

**U.S. DEPARTMENT OF VETERANS AFFAIRS BUDGET
REQUEST FOR FISCAL YEAR**

HEARING

BEFORE THE

**COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES**

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U.S. DEPARTMENT OF VETERANS AFFAIRS BUDGET REQUEST FOR FISCAL YEAR 2016

Wednesday, February 11, 2015

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The committee met, pursuant to other business, at 10:35 a.m., in Room 334, Cannon House Office Building,

Hon. Jeff Miller [chairman of the committee] presiding.

Present: Representatives Miller, Lamborn, Bilirakis, Benishek, Huelskamp, Coffman, Wenstrup, Abraham, Costello, Radewagen, Brown, Brownley, Titus, Kuster, O'Rourke, Rice, McNerney, and Walz.

OPENING STATEMENT OF CHAIRMAN JEFF MILLER

The CHAIRMAN. The hearing will come to order.

We are here to discuss the President's fiscal year 2016 budget request for the Department of Veterans Affairs.

Mr. Secretary, welcome to the committee. I understand that your testimony will be a little bit different today than what we are accustomed to with reference to charts to help us better understand what you are seeing in terms of the challenges that lay ahead.

And I would say that is indeed a welcomed change. So, too, is the openness that you have had with me, with the Members of this committee, and this Congress about your plans to change the culture at VA.

As your testimony illustrates, you have been extremely active in visiting VA facilities, I think it is well over 90 at this point, talking with employees, veteran groups, and your private sector colleagues with one aim in mind, putting everyone's focus squarely on the needs of veterans.

Thank you for your willingness to take the job of secretary and thank you for putting everything that you have into that job.

Turning to the business of examining the VA budget request, I see some very positive things, but also there are some areas where we will have considerable question marks.

The committee's task will be to learn as much as possible in order to inform our views and estimates letter that is due next Friday.

On the positive side, Mr. Secretary, you have boldly tackled a very sensitive issue of VA's aging infrastructure coupled with a more realistic budget request for VA's major construction program. Addressing the closure of unsafe, vacant, or underutilized facilities

begins an important conversation about the future alignment of VA's infrastructure.

I have long argued that we needed a strategic reassessment of VA's construction program. That is in part what the independent assessment and the Veterans Healthcare Commission established in last summer's Choice Act were tasked with examining.

You have my commitment and this committee's commitment to work with you as this conversation begins in earnest.

Now, I have several areas of concern that I hope you and our second panel can address. First, and I am going to be frank as I have in the past with you on this particular issue, the proposal to reallocate any portion of the \$10 billion appropriation for the Veterans Choice Program is a non-starter.

I understand there is a great degree of uncertainty about the program's utilization. But in appropriating the money, the Congress had to work with the best estimates that we had at the time to stretch those dollars including limited eligibility criteria for veterans.

So if there is going to be any reallocation, it is going to be to further improve and strengthen the program itself and not address other unspecified needs.

Secondly, the budget requests an additional \$1.3 billion for VA medical care on top of the advanced appropriation for fiscal year 2016, bringing the total proposed increase to 7.4 percent.

At a threshold level, I do not understand how this request interacts with the \$15 billion that Congress provided last summer for non-VA care and infrastructure as part of the Veterans Access, Choice and Accountability Act.

It would appear that there are considerable unknown variables in this area such as the degree to which the Choice Program alleviates the workload and resource pressure on VA, the productivity standards that VA should expect from its clinical workforce, and the ability for VA to hire medical professionals in the face of an already large vacancy rate and a national shortage of healthcare professionals.

I hope to expand on this a bit more during questioning.

Thirdly, I note the 6.5 percent increase for the Veterans Benefit Administration principally to hire additional staff to address the workload.

Mr. Secretary, there are several of us on this committee, the ranking member included, who have long memories on this issue. We know the disability claims staffing has doubled in ten years and nearly tripled since I arrived in Congress in 2001. We have invested over a half a billion dollars in VBMS, millions more in other systems, and we have provided tools to encourage veterans to file fully developed claims which in turn enables a quicker decision.

All of these investments were made with a promise that productivity would markedly improve and shift the department away from the usual trend of relying on an ever-increasing workforce and overtime to deal with the workload.

Although I note the production improvement in the backlog over the last two years, it is a far cry from seeing individual worker productivity improve given the resources that have already been pro-

vided to the department. Again, this is another area I hope to address in questioning.

And, finally, a big lesson learned last year is that veterans are better served with constant and aggressive oversight. Ms. Brown and I have asked for a larger committee budget towards that end.

One thing that you and I have talked about is the Office of Inspector General. I, too, believe that they need an increase larger than the .3 percent increase provided in the budget. The proposed amount is not even enough to cover inflationary costs, let alone the increased oversight we all rely on so heavily.

Again, Mr. Secretary, thank you for what you are doing. I look forward to your testimony and I look forward to hearing from the veteran service organizations on the second panel. The VA system is for them and those they represent, so their input on budgetary matters is critical in informing the committee and the Congress on VA's budget request.

[THE PREPARED STATEMENT OF CHAIRMAN JEFF MILLER APPEARS IN THE APPENDIX]

And with that, I recognize Ms. Brown for her opening remarks.

**OPENING STATEMENT OF RANKING MEMBER CORRINE
BROWN**

Ms. BROWN. Thank you, Mr. Chairman.

And welcome, Mr. Secretary. I want to say that I am very happy that you are here this morning and I am looking forward to hearing how this budget request will meet the needs of our veterans.

The President has proposed a large increase for VA. For fiscal 2016, the President has proposed nearly an eight percent increase in funding for VA healthcare, personnel, construction, research, and claim processing.

Given this large request, I am looking forward to our discussion today and how it will assist our work as a committee to make sure that this proposed budget gives you the dollars that you need but also assures us how in Congress that every dollar you receive will be spent wisely.

I certainly wish that my bill, H.R. 216, the Department of Veterans Affairs Budget Plan and Reform Act of 2015, was the law of the land. It is an important tool to assist us and you in matching resources to the needs of our veterans and ensuring that we are planning for the future to make sure that we don't let our veterans down.

Mr. Secretary, the first question I will ask is does your proposed budget give you all of the dollars you need to fix the problems that you face, meet the goals and initiatives the department has laid out, keeping in mind that funding provided by the Choice Act.

I hope that we can discuss whether you have enough resources to ensure that veterans do not face intolerable delays in getting access to healthcare. I hope we can discuss how you are looking down the road to ensure that veterans have the access to VA care in the future.

I always hear from veterans how they prefer VA care when it is available. I hope that we are going to all work together to make sure that healthcare our veterans prefer is available to them when they need it.

This is the first year that VA benefits programs will be fully funded under advanced appropriations, how veterans won't have to worry about what we are doing in Congress, and it won't affect how we operate.

Finally, I want to hear about your reform and reorganization efforts and how this budget request will support these efforts.

I also want to hear about how you are making progress in an effort to reform and re-energize, invigorate the VA. Too often all we hear about is the problems VA is having. I would like us to also consider what we can do to fix those problems and to point out what VA is getting right.

I am pleased with this budget request and I hope these dollars can fix what is wrong and strengthen what is right with the VA.

And with that, Mr. Chairman, I yield back the balance of my time.

The CHAIRMAN. Thank you very much, Ms. Brown.

[THE PREPARED STATEMENT OF RANKING MEMBER CORRINE BROWN APPEARS IN THE APPENDIX]

I would like to welcome our first panel to the table this morning.

Accompanying the Honorable Robert McDonald, Secretary of the Department of Veterans, is Dr. Carolyn Clancy, Interim Under Secretary for Health; the Honorable Allison A. Hickey, Under Secretary for Benefits; Mr. Ronald Walters, Interim Under Secretary for Memorial Affairs; Ms. Helen Tierney, Executive in Charge for the Office of Management, and VA Chief Financial Officer; and Mr. Stephen Warren, Executive in Charge and Chief Information Officer with the Office of Information and Technology.

Mr. Secretary, again, thank you for being here and please proceed with your statement.

STATEMENT OF ROBERT A. MCDONALD, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY CAROLYN CLANCY, INTERIM UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS; ALLISON A. HICKEY, UNDER SECRETARY FOR BENEFITS, U.S. DEPARTMENT OF VETERANS AFFAIRS; RONALD E. WALTERS, INTERIM UNDER SECRETARY FOR MEMORIAL AFFAIRS, U.S. DEPARTMENT OF VETERANS AFFAIRS; HELEN TIERNEY, EXECUTIVE IN CHARGE FOR THE OFFICE OF MANAGEMENT, AND VA CHIEF FINANCIAL OFFICER, U.S. DEPARTMENT OF VETERANS AFFAIRS; STEPHEN WARREN, EXECUTIVE IN CHARGE AND CHIEF INFORMATION OFFICER, OFFICE OF INFORMATION AND TECHNOLOGY, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF ROBERT A. MCDONALD

Secretary MCDONALD. Thank you.

Chairman Miller, Ranking Member Brown, Members of the committee, thanks for the opportunity to discuss VA's 2016 budget and 2017 advanced appropriations request.

Thank you as well for joining me at 810 Vermont last week for a groundbreaking town hall meeting.

We deeply appreciate the President's and Congress's steadfast support for veterans, their families and survivors, as well as the advocacy of veteran service organizations.

