA noted was lacking in the initial denial. Because everything stays within the VARO, correspondence with the veteran and with a service officer helping that veteran is direct and many claims can be resolved more quickly through this process. The DRO review can be one of the best tools for speedy adjudication of an appeal and to reduce the appeals backlog. However, the unfortunate case recently is that DROs have not always been free to handle their appeals workload.

The Veterans Benefits Administration (VBA) has been under a singular mission to reduce the backlog. To this end they have forced over four years of mandatory overtime, and key veteran staffers including DROs have seen their workloads adjusted to focus on the initial claims, the claims that are counted in the VA statistics for "backlog." This can have the effect of keeping DROs from devoting full attention to their appeals workload, and the growing appeals backlog cannot be seen as an accident.

Last year, The American Legion noted that occasional mandatory overtime in a short term crisis is prudent management, but four straight years is indicative of an organization that's clearly understaffed. The American Legion reiterates our call for better study of VBA staffing models, but also notes that last year VA had proposed making the DRO process more robust, something we wholeheartedly support.

> "DROs can often resolve appeals more rapidly than the appeal process at the Board of Veterans Appeals (BVA) and with greater accuracy and clarity than the average VA rater. Reports have indicated in some offices the DROs have been reassigned to other tasks as the pressure mounts to work on initial claims. It would be the hope of The American Legion that renewed interest in hiring and increasing the DRO force would allow DROs to return to their appeals duties, and help prevent a rising backlog in the appeals area."[10]

There have been many recent proposals for measures to transform appeals as the initial claims process was transformed by the Veterans Benefits Management System (VBMS) and the Fully Developed Claims (FDC) process. The American Legion is supportive of transformative thinking, clearly the system as it has existed in the past has many flaws and has not always served veterans with the ability to develop prompt and accurate decisions on disability claims. However, it is also critical to understand that there is important due process in the system to protect veterans, and we cannot abandon these things in the interest of simply faster decisions or more convenience for VA.

Due process is important to protect veterans, especially veterans who may be uniquely vulnerable due to their disabilities incurred in the service of this Nation. It is one of the reasons the veterans' disability claims system has been specifically cited as "uniquely pro-claimant" in the manner it serves veterans filing for bene-

[8] VA Claims Backlog Dashboard—January 30, 2016
[9] VA Monday Morning Workload Report—February 1, 2016
[10] Testimony of The American Legion—HVAC Hearing February 11, 2015

fits.[11] Veterans need to depend on the ability to get a DRO review in a timely fashion, or to submit evidence in response to the VA when they are informed their claim is lacking proof of a key point, such as documentation of an event that happened in service.

One of the best things to help address the growing appeals backlog would be to increase funding for DROs to fully staff all offices and to add additional full time employees elsewhere within the offices to get the DROs back to doing what they do best, reviewing appeals in a timely manner. The budget should also reflect additional funding to study proper staffing levels within the VBA, because four years of mandatory overtime is a warning flag that has been waving to tell us we're not supplying enough staff to deal with the backlog of veterans' claims.

Whether it is appeals or initial claims, a backlog is a backlog, and the budget must reflect sufficient resources to address these claims, otherwise veterans will be forced to do what we have become all too familiar with—wait.

CONCLUSION

The VA cannot afford to be run as an entity reactive to one crisis after another. Effectiveness stems from long term planning, and to be truly effective that long term planning needs to include all stakeholders. While there are other areas that can benefit from predicting crises before they occur and providing resources to perceived needs, these three areas represent a key start in the sort of thinking that must be adopted to make VA successful in the long run.

In order to assimilate all outside care under one cohesive management authority VA needs the budget flexibility to utilize the Choice Card funds for community care as well as to see a boost to community care funding commensurate with the increased demand. The VACAA infused $10 billion in care funding because there was an emergency, but the demand has not gone away and future funding levels must reflect this as part of the plan, not a reaction to a crisis.

There must be attention paid to VA's hiring and incentives, and if additional resources are needed to secure key providers like psychologists and physician's assistants, then VHA must be provided with the funding needed to secure those key performers. That is the long term key to ensuring veterans get the care they need in a timely fashion in the system that is designed to treat their unique wounds of war.