Our Nation is emerging from the longest war in its history. VA is emerging from one of the most serious crises the department has ever experienced. We now have before us the greatest opportunity we have ever had to improve care for veterans and to build a more efficient and more effective system. With your support, VA intends to take full advantage of this remarkable timely opportunity.

Members of this committee and VSOs share my goal to make the VA a model agency with respect to customer experience and stewardship of taxpayer resources, an example for other government agencies.

With efficient and effective operations, we look to be comparable to the very top private sector businesses. This is how we best meet the Nation's obligations to all veterans.

The cost of fulfilling those obligations to our veterans grows and we expect it will continue to grow for the foreseeable future. We know that services and benefits for veterans do not peak until roughly four decades after a conflict ends.

[Chart]

Secretary MCDONALD. This chart demonstrates the number of veterans receiving service-connected disability benefits from World War I peaked in 1958. For World War II, it peaked in 1985. For Korea, it peaked in 1993 and for Vietnam veterans, it was just last year, 2014, when it peaked.

It is worth remembering that today, almost 150 years after the Civil War ground to a halt, VA is still providing benefits to the child of a Civil War veteran. We still have troops in both Iraq and Afghanistan. And in the last decade, we have already seen dramatic increases in the demand for benefits and care.

[Chart]

Secretary MCDONALD. This chart shows how for 40 years, from 1960 to 2000, the percentage of veterans receiving compensation from VA was stable at about eight and a half percent. But in the last 14 years, since 2001, the percentage has dramatically increased to 19 percent, more than double.

Simultaneously, the number of claims and the number of medical issues in rating related claims that VA has completed has soared.

[Chart]

Secretary MCDONALD. As this chart shows, in 2009, VBA completed almost 980,000 claims. In fiscal year 2017, we project we will complete over 1.4 million claims. That is a 47 percent increase. But there has been even more dramatic growth in the number of medical issues in claims, 2.7 million in 2009 and a projected 5.9 million in 2017. That is a 115 percent increase over just eight years.

These increases were accompanied by the dramatic rise in the average degree of disability compensation granted to veterans. For 45 years, from 1950 to 1995, the average degree of disability held steady at 30 percent. But since the year 2000, the average degree of disability has risen to 47.7 percent as this chart shows.

[Chart]

Secretary MCDONALD. So while it is true that the total number of veterans is declining, the number of those seeking care and benefits from VA is increasing. Fueled by more than a decade of war, Agent Orange related disability claims, an unlimited claims appeal process, increased medical claim issues, far greater survival rates among those wounded, more sophisticated methods for identifying and treating veterans' medical issues, demographic shifts, veterans' demands for services and benefits has exceeded VA's capacity to meet it.

It is important that Congress and the American people understand why this is happening. The most important consideration is that America's veterans are aging. As with any population, healthcare requirements and the demand for benefits both increase as veterans age and exit the workforce.

[Chart]

Secretary MCDONALD. This chart reveals an astounding shift. In 1975, the year I graduated from West Point, just 40 years ago, only 2.2 million American veterans were 65 years old or older, 7.5 percent of our veteran population. In 2017 here on the far left, we expect 9.8 million will be 65 or older or 46 percent of veterans. That is 7.5 percent to 46 percent, an astounding increase.

So today we serve a population that is older with more chronic conditions and less able to afford private sector care. We predict that benefits for veterans of recent conflicts will peak around 2055 if we assume that Afghanistan and Iraq are winding down this year.

And it is fair to imagine that Members of Congress, the President, and the secretary of Veterans Affairs in 2175 will be debating resources that will in part help care for the family members of Iraq and Afghanistan veterans.

Currently 11 million of the 22 million veterans in this country are registered, enrolled, or use at least one VA benefit or service. Veterans are demanding more VA services than ever before. The number of all veterans who are seeking VA medical care is steadily growing.

The requirement for women veterans, a very important issue for us, and mental health, another very important issue for us, have increased dramatically. Over 635,000 women veterans are now enrolled in VA healthcare and over 400,000 actively use VA for care. That is double the number using VA care in the year 2000.

We see annual increases in women veterans seeking care of about nine percent and this trend will continue and probably even go higher. Our women veteran call center now connects with over 100,000 women veterans per year.

Over 1.4 million veterans with a mental health diagnosis are enrolled in VA, an increase of 64 percent from the year 2015. There were approximately 19.6 million mental health outpatient encounters in 2014. That is an increase of 72 percent from 2005.

Since its inception in 2007 through 2014, the veterans' crisis line has answered over 1.6 million calls and assisted in over 45,000 rescues. Over one million veterans received services through the primary care mental health integration program begun in 2007 through November 2014. The annual number of encounters has

grown from about 182,000 in fiscal year 2008 to over one million in 2014.

As veterans witness the results of the positive changes VA is making and regain trust in the VA and as the military simultaneously downsizes, the number of veterans choosing VA services will continue to rise. It should and our veterans have earned it.

We are listening hard to what veterans, Congress, employees, VSOs, and other stakeholders are telling us. And what we hear drive us to a historic, unprecedented department-wide transformation changing VA's culture and making the veteran the center of everything that we do.

That transformation we call MyVA because that is the way we want veterans to think about VA. It is theirs. It is personalized. It is customized. And this transformation entails many organizational reforms to better unify the department's efforts.

MyVA focuses on five objectives, which I have shown here on the bottom. First is improving the veteran experience so that every veteran has a seamless, integrated, and responsive customer service experience every single time.

Second, improving the employee experience and eliminating barriers to customer service to achieve people excellence so employees can better serve veterans. We have no hope of taking care of veterans if we don't take care of the employees of VA.

Third, improving our internal support systems and services.

Fourth, establishing a culture of continuous improvement so local levels can identify and correct problems more immediately and then replicate proven solutions across our entire network.

And, fifth, enhancing strategic partnerships. MyVA revolutionizes VA's culture and reorients the department around the needs of veterans, measuring success by veterans' outcomes as opposed to some kind of internal metrics.

We intend every veteran to have a seamless, integrated, and responsive customer service experience every single time.

Reorganizing the department geographically is a first substantial and important step in achieving this goal.

In the past, VA had nine disjointed geographic organization structures, one for each line of business. So imagine a business with nine different businesses, nine different sub-businesses each having a different organization structure and a different middle management.

Our new unified organizational framework has one national structure as shown in this chart.

[Chart]

Secretary MCDONALD. This new structure has just five regions aligning VA's disparate organization boundaries into a single framework. This facilitates internal coordination and collaboration among business lines, creates opportunities for integration at a much lower level, and promotes effective customer service. Veterans will see one VA rather than individual disconnected organizations.

Last, MyVA is also about ensuring VA is a sound steward of taxpayer dollars. We will integrate Lean Six Sigma systems and efficiencies across our operations to ensure we balance veteran-centric

service with operational efficiency, but we need the help of Congress.

VA cannot be a sound steward of the taxpayers' resources with the asset portfolio that we are currently carrying. No business would carry such a portfolio. Veterans deserve much better. It is time to close the VA's old substandard and underutilized infrastructure.

Nine hundred VA facilities are over 90 years old and more than 1,300 are over 70 years old. VA currently has 336 buildings that are vacant or less than 50 percent occupied. That is 10.5 million square feet of excess, which costs us an estimated \$24 million a year to maintain. These funds could be used to hire roughly 200 registered nurses for a year or to pay for 144 primary care visits for veterans or to support 41,900 days of nursing home care for veterans in community living centers.

We need your support to do the harder right rather than the easier wrong. These MyVA reforms will take time, but over the long term, they will enable us to better provide veterans the services and benefits they have earned and that our Nation promised them.

Our 2016 budget will allow us to continue this critical transformation to meet the intent of MyVA. The 2016 budget for VA requests \$168.8 billion, \$73.5 billion in discretionary funds and \$95.3 billion in mandatory funds for benefit programs.

The discretionary request is an increase of \$5.2 billion or 7.5 percent above the 2015 enacted level and it provides the resources necessary to continue to serving the growing number of veterans who have selflessly served our Nation. The budget will increase access to medical care and benefits for veterans. It will address infrastructure challenges including major and minor construction, modernization and renovation. It will end the backlog of claims and veterans' homelessness by the end of calendar year 2015. It will fund medical and prosthetics research and it will address the IT infrastructure and modernization.

We know this is a large request, but it is not sufficient to meet all the requirements for either 2016 or 2017. Therefore, the President will transmit a legislative proposal to allow flexibility as necessary to reallocate, if needed, a portion of the Veterans Choice Act funds to improve VA operations within a fiscally responsible, budget-neutral approach to best care for veterans.

[Chart]

Secretary MCDONALD. As this chart demonstrates, this proposal is largely driven by our uncertainty of what resources we need to fund the new Veterans Choice Program. It is difficult to predict veterans' use of the program or its interaction with the medical care base budget because it is all new.

We have no long-term data to draw upon yet. Our current estimates of demand range from a low of about \$4 billion to a high of about \$13 billion over the three-year program. We want and need the flexibility to move resources if veterans decide to stay inside VA rather than move outside VA.

This is about ensuring every veteran receives the care they have earned and deserve regardless of where they choose to get it from.

Mr. Chairman, Members of the committee, we meet today at a historically important time for VA and the Nation. March will mark the 150th anniversary of President Lincoln's solemn promise to those who had fought the most devastating war in our country's history. He promised that we would care for those who shall have borne the battle and for their families and their survivors.

That is VA's primary mission. It is our only mission. It is the noblest mission supporting the greatest clients of any agency in the country, and we count on your support to uphold that sacred commitment.

Thank you again for your unwavering support for veterans, for working with us on these budget requests, and for making things better for all of our great Nation's veterans. We look forward to your questions.

[THE PREPARED STATEMENT OF ROBERT A. McDONALD APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much, Mr. Secretary, for your—

Secretary McDONALD. Thank you, sir.

The CHAIRMAN [continuing]. Testimony. And as we approach President Lincoln's birthday tomorrow, we are ever mindful of his commitment to the veterans of this Nation and our responsibility as a Congress and as an administration.

Can you tell me a little bit about how the \$15 billion that was appropriated last year in addition to the budget, how that is accounted for in this budget?

Secretary McDONALD. Well, sir, as you know, that money gets obligated only when veterans use the program. So, so far in terms of Veterans Choice Program, we have had nearly a half a million calls from veterans about the program, veterans and providers. So far, we have had roughly 24,000 veterans make appointments on the program and go outside. So we obligate that money as it is.

Also, we are in the process of leasing 27 new facilities and that work is already underway. And we are using the money to hire more doctors, more medical professionals. We have a net new increase of over 8,000 medical professionals. That is in the last nine months. November was our biggest month of hiring. We hired over 2,000 more medical professionals than we lost.

Our turnover rate is about eight percent, 8.9 percent. The turnover rate in the industry is about 18 percent, so we are trying everything we can do to retain the medical professionals and hire those that we need.

Let me ask Helen. Is there anything I missed, Helen?

Ms. TIERNEY. Thank you.

Yes, we did have a shift of just over \$500 million where we think the costs will shift to the Choice Program.

The CHAIRMAN. Yeah. Could you explain that a little bit further? I know there was a telephone conference with staff, but talk about the shift.

Ms. TIERNEY. So understanding the program is still very new, we thought that some of the costs that we normally see in the Fee Program would be picked up by the Choice Program. Right now, though, our actual results are we are seeing much more demand for the Fee Program on the VA side of the budget.

The CHAIRMAN. Yeah. I would say that is a critical component to knowing whether this request is adequate or not. That is why the hesitance to do anything, Mr. Secretary, with the Choice piece.

Again, we arrived at the 40-mile criteria because we wanted to have zero. Any veteran out there had a choice. That number came back from CBO at about 50 billion. We couldn't do that, so that is where the 40 got.

But there has to be some savings, I would suspect, that are derived by alleviating some of the pressure within the system by those that are going outside because of the Choice Program.

Ms. TIERNEY. And we are going to be looking at that very carefully. What we also don't understand is what level of suppressed demand that we had from veterans who did want to use the services who weren't using the services because of long wait times, distance. So there is still a lot to understand about Choice.

Secretary McDONALD. Mr. Chairman, I don't know that now is the time to make a move of any funds. What I am trying to do is sensitize the committee to the fact that there is a lot of uncertainty. And in our budget, we have roughly 70 line items where we have inflexibility. We can't move money from one line item to another.

And what I am asking is that we work together to have flexibility so no matter where a veteran goes, we can move the appropriate money there and make sure that veteran receives care.

The CHAIRMAN. I will commit to helping you have flexibility, Mr. Secretary, in just about everywhere within your agency except within that Choice piece because of the uncertainty that is there. That is what is interesting about this budget request.

You talk about, Ms. Tierney, about all the uncertainty that is out there, yet we are asking for increases in FTEs. We are asking for increases in dollar amounts.

Let me get back real quick. I have got one other question and then I need to give it to Ms. Brown.

One of the things that I think a lot of us have asked, I know the physicians on this committee have asked over and over again, have never really gotten an answer, it is twofold, number one, how much does it cost for a veteran to be seen within the VA versus the private sector? The private sector, Mr. Secretary, you know could answer that right away. We have a hard time answering that within the department. And then the other issue is, do we know whether the clinical workforce is operating at its maximum capacity and efficiency based on the workload that is out there? There has just been a lot of anecdotal evidence that has been presented to this committee that would say that it is not, that physicians are seeing as few as two patients a day which is just absolutely unheard of.

Dr. Clancy.

Secretary McDONALD. Let me ask Dr. Clancy to comment on that. But before she does, let me say that, as you know, my first trip was to Phoenix. And when I arrived in Phoenix, I discovered we were short 1,000 people and each primary care doctor had one clinical room. And in the private sector today, a primary care doctor has three clinical rooms.

So we have an issue of both staffing, which the committee helped with the Choice Act, but we also have an issue on infrastructure.

It is an old infrastructure. We have got women veterans and we don't have the clinical rooms that are currently the situation today.

In Boston, I would visit operating rooms where operating rooms are 35 percent smaller than they need to be. If you have an operating room which is 90 years old, they didn't use robots or computers in operating rooms 90 years ago. We need that equipment today to be able to provide our veterans the best operating surgery that we can possibly do.

Dr. Clancy.

Dr. CLANCY. Yes. So just on the productivity issue which I think is incredibly important, we have a tool, and we have discussed this and briefed Representative Wenstrup, called SPARC where facilities can look at the productivity of different types of clinics understanding that it is both about what the clinician is doing about the space issues that Secretary McDonald just mentioned and also about the efficiency and capabilities of the people around them who are supporting those needs.

That tool has been deployed system wide. We are right now examining some of the data quality issues and very importantly are having that externally reviewed. So we would be happy to come back and brief you in more depth.

We think it is a good tool. At this point, it is more diagnostic than it is kind of in a place where we could give people grades, for example, but we also want to make sure that some of the best and brightest minds have taken a look at it, have kicked the tires and so forth so that we are confident as we measure productivity.

And I just want to reinforce what the secretary just said a minute ago. Some of our clinics, some of the better clinics, it would bring tears to your eyes in terms of how well they are doing, but they are really, really landlocked. One room almost feels like a gift much less the two or three that you would see in the private sector.

The Chairman. Ms. Brown.

Ms. BROWN. Thank you, Mr. Chairman.

Before I begin my questions, Mr. Secretary, I understand that you were down in Orlando last Wednesday meeting with the Nurses Association. Can you give us an update of how that went?

And also you made an announcement about the opening of a hospital in Orlando. Can you give us an update on that also?

Secretary McDONALD. Yes, ma'am.

I was in Orlando. I spoke to the American Nurses Association and I was there to tell them about how exciting it would be to work in VA today. And just like you and the chairman went with me to the medical schools in Florida to recruit, we were recruiting. We picked up quite a few people who were interested in coming to work for VA.

The VA is the largest employer of nurses in the country and it is important. Our nurses are very important to us and they do a great job. So that is why I was there.

Separately I did visit the Orlando hospital, Orlando Medical Center. There are now patients being seen. We are in the process of moving in. We expect to have a commemoration ceremony of sorts by Memorial Day.

But between now and then, there will be new clinics being set up every single week there. It is a fantastic facility and I think the

citizens of Orlando and the area of Florida will really enjoy going there.

Ms. BROWN. Thank you.

Dr. Clancy, it is a lot of discussion on this committee about, you know, we have doctors on this committee and they talk about the duties and responsibilities. It is a little different working with the VA because what we expect of the VA physicians is a little more comprehensive.

When a person goes in, let's say I am going into the podiatrist, but they can't just go in and deal with a podiatrist. It is comprehensive. I mean, it is the blood pressure. It is a whole different casework.

Can you explain that to us?

Dr. CLANCY. So we believe that primary care and care for the whole veteran, if you will, is really the foundation of the system. So for the most part, we don't have people just coming in for podiatry or for a hearing aid, for example, a very popular use of our facilities, without also checking some of their other risks to their health and so forth.

We are taking a very, very hard look because our two overarching goals for this year are getting access right, whether it is within our facilities, whether it is virtually by telehealth or something like that, fee care, or with the Choice Program, that all of that is seamless, and our equally high second goal is exceptional veteran experience.

We recognize that some veterans actually might choose to simply come in for podiatry and skip the rest. So we are going to be looking at different options for doing that by way of maximizing efficiency and, frankly, making the veteran experience very satisfactory.

But in general, we have an incredible opportunity because of the entirety of the department to actually have an impact on health that no other healthcare system has because a lot of things affect health besides medical care. That is income. It is education. It is whether you have a place to live and so forth.

And the department has tools through VBA and so forth to actually address all of those needs. So we take that very, very seriously.

Ms. BROWN. The last question I have, what are we doing working with the Department of Defense as veterans transition to make it seamless and, you know, the bumps in the road?

I just met a veteran who has been out two years and only ten percent disability. But the point is he can't get his paperwork from DoD. What are we doing? And we have asked this question for years.

Secretary McDONALD. It is a great question. I have to say that Secretary Hagel and I are totally aligned that we want to have a seamless handoff from the Department of Defense to VA. That is why we have instituted programs like TAP while the person is on active duty.

Maybe I will ask Allison to talk about that.

Ms. HICKEY. So, Congresswoman Brown, some good news to report on this front, though it didn't obviously help that particular veteran two years ago.