Four years of mandatory overtime and reassignment of DROs needs to stop if VA is going to prevent the growing appeals backlog from reaching disaster levels. Funding must be given to better assess the workforce within VBA and to provide the full time employees needed to accomplish the mission while keeping top assets like DROs working on the work they do best.

Chairman ISAKSON. Thank you, Mr. Celli. Thanks to all of you for testifying, and thanks to your organizations for your advocacy.

Mr. Varela and Mr. Celli, let me just get right to the point. Both of you commented directly on objections or concerns about reforming the appeals process and the VA's plans on how they might do that. We cannot continue to do what we are doing now, which is have a backlog of claims at almost half a million, some 25 years old that continue to build up. We need your help to come up with a solution that you support and the VA can implement. Will you all commit to us to work with the Secretary to try and make such a recommendation?

Mr. CELLI. We already have, and we continue to commit to working with the Secretary. We have already had several meetings now with Deputy Sloan Gibson. We have worked with our VSO partners, and I would like to associate myself with the comments of Mr. Varela and DAV as well.

Chairman ISAKSON. Well, your comments were very timely and very appropriate, but being timely means we need to move forward. The Secretary needs some tools in his toolbox he does not have, and one of them is getting this whole backlog straightened out. So,

[11] See *Jaquay* v. *Principi*, 304 F.3d 1276, 1280 (Fed. Cir. 2002); *Nolen* v. *Gober*, 222 F.3d 1356, 1361 (Fed. Cir. 2000); *Hensley* v. *West*, 212 F.3d 1255, 1262 (Fed. Cir. 2000).

let us work toward a date at the end of March trying to come together on some kind of consolidated agreement. Would you all work with us on that?

Mr. CELLI. We agree.

Chairman ISAKSON. Mr. Varela, you commented on the fact that your testimony recommends 158 full-time employees in voc rehab and employment services, and once again this year, the VA has asked for none. Is that correct?

Mr. VARELA. That is correct, Mr. Chairman.

Chairman ISAKSON. Are you familiar with the Workforce Innovation and Opportunity Act, WIOA?

Mr. VARELA. Yes, I am, Mr. Chairman.

Chairman ISAKSON. Are those funds available to the VA commissioners in the various States to utilize for training for vocational rehabilitation?

Mr. VARELA. I will have to take that for the record. I do not know that offhand.

Chairman ISAKSON. I would suggest you check that out. When we did the WIOA act, we made sure to give the States the flexibility to do veterans training and rehabilitation as a part of that. That is a source of funding and personnel that could be dedicated—it would not add personnel to the VA, but it would add the service to the VA's whole quiver. So, I would appreciate your checking on that and being sure.

Mr. VARELA. I will.

[The information referred to follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. JOHNNY ISAKSON TO PAUL VARELA, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Yes, WIOA funds can be used to supply vocational rehabilitation.

However, those funds are "not" dedicated solely for injured and ill veterans, they are available to non-veterans alike, so these two groups would have to compete for those resources.

The Vocational Rehabilitation and Employment (VR&E) services within the Department of Veterans Affairs are dedicated solely for the use of injured and ill veterans.

Chairman ISAKSON. Mr. Blake, your testimony recommends $75 million in directed funding for the Million Veteran Program (MVP) independent of or supplemental to the funds proposed for the medical and prosthetic research account. Could you further explain the recommendation for dedicated funding for the MVP genetic research program?

Mr. BLAKE. Well, Mr. Chairman, that is a special program, a genomic study that the VA is doing as sort of a longitudinal study of all veterans for research purposes that can evaluate the wide variety of issues unique to veterans.

I think our concern is it is a heavy lift to fund that program to function the way it is intended, and the VA does a good job of expending much to all of its resources already dedicated for the existing medical and prosthetic research account. Unfortunately, this year I think the VA is projecting to draw about $60 or $65 million out of its appropriations request just for MVP. That would actually bring the medical and prosthetic research account number back below what was just approved in the appropriations bill back in

December. We think it would be better served to actually direct funding for that program independent of the medical and prosthetic research line item.