We are actively engaged now in the mandatory TAP Program for all of our separating servicemembers including national guard and reserve for which there are now nearly a million who qualify for benefits that did not previously.

Another thing that is starting literally right now is the mandatory separation health assessment. The choice to the veteran told at the TAP session is that if you are going to make a claim to VA for anything, then VA will do a complete separation health assessment on you top to bottom before you leave service so that we capture absolutely everything service connected right there on the spot.

The next thing I will tell you is we have moved substantially forward with DoD on the new Haines System where they give us the complete service treatment record, all the parts and pieces we have talked about before that we used to call the gold standard.

For a while there, the numbers of late ones were really high, but they have come down to now about 21 percent of them are overdue. So they are getting better and we are getting them faster. And we have built all the IT connections now such that we simply note in VBMS that we have got a claim. The system tells the DoD system we are asking for the records and then the records come back automatically into VBMS and are instantly loaded up into our VBMS system for the raters to do it. That has helped substantially.

The last thing I will share with you that we have also done is we have reduced substantially those folks waiting in the IDES process and now are getting much better in our timeliness in the IDES process.

And I can tell you also that the Benefits at Discharge Program, the backlog has been reduced by a significant amount. There is only about five or ten percent of those who are now over 125 days.

Ms. BROWN. Thank you very much.

And I yield back the balance of my time.

The CHAIRMAN. Mr. Secretary, I just want to read a text that I just got from a friend of mine. Said had a reason to deal with the VA in Jacksonville this morning on a home we just finished for a veteran. A guy named X handled my request and was very efficient and friendly. I left the conversation warm and complete. Very good experience. Never had that before. Thank you.

Secretary MCDONALD. Mr. Chairman, may I get the name so I can send a note of recognition?

The CHAIRMAN. Yes, you may.

Secretary MCDONALD. No, I am serious. I do that.

The CHAIRMAN. Unsolicited. It just came in while I am sitting here.

Secretary MCDONALD. As you know, I have given out my cell phone number publicly and nationally and I get about 120 contacts a day. And right now I would say 30, 35 percent are positive. That is not enough. All of us sitting here at this table want 100 percent of those to be positive and we are working on it.

The CHAIRMAN. You bet ya. I will be glad to provide you his name.

Ms. Brown. Mr. Chairman.

The CHAIRMAN. Yes, ma'am.

Ms. BROWN. You did say Jacksonville.

The CHAIRMAN. Yeah, I did.

Ms. BROWN. All right.

The CHAIRMAN. Maybe that is why they never had a good experience before.

Mr. Lamborn.

Mr. LAMBORN. Thank you, Mr. Chairman.

And thank you for being here, Secretary McDonald.

I am pleased to see that you have focused a portion of your budget on construction efforts. Can you tell me the status of the southern Colorado National Cemetery Project and when you anticipate that they will begin accepting earlier burials? I am very concerned that this project stays on track.

Secretary MCDONALD. We are as well. We are in the design phase right now and we think that design phase will take about a year, year and a half.

Ron, would you like to provide more detail?

Mr. WALTERS. Yes.

Congressman Lamborn, as you know, we have made progress, significant progress on establishing the cemetery in southern Colorado. We acquired the 374 acres at Rolling Hills Ranch in El Paso County. We do have sufficient funds in the budget right now to complete the design, complete it through construction documents, the final phase of design.

Once that is completed, we will begin the solicitation phase for construction of phase one. Assuming construction funds are provided in the next budget cycle and that is, you know, yet to be determined, we would expect the first burials to occur sometime in calendar year 2018.

Mr. LAMBORN. Well, I am disappointed that the time line seems to be slipping. I will do everything I can to make sure that those funds are in the budget and I will work with other folks to try to achieve that, but it sounds like there has been some slipping to the right and that is disappointing.

Secretary MCDONALD. We are going through a complete review right now of our construction management process. As you know, Sloan Gibson, the Deputy Secretary, is leading that. And we have asked the Corps of Engineers help. We have got to find a way to shorten these time lines that we face. And so we will be looking at that and obviously any work we can do to accelerate it, we would like to do.

Mr. LAMBORN. And I will work with you if any amendments are necessary or any other legislative action to help you have the authority to make faster progress in the future on this or other projects.

Changing subjects, Secretary McDonald, you mentioned that there are five proposed regions as opposed to 21 VISNs. I guess that is more efficient. Does that mean that you will have fewer personnel doing the same job as before which to me is a hallmark, a result of more efficiency?

Secretary MCDONALD. Well, as I said in my remarks, this organization is focused on productivity improvement. We don't feel like we can come to you and ask for more money unless we are demonstrating that we are saving money at the same time. That is why

we have identified the buildings that are empty that cost us money every year.

Think of nine different geographic maps, each one for a different line of business, whether it is insurance or disability—

Mr. LAMBORN. And I have one other question, so if you could just summarize.

Secretary MCDONALD. Okay. It goes to five regions and we haven't yet determined how many VISNs we will have, but they have to fit those five regions.

Mr. LAMBORN. Okay.

Secretary MCDONALD. And we have a team of directors looking at that now. Everybody is trying to fit into that structure. The point is there will be more efficiency at the middle management level.

Mr. LAMBORN. Good. And I hope that means fewer people doing the same job which means less budget dollars going to personnel.

Secretary MCDONALD. We are trying to put every budget dollar we can against the veteran experience—

Mr. LAMBORN. Okay. Thank you.

Secretary MCDONALD [continuing]. Making the veteran experience better.

Mr. LAMBORN. Thank you.

And lastly, I know we have touched on this, but the transition between DoD and VA, and I have 100,000 veterans in my district and almost that many dependents and other family members. And the Military Compensation and Retirement Modernization Committee has just come out with recommendations. They have said there needs to be better transition.

You have mentioned some things that you are working on. That is good to hear, but what can be done in the future, what could be improved to make that transition better?

Secretary MCDONALD. We met with that committee throughout their work. I think they have done some excellent work. Some of the ideas that Allison mentioned are brand new and before that committee wrote its report. In fact, when they gave us the report, we mentioned some of these things and they missed the report. The report was already in printing.

But this idea of the medical exam before the servicemember leaves the service, that is the biggest idea. And I think the problems that we have had in the past we will be able to resolve with that and also with the way we strengthen the TAP Program. So I think we are getting better, but we are going to continue to look and see if there are other things we can do.

Mr. LAMBORN. Okay. Thank you so much.

The Chairman. Ms. Titus.

Ms. TITUS. Thank you, Mr. Chairman.

Thank you, Mr. Secretary. It is nice to see you again.

Secretary MCDONALD. Good to see you, ma'am.

Ms. TITUS. We appreciate you being here. Before I ask kind of my general question, I am going to bring up what I always bring up and that is the Reno office. You know, we have been without a permanent director for about two years. We are on our second interim.

I understand they haven't started to recruit yet. But if you moved it to Las Vegas, it would be a lot easier to recruit a person to come and take that position. So that is my first point.

Second, you know, the hospital built in Las Vegas was too small by the time it was completed because they didn't anticipate the increased usage. We heard Deputy Secretary Sloan say they were going to move some resources to help with the hospital that is out from Denver, I believe it is, Aurora. I want to be sure that you aren't moving any resources from the Las Vegas hospital to fix the problem in Aurora. So if we could just follow-up with that.

Now, my general question is, for the last couple of years, we have focused on the backlog, fixing that problem and also problems with our hospitals. So I would like to see us as we move into the next two years look at other areas, of benefits and make the VA more relevant to our 21st century veterans.

And I appreciated the things that you mentioned in your testimony. One is women, second is LGBT veterans, and third is the issue of medical marijuana. These are all big issues during these times. You talked about how many more women veterans you expect to have, but really what we don't know is what we don't know.

And the Women Veterans Task Force recommended two positions that are data gathering positions so we can get a better handle on this, a performance analyst and a demographics and research analyst. So I would like to know if the VA is making those two positions a priority and if we have your commitment that those would be positions that would be funded and utilized.

Second, I would ask you, Mr. Secretary, if you would commit to whether you think the law needs to be changed that prevents the VA from giving LGBT veterans the same benefits that other veterans get. They earned them. They deserve them. They just happen to live in the wrong state. I don't think that is fair.

And, third, with the medical marijuana, as more and more states are legalizing medical marijuana, VA doctors aren't able to make any kind of recommendations concerning that. I wonder how VA policy might be moving to address that issue.

Secretary MCDONALD. Thank you for the questions.

First on women, I took down a painting in my office that had probably been on the wall since Omar Bradley was the administrator of VA and I put up a poster that says women in the military. And it has a picture of a woman in service in each branch of the military. And I did that on purpose because this is going to be a defining issue for those of us leading the VA right now.

You already heard that our buildings are old. We need space to be able to create the women's clinics. We just opened a women's clinic here in Washington, DC, at our facility. I would encourage you to go see it. It is a beautiful clinic, but it is different than where the men would want to go.

Ms. TITUS. Yes.

Secretary MCDONALD. And, of course, the care is different because we have gynecologists and other kinds of care. So this is a very important issue for us and we are working very hard to identify where can we put women's clinics with women care.

We just got a building from DoD in Fort McPherson, Georgia, where we have set up a women's clinic. This is a very big issue for us and we are going to stay after it.

Relative to LGBT, we are following the law. You know, if the couple is married in a given state, we will give them benefits. We need a new interpretation in the law or a change in the law. We are following the law.

There is an exception to that. In national cemeteries, if we are able because of the legal authority I have to be able to bury partners together when they so choose, and in every case that we have done that, we have looked at the relationship and we have granted that, so—

Ms. TITUS. If I may interrupt you. I appreciate that. But in state cemeteries, it still remains a problem as I understand it.

Secretary McDONALD. Yes, ma'am. I don't control those.

Ms. TITUS. Yeah. But they get funding from the VA, the state—

Secretary McDONALD. Some. Some.

Ms. TITUS [continuing]. Veteran cemeteries.

Secretary McDONALD. Some.

On the medical marijuana, let me ask Dr. Clancy to comment.

Dr. CLANCY. Sure. So a fair number of our clinicians have veterans who use marijuana, I will put it medically in quotes. They live in areas where this is legally possible and so forth. It is very, very early for us to have medical policies, but there are active discussions going on now and trying to learn from what we know about treating it for different conditions which, by the way, are not necessarily identical with those conditions for which veterans believe that they are helpful.

I actually think that there is an incredible opportunity for us to learn from some of those experiences, but I think that we have to be careful given the variation in legal issues. But we would be happy to provide more detail for the record.

Ms. TITUS. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

I yield to Ms. Brown for 30 seconds.

Ms. BROWN. Yeah. On the area of medical marijuana, we have constantly passed the bill saying that the VA doctors cannot administer even if the state in the area says it is legal and they could be charged with a felony. So it passed last year on the floor. I didn't vote for it. And it is an issue for Congress. I mean, so if you feel strongly about it, then I think maybe you should introduce a bill. But as we speak, it is illegal for a VA doctor to administer marijuana.

Dr. CLANCY. Yeah, that is correct, Representative Brown, and I was not clear enough on that point. That said, again, trying to be responsive to veterans' experiences and what they are telling us. We are trying to learn from that and understand and anticipate what a different future might look like.

Ms. BROWN. Oh, absolutely. There are all kinds of additional kind of therapy, but as we speak now, it is illegal for a physician to administer it. Am I correct?

Dr. CLANCY. [Nonverbal response.]

Ms. BROWN. And last year, we passed a bill on the floor saying it was illegal for a VA physician.

I yield back.

The CHAIRMAN. Thank you.

Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman, very much. Thank you.

First of all, I wanted to thank you, of course, Mr. Secretary, first of all, for taking the position and being so accessible to us, but more importantly to our veterans. And, again, you have made a great deal of progress and we want to help you make more progress, so thank you for your cooperation and we are here for you.

First of all, I have some questions with regard to lease authorizations. First of all, I want to thank you for working with me to ensure veterans and community stakeholders in my area are being engaged regarding the Pasco County lease consolidation located in central Florida.

To ensure the success of its utilization, it is important that their opinions on potential locations and what specialty services should be offered are considered. I know you agree.

I am pleased to hear that there will be a potential site visit. Can you give me an idea of when that might be?

Secretary MCDONALD. Our staffs are meeting. They met this morning actually. So I don't know the outcome of that meeting, but I think it should be imminent, tomorrow or the next day.

Mr. BILIRAKIS. Thank you.

Again, is there something we can work with you on to expedite the activation of these leases in general, the leases in general? I am talking about the 27 leases that were authorized last year.

Secretary MCDONALD. Right. As I said, Sloan Gibson, our Deputy Secretary, is going through a process right now to understand how can we speed up our ability to design, lease, construct. And as we go through that, if it looks like there is an opportunity for legislation, we will come back to you and ask you for your help. Right now we are not ready for that, but we are taking a close look at it.

Mr. BILIRAKIS. All right. My next question has to do with the future lease authorizations. I understand that there is an issue between VA and GSA with future lease authorizations, not the 27 that were authorized last year.

Can you discuss what options are being considered and if there is enough requested in the budget, should funds for the full extent of the lease be required? It is so very important that we plan ahead.

Secretary MCDONALD. I will start and then maybe Helen can help.

At one time, over a year ago now, we had a blanket lease authorization from GSA which would allow us to enter into leases quickly, easily with our authority. That has been revoked and it requires us to go to GSA for them to study our leases. In some cases, if the cost of the lease exceeds, I think it is \$2.85 million, then they actually have to take it to a committee which takes even more time.

They have been very helpful. We have been working with them to speed up the process, but we are also trying to see if there is a totally different way that we can do it. We are applying Lean Six Sigma technically to see if there is a way we can improve the process even more.

Helen.

Ms. TIERNEY. GSA has been working very cooperatively with us. We are working on getting those processes right and making sure that we all are working under the same standards for scoring. So I think that is progressing well right now.

Mr. BILIRAKIS. Okay. Very good.

Anyone else.

[No response.]

Mr. BILIRAKIS. Thank you very much.

I do want to discuss with you in the future, Mr. Secretary, expanding dental healthcare for our veterans within the VA and some of the clinics.

But I yield back at this time. Thank you, Mr. Chairman.

Secretary MCDONALD. We would be happy to do that.

Mr. BILIRAKIS. Thank you.

The CHAIRMAN. Ms. Kuster, you are recognized.

Ms. KUSTER. Thank you very much, Mr. Chairman.

I want to start by commending you, Secretary McDonald, for the efforts that your team has done to settle the lawsuit out in west Los Angeles.

We had a hearing yesterday in the Oversight and Investigation Committee and we had a discussion about the steps that will be taken.

A couple of things in follow-up and I will be working with our subcommittee chair, Mr. Coffman. But one is we want to stay in very close touch with your team about the plan for the west LA facility, particularly addressing homelessness of veterans in west LA, and then we have suggested to have a follow-up hearing next fall when you come back with your report so that we can stay closely engaged with that.

Secretary MCDONALD. We would love to do that. I think what we demonstrated in west LA more than anything else is this is a team sport and we all need to play together on the same team. And it is just silly to think that we have a national issue with veterans being homeless. And in the city with perhaps the largest homeless population in the country, we had a lawsuit going for four years that prohibited us from making progress.

Ms. KUSTER. Yeah. And the representative from The American Legion said it had been 30 years that they have been working on this problem which obviously goes through a number of administrations, so—

Secretary MCDONALD. We got the land in 1880 something.

Ms. KUSTER. 1888, yeah. I wanted to go to the opposite end of the country to my district in New Hampshire and talk briefly about the Veterans Choice Program. My colleagues in the Senate, Senator Ayotte and Senator Shaheen, have introduced a bill to make sure that the Veterans Choice Program, whatever happens elsewhere, will continue in the states that do not have a full service VA hospital.

This is critical for us because we have got folks that, and I know they don't travel the distances that my colleague, Beta O'Rourke's constitutes travel, but with weather and such particularly of late, that is important.

Can I ask about how the Veterans Choice Act is working in those states? And you mentioned briefly about hiring new physicians and medical personnel for filling the gap. I am particularly interested in mental health provider and if you could comment on that, it would be very helpful.

Secretary MCDONALD. First of all, I want to make sure that we are clear that the leadership of VA believes that the system of the future will be a network of both VA and outside care. Already we, in the last year, we did about 550 million appointments in outside care. That was up 48 percent above a year ago. So that is even before the Choice Program.

So we are believers in that because that is the way our veterans will get served the best. It was misinformation. There was never intent to either gut the Choice Program or somehow eliminate the Choice Program. It was simply I was asking for recognition that we have 70 line items of budget that we can't move money from.

Imagine your household. You have a checking account for gasoline. You have a checking account for groceries. The price of gasoline goes down by half. You are hungry, but you can't move the money from the gasoline account to the food account. Well, that is the situation I face. I am trying to serve veterans and I don't have the flexibility to do that. I ran a relatively large business. You know, it is very hard to achieve customer satisfaction when you have all these strictures and restrictions on how you can take care of customers. So that was the only point I was making.

The Choice Program is a good program. It is very early days. As I said, we have had nearly 500,000 calls and about 24,000 appointments, but we are going to be watching it very closely every single day and we will let you know what we see.

Ms. KUSTER. Yeah. Again, that is something that I would assume the Oversight Committee would want to stay in close contact.

Secretary MCDONALD. We invited over, and I will make this invitation to everyone, we invited over Congresswoman Brown, Chairman Miller. They came over. They went through our daily—we have something we call a daily standup. It is a Lean Six Sigma technique. We review the data from that day and you make changes to the next day.

Deputy Secretary Gibson leads it. And I would invite any Member to come over and watch us do that. I would argue that it might give you confidence in the data that we are giving to you and you can also see the trend lines.

Ms. KUSTER. Thank you very much. My time is expired.

Secretary MCDONALD. You are welcome. Thank you.

Ms. KUSTER. I yield back.

The CHAIRMAN. Mr. Coffman.

Mr. COFFMAN. Thank you, Mr. Chairman.

Mr. Secretary, in the budget submission for the Office of General Counsel, you list as recent accomplishments, and this is a quote, "Defending against complex litigation such as the construction

projects in Orlando and Denver,” end quote. How is that a success? You lost that case on every single point.

For the hospital in my district that is hundreds of millions of dollars over budget and years behind schedule and the only way the construction could continue was that the general contractor demanded that the VA construction management personnel be kicked off the project and that the Army Corps of Engineers come in and take over the project.