Chairman ISAKSON. Well, thank you for your testimony and for your organization, and I want to repeat what I said at the beginning to Mr. Varela and Mr. Celli and Mr. Kelley. Mr. Blake, this applies to you as well. If we can form a goal to get this appeals process worked out in terms of VA claims and VA's appeals, that would be a major move forward, and your organizations' support of doing that would be critical. We are at a point now where the Committee I think is prepared to move forward on some major legislation to resolve some of our problems. Let us not let another year go past by kicking the can down the road. Let us make the reforms necessary to get the VA straightened out. I appreciate your help in doing so.

Senator Blumenthal?

Senator BLUMENTHAL. Thanks to all of you for being here today. Thank you for your service. I apologize that I was not here earlier, but this is my fourth Committee meeting today, and one of them was the Armed Services Committee where we are assessing the capability of our military force in the South Pacific, an issue I know you feel is important as well. So, thank you to the men and women who serve with you, and thank you for your advocacy here.

I want to come back to a topic that I asked the Secretary about, which is the capacity of our VA to deal with women's health care, and although we have an all-male panel here, or maybe because we have an all-male panel, I want to ask how you feel the VA is doing judging by what you are hearing from members of your organizations.

Mr. CELLI. If you do not mind, I will start. The American Legion has a program that we call "A System Worth Saving." We visit VA hospitals around the country. One of the things that we specifically look at is women's health care. Female veterans, as we all know, are the fastest-growing population of veterans, and while VA has had a very difficult time standing up women's health care programs, lately they have come a long way. There are several new women's health care clinics spread out across the country. Does every CBOC and every hospital have a women's clinic? They do not. Do they have women's sections? They do. Could they be improved? Yes, they can. They are moving in that direction. They need to make sure that they maintain the flexibility in spending and the funding to create that.

Also on that, we also need to make sure we continue to keep an eye on child care. There are a lot of women veterans who will forgo their medical appointments because they do not have sufficient child care. VA has a program by which they can stand up some child care clinics within the women's health care clinic center. We need to make sure those remain funded.

Senator BLUMENTHAL. That point about women's child care is very, very important. I have heard this repeatedly in Connecticut. We have a new facility, a new clinic in Connecticut. It is a tremendous improvement. But, the issue of child care, the issue of transportation, the issue of taking off from work, which may affect men

as well as women, but particularly so for women. I would welcome any other comments.

Mr. BLAKE. Mr. Blumenthal, one of the things I would mention is while I obviously cannot speak from the perspective of how women are experiencing the VA, we appreciate that the VA has dedicated new additional resources, I think to the tune of about $40 million, for their programs. I would believe that more could even be done. The *IB* actually recommends about $90 million in 2017 and an additional $100 million in 2018.

I would also offer that while I think it would be unfair to say that there are not still some challenges in delivering health care to women veterans, one of the areas where we clearly see some difficulty still is in meeting the needs of women veterans who have catastrophic disabilities, particularly women with spinal cord injuries like our membership.

If it is a challenge to deliver care just to women veterans, when you add on the aspect of complicated services and the specialized services program, that adds a whole new element that I do not think they have thought completely out of the box on yet.

Mr. KELLEY. As quick as I can, we just commissioned a survey and got the results back, and we are going to be sharing those on Capitol Hill when our folks are here next week doing "Storm the Hill." As a recap, women veterans who access VA are, by and large, pleased with it. They want better access to women health care providers. Only 40 percent of them are being provided access to a female provider if they ask for it.

Also, it goes much further than just access to health care. You mentioned child care. One of the leading causes of lack of ability to get to health care services and also employment services that VA has is the lack of child care. It is a hindrance. It is leading to homelessness and people sleeping on other people's couches with no way out. So, we need to tackle that as a larger issue.

Also, women veterans who are over the age of 55 use VA at a much lower rate than the current generation of veterans, so we need to figure out how to do outreach to that generation of veterans to let them know that the services at VA are there for them as well.