And so, you know, I think that is just characteristic of your glossing over the extraordinary problems confronted by your department. This is a department mired in bureaucratic incompetence and corruption.

And I have got to tell you I think the public relations is great today, but there is no substance. There is no substance. And I—

Secretary MCDONALD. I am highly offended by your comments, Mr. Coffman.

Mr. COFFMAN. Let me finish first because I fundamentally believe that as unfortunate as it is that at the end of the day, at the end of this President’s term that you will not have made a difference in changing the culture of this organization by virtue of the fact that you continue to gloss over its problems.

Secretary MCDONALD. I am offended by your comment. Actually, I have been here six months. You have been here longer than I have. If there is a problem in Denver, I think you own it more than I do.

I found it ironic that when I went out to LA to solve a four-year-old lawsuit, you were busy calling for a hearing to discover what happened five years ago. I am working on the future, sir, and I am going to correct the past. But I am working on the future because that is what our veterans want.

Mr. COFFMAN. For you to say that you are going to the Army Corps of Engineers to advise you as to how to correct the extraordinary problems, let me tell you I think what you need to do is focus on providing the healthcare benefits and the other benefits that veterans have earned and get out of that construction management business and to cede it to the Army Corps of Engineers.

Secretary MCDONALD. We know that is your point of view and—

Mr. COFFMAN. Each major construction project is hundreds of millions of dollars over budget and years behind schedule. That is a problem.

Secretary MCDONALD. I think we work very closely with the Corps of Engineers. General Bostick is a good friend. He has also been very helpful. He has told us he does not want total responsibility for all of VA’s construction.

We are going to work with him. We are going to find out the right balance of that. We are doing it in Denver, as you know, and we appreciate your help to get that building finished and get it finished for a good value for taxpayers.

Mr. COFFMAN. I hope you can make a difference. I hope you can.

Secretary MCDONALD. I would just say maybe if you want, I will give you my cell phone tonight and you can answer some of the calls and see if I am making a difference for veterans and see what

they say or go on the Web sites, see what the veterans are saying on the Web sites. Ask the VSOs in the next group.

Mr. COFFMAN. The fundamental challenge—

Secretary MCDONALD. I run a large company, sir.

Mr. COFFMAN. The fundamental challenge is for this organization to reflect your values and I am not sure that that is going to happen. And I hope that it does.

Secretary MCDONALD. I want your help to do that.

Mr. COFFMAN. Mr. Chairman, I yield back.

Secretary MCDONALD. I need your help.

The CHAIRMAN. Thank you, Mr. Secretary.

Mr. O'Rourke.

Mr. O'ROURKE. Thank you, Mr. Chairman.

Mr. Secretary, let me begin by thanking you for your service. I have only been in Congress a little over two years. But in that short time, I really feel that you personally have set a new bar for leadership and accountability and responsibility for the problems that you encountered that you are turning around and, in fact, facing the future so that we build a better VA and do better for the veterans whom we serve.

Case in point, two days after the tragic murder of Dr. Fjordbak in El Paso, Texas, you were there on the ground meeting with VA leadership, the incredible staff that works under Mr. Dancy. You, in fact, ensured that we had Mr. Dancy there to begin with. You replaced leadership and ensured that we had someone there who could be transformational and that is what we need in El Paso right now. So I want to thank you for that.

I also want to thank you for your willingness to work with us to do better in El Paso. I mean, again, no need to focus on the past. We are not a top-tier performer. We want to be and I want to figure out how we are going to do that.

To some of the points that Mr. Coffman just raised and a, you know, six or eight hundred million dollar facility now projected to be \$1.1 billion or 1.4 at the high end, we can't do that anymore.

In El Paso, we have partners like Texas Tech and the four-year medical school there, University Medical Center, the public hospital, private providers, Tenet and ACA, all of whom are desperate to work with us.

I would like your commitment that we are going to in the short time that we know that you have within this administration, 22 months, put together a plan and get it to a point where it is unstoppable so that should we be lucky enough to have you as secretary in the next administration or your successor will be able to work with us to implement that.

Can I have that commitment from you publicly to work with me on that?

Secretary MCDONALD. As you and I talked when we were there and we went to the Texas Tech site, what we want to do in El Paso is exactly what we did in Los Angeles which was we got everybody together. We looked at all the options and we are going to make the decision together. We are going to work together to get this done.

This is a team sport. We can't do it by ourselves and we know that. And so I look forward to working with Texas Tech. I look for-

ward to talking to Department of the Army because, as you know, currently our facility is connected to Beaumont, but Beaumont is closing. But, yes, we will work together to develop a plan for El Paso.

Mr. O'ROURKE. Thank you.

And I also want to thank you for the presentation you made at the outset of this meeting. I think you placed our current problems in context. And they, not all of them, some of them originate in the VA, but the wars that we choose to engage in, and you mentioned that, you know, hopefully we are at the conclusion of our commitment in Afghanistan and Iraq and we are going to peak in terms of commitments to those veterans in 2055.

I would argue the point that we are still at war in Afghanistan. We have 10,000 servicemembers there whose lives are on the line. The NATO commander says expect more U.S. casualties. We are about to consider an authorization for the use of military force in Iraq and Syria. We are and have been in a state of perpetual war and there is a cost to that beyond sending the servicemember over, funding the assets that follow him or her. It is the cost to care for them and their family and their children when they return.

And I just hope that we are all keeping that in mind as we go forward. There is a much larger cost than the immediate one that we consider.

The Veterans Choice Act passed this August included a component to assess VA healthcare processes and it was supposed to be an independent assessment.

What do you have in this 2016 budget that would fund implementing the findings from those assessments, if any? And I don't know when that assessment is supposed to conclude.

Dr. CLANCY. Thank you, Representative O'Rourke.

As you said, the Choice Act actually has required a number of assessments which, frankly, we think are an incredible gift.

I last weekend spoke to a Blue Ribbon panel that they have assembled who will take a look across all of the assessments. They will be finished their work by this August and are working very, very hard, weekends, evenings, whatever they need to make sure that that happens. And they are looking at all aspects of our operations.

Mr. O'ROURKE. You have dollars in this budget to implement the recommendations that are made?

Dr. CLANCY. I don't think that we have explicit dollars. I think what we have is we expect that this will be a core part of management and how we do business. And we are providing them with all of the data that they need to actually make the recommendations as actionable and relevant to VA as possible. So we are very much looking forward to those.

Mr. O'ROURKE. Okay. My time is expired, but I would love to follow-up with you on that—

Dr. CLANCY. Great.

Mr. O'ROURKE [continuing]. To find out what that might cost. Thank you.

Thank you, Mr. Chair.

The Chairman. Dr. Wenstrup.

Dr. WENSTRUP. Thank you, Mr. Chairman.

And thank you all for being here today.

If I may, I am going to go back to something I touched on briefly the last time that we met and that is what we actually spend for the care that is delivered.

And I had asked about knowing the number of how many RVUs per year does the VA generate with their caregivers, the relative value units. And that is a common term used both in private sector and in the VA, and then what the total cost is. And then by total cost, I don't mean just what the doctor is getting paid, but you are including everything, administration, physical plant.

And Mr. Gibson said, oh, we are a long way from coming up with that number. And my question is, how do you come up with a budget if you can't say what that number is today? So how much did we spend on everything to do with healthcare per RVU that was generated?

And so I am curious why we can't come up with that number for one because I wonder sometimes when we look at Choice, are we really determining is it more cost effective and a patient benefit in some regions to refer out rather than build out, you know?

And because the cost per RVU to the outside doc is pretty easily defined. You know what you paid that doctor, but that doctor is then paying for their physical plant and their staff and their malpractice and all those other expenditures. So that is pretty well defined, but we are not being realistic if we don't look at the overall picture of what we are spending per RVU.

So if you could comment to those issues.

Secretary MCDONALD. As Sloan said, that is a system we have to develop. We are in the process of doing that. It is not perfected yet. The numbers aren't as valuable yet.

The department has had a history of working to a budget. It has not worked to a demand or to a customer focus. As a result of that, Congress would provide a budget and that is what the department would work toward. That budget would be allocated throughout the department.

So we are actually, contrary to what Congressman Coffman thinks, we are actually making some relatively large changes here to focus the organization on the customer and to be able to get that data.

Dr. Clancy can talk about the process of doing that, but this is a big undertaking.

Dr. WENSTRUP. So if we know what the budget is for all the health administration costs and what that is, can't that give us something to start with? In other words, I feel like we need a baseline. We can start to look at that more closely at different facilities as we project out.

I am looking down the road, you know. I am here for the same reason I think you are, is to make a difference and to make good decisions, but we have got to come up with those numbers because you can't decide if Choice is working better or worse and effectively, especially when it comes to the dollars.

Secretary MCDONALD. Yeah.

Dr. CLANCY. Thank you.

That is part of the independent assessments that we will be getting as well. One of the wild cards here that I am sure you are

quite familiar with in terms of comparing how efficient and productive we are, cost per RVU versus the private sector is that there is a big difference in terms of fixed costs versus variable costs.

If you have got a building where you have to keep a cafeteria running and all that kind of stuff, that is the point that was in the overall opening statement from Secretary McDonald. In the private sector, they have got a lot more flexibility.

But we will be looking at that very, very hard because as we look to a future where, as Secretary McDonald said a few minutes ago, it is going to be both about what we provide in VA as well as what we send out to community partners through non-VA or fee care and Choice and so forth or something like it possibly with a different name.

We have got to be very, very smart and as strategic as possible about make or buy decisions and—

Dr. WENSTRUP. Well, I look forward to seeing those types of numbers because that has got to be our guide—

Dr. CLANCY. Yes.

Dr. WENSTRUP [continuing]. As we try to decide what is best for the veteran and the VA itself as we go down the road.

Dr. CLANCY. Absolutely. And those answers are probably going to be different in some communities than in others depending on local capacity and so forth.

Dr. WENSTRUP. Sure. No, I think you do have to evaluate locally, but you can start with what it is in the big picture—

Dr. CLANCY. Yes.

Dr. WENSTRUP [continuing]. And then take a look locally, because every place is going to have a little different demand based on VA population, et cetera. So I look forward to working with you on that and, thank you, I yield back.

Dr. CLANCY. Great.

The Chairman. Mr. McNerney.

Mr. MCNERNEY. Well, thank you, Mr. Chairman.

Hey, I am really glad to be back on the committee. I was here for three terms starting with the 110th Congress. It is a pleasure to be back.

I want to thank you, Mr. Secretary and the Under Secretaries for your dedication. This is an enormous challenge, as you pointed out in your opening remarks. A lot more service is required, a lot more veterans seeks help and so on. So, I think we are making progress, but there is still a long ways to go.

My first question will go to Ms. Hickey, who I have had that lot of dealings with in the past. I would like to just give a brief update on the backlog, specifically focusing on some of the California ROs who had such a problem a few years ago, and please kind of be brief, if you would.

Ms. HICKEY. Absolutely. So let me just start, for all of you, the backlog is down nationally sixty-two percent and we are on target to hit our 2015 goal.

Our productivity is up 25 percent, per FTE. We are producing now, at the claim's perspective, 47 percent more than we did before we started this transformation effort; a 101 percent from a claims—from a medical issues' perspective.

Our quality, we have not traded for; in fact, it is up eight percentage points at the claim level at 91 percent, and at the medical issue level, it is now up at 96 percent.

What I will tell you—a non-rating, by the way, we have not put off non-rating; we just have a lot of it, it is volume, it is need. When we do more regular, you know, first-time claims, it opens the door to more follow-on non-rating opportunity for our veterans. So, by exactly, when we did record breaking, never done in our history before, at 1.32 million claims last year, and as you saw on the chart, the disability level is now on average at 47.7 percent, you have a wider opportunity for many more veterans to get that additional benefit as well.

Oakland, since we last saw you here in the room—glad to have you back, Congressman—phenomenally much better. Their backlog is down 67.3 percent. Their quality is up at 90 percent on issue basis and they are doing much better than they were. They also have done much better on the mail issues, which we are doing nationally, so I thank this whole Committee, both now for the funds that you have invested in centralized mail. We are really starting to see the benefit of that, moving mail timeliness down from 32 days down to eight days; that is a phenomenal saving to our veteran, in getting that mail associated with that client.

Mr. MCNERNEY. Okay. Well, you know President Reagan had a saying, “Trust, but verify.” I am really glad to hear these numbers, and you know that we are going to be looking into them to be sure.

Ms. HICKEY. Absolutely.

Mr. MCNERNEY. Thank you.

The next question goes to Mr. Secretary. Following up on Mr. Bilirakis’ questioning, I would like you to comment a little bit on meeting construction challenges. You said in almost a quote that the VA is not ready for legislative help on this issue. But I would like to see if you think private partnerships would be beneficial in moving forward with the construction backlog or where do you stand on that sort of issue?

Secretary McDONALD. First of all, as I said in my remarks, on my VA, strategic partnerships is one of the five planks. This is a really big deal. Historically, VA has not had as many strategic partnerships as had been possible, and one of the first things I found as secretary is I had a lot of people willing to offer help that we did not accept.

So we set up an office of strategic partnerships. We have somebody leading it. They came from the private sector. We are hoping to making good progress there.

Secondly, relative to construction, a lot of changes have been made over the years, probably since the last time you were on the committee. Number one, originally, a lot of the times, the design was done by architects. Engineers have now been added to the design committee and there is a whole design committee now that reviews it.

Many of the structures that we are building now, frankly, as an engineer—I am an engineer—I would not have built, because they are architects’ dreams, but they are very expensive and they will be very expensive to operate.

Secondly, we have looked at that entire process. We are training, do a better job of training the project managers. We will implementing GAO recommendations, about how to make the process more efficient. So there are a number of steps being taken.

As Congressman Coffman said, we are now also working with the Corps of Engineers and we have asked them to do a complete review for us from A to Z of our process and see if we can improve it, as well as what part of the process could they help us in.

Mr. MCNERNEY. Well, thank you.

On a parochial issue, in the French Camp Project there is been some temporary structures put up, but some of the basic requirements such as disability-accessible bathrooms have not been met yet, even though the project has been up there for more than year.

Can I get your commitment to take strong action to make sure that those basic requirements are met, sir?

Secretary MCDONALD. We will get into that.

Mr. MCNERNEY. Thank you, Mr. Secretary.

Secretary MCDONALD. Thank you.

The Chairman. Dr. Abraham.

Mr. ABRAHAM. Mr. Secretary, first, if you for your effort and your attitude, and that of your staff, for trying to help our veterans, as great as they are.

Two quick questions. One, on the—we have hit this before on some of the electronic health record issues, the VA budget states, and I will quote this, “In addition to VistA improvements, the VHA 2016 investment supports our commitment to achieve interoperability with the Department of Defense electronic health record and community health care providers, including those who are participating in the new Veterans Choice Program.”

My question is this: With a 136 percent increase in EHRs and VistA funding from fiscal year 2015 to 2016, and given your stated emphasis on making seamless transition possible, can we now expect to see third-party administrators and non-VA providers get access to these systems?

Secretary MCDONALD. Let me talk on the high level and then I will ask Steph to talk about specifics.

Mr. ABRAHAM. Okay.

Secretary MCDONALD. I believe that the electronic medical record that will win in the future will be a record which is open-source, free to everyone—

Mr. ABRAHAM. Right.

Secretary MCDONALD [continuing]. As well as crowd-sourced in terms of the innovation. Crowd-sourced innovation occurs in a much more rapid pace than any company with protect their own innovation rate. So our record is open-source. It is crowd-sourced in terms of innovations. We get innovations back—I was at the AMA convention talking about the importance of private sector providers using our record so we could do a really warm handoff of our veterans to the private sector and back under the Choice Program.

Mr. ABRAHAM. Is that working pretty good, the warm handoff?

Secretary MCDONALD. It is early days. It is early days. But we have more work to do to make sure that the veteran’s record is there when they get there and to make sure that we get the anno-

tations back from the doctor in the private sector who works on them, and that is part of the work that we are doing.

Mr. ABRAHAM. You know, heretofore, some of the private providers were getting the veteran's health records, but it was the entire record and sometimes it was hundreds and maybe even thousands of pages—

Secretary MCDONALD. Yes.

Mr. ABRAHAM [continuing]. Whereas that provider only needed maybe the last discharge summary, and it would have taken two to three hours to get through that stack.

So we need something certainly more seamless, certainly more efficient—

Secretary MCDONALD. Yes.

Mr. ABRAHAM [continuing]. For the outside Choice providers.

Secretary MCDONALD. In a sense, the good news is that we need that interoperability too, with DoD, too.

Mr. ABRAHAM. Right.

Secretary MCDONALD. So we need the interoperability back and we need it forward, and Steph can talk about the steps that we are taking.

Mr. WARREN. Thank you, Mr. Secretary.

If I could submit for the record, actually, four charts that walk through what is the sharing that we are doing today?

[Chart]

The CHAIRMAN. Yes.

Mr. WARREN. And it includes sharing with third-party providers. So we have 31 partners, UC Davis Medical Systems in terms of where we are sharing data already. There also is a way of sending the email as—or sending the information to the third-party provider as an email.

The other piece that we are doing, to recognize your point about, we would send the full medical record.

Mr. ABRAHAM. Right.

Mr. WARREN. We are taking the Janus Viewer which shows a VA record and the DoD record together and we are going through and modifying it so we can actually provide that to the third-party provider. So when we send the veteran out for that third-party care or through Choice, we are able to send a URL. The provider can click on the URL and the record comes up.

Mr. ABRAHAM. Do you have a timeline when this might—is this going to happen within six months? Twelve months?

Mr. WARREN. Again, these documents are what is happening now. It will give you the record in terms of using the existing systems. The one where we are sending the provider a link so they can look at, we are about a year away.

Mr. ABRAHAM. Okay.

Mr. WARREN. Because we need to make sure when we do it—we have a Choice issue with respect to veterans opting in to us sharing that information to somebody outside of the system, and that is one of the systems that we are working through programatically.

So, the technology piece, the team is looking at it. We are using the viewer that we deployed last year to add in the capability out to third-party providers.

Mr. ABRAHAM. Okay. My second question real quickly, because my time is limited, going back to the efficiency of the providers, whether it be a physician, a PA or an NP, and I understand the limitation of space being one or two exam rooms, but even with that, is there a measurement for a provider on a daily basis that we can access or you can access and give it to us that shows how many patients they are seeing a day? Like Chairman Miller said, two patients a day, even with one exactly room is not anywhere close to being acceptable. As a physician, I know what one exam room can see during a day. And I understand the complications that VA patients have, as having multiple-organ system issues, so can you address that, please?