Senator BLUMENTHAL. Before we go to Mr. Varela—and I welcome your comments, too—Mr. Kelley, the survey that was done, is that of the VFW members or of women veterans generally?

Mr. KELLEY. We sent it through our membership data pool, and we also shared it within the community for them to send out to their membership as well. We have active duty, Guard, Reserve, veterans from multiple organizations and walks of life.

Senator BLUMENTHAL. The number that you mentioned, 40 percent, that is the number of women veterans who want to see a woman health care provider? Maybe you could just explain that.

Mr. KELLEY. It is 40 percent of those who are seeking health care through the women's health care clinics, 40 percent of them are being seen by a female provider. But, by and large, all of them want to be seen by a female provider.

Senator BLUMENTHAL. But, only 40 percent are now.

Mr. KELLEY. Yes.

Senator BLUMENTHAL. In addition to the other challenges that the VA has in recruiting more professionals, female professionals to deal with women's health care issues——

Mr. KELLEY. Right. In VA's defense, they are doing a great job of training the doctors that they have for the particular needs of women veterans. But, when asked, "Would you prefer to have a female doctor?" by and large, they want to have that as well.

Senator BLUMENTHAL. That may be a key to involving more women in seeking health care through the VA system, the availability of women physicians.

Mr. KELLEY. Absolutely.

Senator BLUMENTHAL. Thank you.

Mr. Varela?

Mr. VARELA. Thank you, Senator Blumenthal. I would align our comments and sentiments with those of the VSO panel up here. I would also add that the women veterans that we hear from routinely say they do not want better care; they want comparable care. We do believe that the VA is moving in the right direction, but more can be done.

Senator BLUMENTHAL. I would just like to finish, with the Chairman's indulgence. I know, Mr. Blake, you said that the VA's dollar amount for health care for fiscal year 2018 is lower than you would like to see. Is that correct?

Mr. BLAKE. That is correct. One——

Senator BLUMENTHAL. But—sorry, go ahead.

Mr. BLAKE. No, sir. You.

Senator BLUMENTHAL. What is the number that you think it should be?

Mr. BLAKE. The *IB* recommends for 2018, overall for medical care, our recommendation is about $77 billion for medical services alone. It is about $64 billion. One of the things I would point out, though—and this is a touchy subject even for our membership, but looking at the community care account alone—the VA projects to spend $12.2 billion in 2017 on all community care, that is through Choice and through its community care account. Yet their projection for 2018 reduces that projection by almost $3 billion. Now, I am not here advocating for expanding community care, but I am not sure how they can even square that fact.

Senator BLUMENTHAL. Thank you very much. I think that is a very, very important insight.

I want the record to show that Secretary McDonald and his team are here. They are listening to you. I want to thank them for remaining here. It is not always the case, as you know, that the head of an agency stays to hear panels afterward, but I think it is a mark of the expertise and experience and insight that this panel brings to this process that he and his team have stayed, so I want to thank all of them for being here, and thank you particularly for, again, your service to our Nation in uniform and afterward in the organizations that you serve now. Thank you.

Chairman ISAKSON. Thank you, Senator Blumenthal.

Senator Boozman?

Senator BOOZMAN. Thank you, Mr. Chairman. I would echo the Ranking Member. We do appreciate your service in so many different ways to your country and your fellow veterans.

We have your written testimony and we have heard your spoken testimony. There are lots of issues today, lots of concerns. If you would just take a second to go through and have you tell me, if you had to summarize the top one or two things that you are really concerned about with this budget. That is really what we are talking about today. What is at the top of the list? What are your real concerns regarding the numbers that we are seeing on the budget as to where they are going?

Yes, sir, Mr. Blake?

Mr. BLAKE. Senator Boozman, I would say from PVA's perspective, our concern is clearly what is a projected escalated growth in community care spending. I recognize it is a need to address access, but that does not improve access for PVA's members. The fact is, by and large, our members do not use the existing Choice Program. They do not use PC3. They do not avail themselves of the community care programs because they are best served by the SCI system of care in VA.

For all of this work toward expanding community care access, PVA's members feel like they are maybe being left out in the cold in that discussion. VA is certainly committed to making sure there is access for our members in the SCI system of care, but there is certainly more than can be done.

Senator BOOZMAN. Very good.

Mr. KELLEY. I would like to include capital infrastructure. If you just look at the way the SCIP has ben put together, in between, it is around $60 billion in construction and infrastructure needs that VA would need to do under the current model to close that out over the next decade. That is a tremendous amount. We need to look at ways to afford VA the opportunity to enter into public-private partnerships, do sharing agreements with other Federal agencies, to ensure that we can reduce some of that backlog on new construction, but also get us out from underneath some of these older buildings that have non-recurring maintenance costs that are outrageous because they are so old. I mean, as mentioned in the first panel, if you are trying to maintain a building that is 90 years old, the non-recurring maintenance value of that is much, much higher than a building that is 10 years old.

So, we need to give them the ability to do those things, so we need to really clearly look at where are we going with construction in the future and then try to align that $60 billion. What can we carve off of that if we have these other opportunities afforded to VA in the future?

Senator BOOZMAN. Very good.

Mr. CELLI. I think by far recruiting and retention. The independent assessment clearly highlighted some leadership deficiencies within the Department of Veterans Affairs that everybody recognizes needs to be fixed immediately. If you have got a skeleton crew working, you are not going to be able to serve veterans. If you have got people filling in for jobs that they are not going to be keeping, you have got a leadership that is unwilling to make decisions, which then goes ahead and contributes to whistleblower retaliation, people being dissatisfied with their jobs. We have got to get these positions filled.

I heard the Secretary and Dr. Shulkin talk a little bit about reviewing the infrastructure to find out how many of these positions are actually needed. We cannot make that decision. They will have to do that assessment. But, if they do eliminate those positions, the people that are filling those positions that have been pulled from other positions will go back. It is a ripple effect.

We have, like I said, roughly 50 percent over the VHA landscape of leadership that is either in a temporary position or vacant. If those individuals that are filling in those leadership positions are just plugging the gaps so that the operation can move forward, their positions are now vacant. So, it is a very difficult situation that needs to be fixed, and it needs to be fixed immediately.

Senator BOOZMAN. Yes, sir?

Mr. VARELA. Thank you, Senator. If I could just comment on the VBA portion, which is my area of oversight within the *IB*, our serious concerns lie within the amount of personnel that they have requested for VBA particularly to process appeals. As we said, we think about 1,000 FTEEs should be dedicated to processing appeals only.

I would say that we have tempered that request also not simply saying that we need to hire 1,700 new FTEEs for that program specifically, but to temper that with hiring on a temporary basis maybe a portion of that so that once we get the backlog managed and once we get the inventory managed, we may not need all of those people.

Also, within VR&E, one of the most important programs with the VA, you take wounded, injured, and ill veterans, help them overcome their obstacles, and put them right back into the workforce. I mean, how does the program continue to increase each fiscal year, yet their staffing levels do not? That is a major concern for us.

Senator BOOZMAN. OK. Very good. Thank you, Mr. Chairman. Thank you, gentlemen.

Chairman ISAKSON. Thank you, Senator Boozman.

Senator Blumenthal, thank you, and I want to thank the Secretary for staying. Dr. Shulkin, thank you very much for your testimony. To the VSOs: we depend very heavily on what you have to say and your active participation as we all work together for the best benefit of our veterans. Thank you for your testimony, and thank you for what you do.

Remember what I said about our goal. We really want to try to take action by the end of March and have a consolidation of bills put together that give flexibility of direction and the flexibility the Secretary needs to have accountability within the VA; make sure we make a move forward on reducing the backlog of claims, not by cutting people's ability to make them out, but by streamlining the process to make sure it is faster and more accountable to the veteran.

Thank you all for your testimony. We stand adjourned.

[Whereupon, at 12:03 p.m., the Committee was adjourned.]

○