Mr. WARREN. The answer is and I will let Carolyn talk about it.

Dr. CLANCY. So, the great news, and as a few of you got to see last weekend, the secretary invited anyone else who wants to come, we literally go over these data every single morning, so it is much more visible how many patients per day providers are seeing. Understand that some of our providers are also teaching or doing research and so forth, but we have to be as transparent about all aspects of that as possible. So this entire exercise not only gives us close to realtime information—and we post this publicly every two weeks, in terms of—

Mr. ABRAHAM. Are we doing anything with the information?

Dr. CLANCY. Yes.

Mr. ABRAHAM. Are we incentivizing or maybe—and punishment is the wrong term—but if that physician or that provider is not pushing himself a little bit, are you guys pushing him or her a little bit more?

Dr. CLANCY. I think the word would be “motivating.”

Mr. ABRAHAM. That would probably be a better word.

Dr. CLANCY. Yes. Yes.

Secretary McDONALD. Given the issues on access, that is not a problem. Everybody is looking at this data locally and regionally and nationally because of our issues on access.

Mr. ABRAHAM. Okay. Thank you.

The Chairman. Mr. Walz.

Mr. WALZ. Thank you, Mr. Chairman and Ranking Member, and thank you for the opportunity to be back on this committee. It truly is one of the greatest honors that I have experienced in my life.

Mr. Secretary, thank you for being here for numerous reasons. I say thank you as a veteran. I am glad to know you are there and that means a lot.

I think this room, when I look around, I mean back here, is filled with some of the most honorable, patriotic and professional people I know, at this table, those behind you, the VSOs, members here. I have to say it is certainly somewhat objective, but over the last year we have had difficult conversations, all of us, and we have worked closely together. They were difficult because all of us understood the implications of our actions impacted veterans, and if it was Phoenix or wherever—but trying to find solutions.

And I can say from my experience, and I think it is the one that you are hearing here, the professionalism and the willingness to fix this amongst this team has been greatly gratifying, and I say again, maybe subjectively, but it feels to me like for the first time

in a while, the Department has its feet back under it. That this idea of moving towards solutions—and it is not that we will ever going to stop having accountability of where we are going to stop, whether it is problems as they bring up, but trying to find those solutions.

So I, for one, accept that and I believe that your challenge is right; we all are in this together. We have responsibilities to get this. And when we bring up these things, these parochial issues, those are the things that our constituents are talking about. Those are the things.

But I go back to what you said, Mr. Secretary, I do believe this is a unique opportunity for transformational change, and this window will close over a certain amount of time, just the nature of politics and everything else that goes with it, so I think we need to seize on it. The feeling I have gotten is that there is a desire.

And I can tell you from the folks that work out there—and I just came from a meeting with a group of your fantastic VA nurses and they are committed. They want to get this right. Their morale is—I care about that, because if we freeze their pay and we hammer them and we tell them that the VA is not working, they know that is not true in the cases where they are out there on every case. So I think when we hear from them, I hear this feedback, I hear from the different groups and we try to get it right.

And I just wanted to go on, on this providing solution things, that I think there are new ideas out there. I think this new model is starting to get there and I want to tie it all together. When I first got here eight years ago, the first thing I worked on was VHA's pain management issue, and this comes back to me again and again, mainly because it ties in on so many levels of veterans care, especially mental healthcare.

And I think it is timely in that yesterday we signed in and tomorrow it will be signed by the President, the Clay Hunt Bill which is—we recognize one step. I recognize the incredible work that is already being done at VA, but I think it might be a new way at looking at this, a new approach, and it ties in with, again, why we bring these solutions and why we want to interact with you is, is the Tomah situation with the opiates. These are all connected. And I agree with you, if I had been here eight years and Tomah's in my area of operation, I own some of that, and I get that.

So what I ask is, when we provide and we move forward on something like Clay Hunt, if we figure out a new model on how that Act is going to—and before we wait for it to run its course, we correct and self-correct. So I know it is a—I am throwing it out to you because I, for one, have bought into your vision of transformation. I, for one, want to be that partner and I, for one, want to make sure that I didn't pass a piece of legislation that added more to your plate and didn't improve the care of veterans.

Secretary MCDONALD. We are very much in favor of the Clay Hunt act or the SAV Act, as it is called. We partnered with everybody who wants to do it. We are very much in favor of it.

I had the opportunity to be on the Charlie Rose show last night with the writer of American Sniper with the leader of Team Rubicon, and I talked about the fact that we at VA are the canary in

the coal mine for American medicine. We see things because of the battlefields that our veterans go on way before the American public. Mental health is a big issue in this country. Any veteran committing suicide is disastrous.

And the work that you have done on the Clay Hunt Act, it gives us more residencies. It gives us the ability to pay back student loans. The average medical school student is graduating with about \$185,000 in debt. The Care Act moved it—we can repay from \$60,000 to \$120,000. This is \$30,000, additionally. I am working hard to try to get more residencies for mental health and to get greater throughput for mental health.

But of those 22 veterans who we estimate commit suicide today, 17 of them aren't committed to the VA, aren't connected to the VA.

Mr. WALZ. That's right.

Secretary MCDONALD. So one of the things I am working on is how do we get more people connected, because we do have treatments for post-traumatic stress. We do know how to alleviate it, and we just need to get those people connected. So we are working very, very hard on that.

Mr. WALZ. Well, to all of you, again, I am thankful, and thank you for working as partners in this, and as I said, they are difficult conversations because our veterans are counting on us to have those difficult conversations.

I yield back.

The Chairman. Ms. Radewagen.

Ms. RADEWAGEN. Thank you, Mr. Chairman.

Mr. Secretary, I first want to thank you for the opportunity to have breakfast last week and share with you the concerns of some of our American Samoan veterans, who, because of our geographic and economic isolation, don't share in all the benefits that they are entitled to. And I want to thank you for presenting me with the seal, the beautiful seal of the Department.

Our veterans, who make up ten percent of our entire population, have issues that are basic and comparatively small, but they are generally taken for granted, here in the States. In a nutshell, they need a cemetery. We have no map flights. We need access to better health care. Our local hospital has no CAT scan, no cancer specialists, so our veterans must always seek care off-island.

ObamaCare, most of our veterans do not understand. Our troop store is always out of merchandise and there is always complaining as to why it is that we don't get merchandise and services provided to the PXs off-island.

Our veterans have difficulty getting their medical records to even apply for benefits.

But, Mr. Secretary, what I would like to ask you is: The VA's budget submission has identified an expected increase in claims receipts for fiscal year 2015 at \$1.3 million and fiscal year 2016 at \$1.4 million. These figures represent an increase of 17 and 20 percent, respectively, over the 1.14 million claims received in 2014.

Can you please explain what factors and information you considered in determining the anticipated volumes of claims receipts for these two years?

Ms. HICKEY. Congressman [sic], absolutely.

Let me just tell you that the largest portion of that is not going to be the brand-new veteran who is now leaving service, transitioning to us; it is going to be the fact that we have done so many veterans claims, 1.32 million, and every veteran is entitled to come back for any supplemental claim, which, by the way, is about 67 percent of our workload, meaning it is the majority of our workload is not our original claim, it is the, it has been aggravated, it got worse, and so as a result, you can come back and get another one. That growth largely attributed to the increased expectation for supplemental claims, and that is where the majority of it is.

Ms. RADEWAGEN. Thank you, Mr. Chairman.

Secretary MCDONALD. Ma'am, I would like to—if we can, I would like to bring our leadership over and sit down with you and go through all the issues on Samoa and see if we can help and fix it. We care very much about every veteran and we care about those in Samoa.

Ms. RADEWAGEN. That would be great, Mr. Secretary.

Secretary MCDONALD. We would love to do that.

Ms. RADEWAGEN. Thank you, Mr. Chairman.

The Chairman. Ms. Brownley.

Ms. BROWNLEY. Thank you, Mr. Chairman.

And, Mr. Secretary, I, too, want to thank you for your extraordinary leadership over the last six months, and I feel very confident that the rudder of the VA is being repaired and we certainly—I believe we are on a good trajectory for really righting the ship, and I really want to thank you for that leadership. And I want to thank you also for today's presentation and the analysis in the presentation, because I do think it absolutely demonstrates what the challenges are within the VA, both in the short and the long-term, and the fact that all of the challenges that we all must, collectively, tackle for our veterans. So thank you very, very much for that.

I appreciate the meeting that we had in our office last week and I was very excited to go home this weekend and talk to my veterans in Ventura County and to let them know an important milestone has occurred here, including a new clinic in Oxnard for our veterans. It was quite clear to me that our veterans were underserved when I was first sworn into Congress, and I think this clinic will, indeed, right a wrong, and our veterans will be better served.

And so I just wanted you to speak to that because I wanted my veterans in Ventura County to hear from you directly your agreement for the need of this clinic and what you think the time estimates will be to acquire the lease and build out the facility. If you could comment on that, I would really appreciate it.

Secretary MCDONALD. Well, first of all, I apologized to you for not visiting Ventura County when I was in Los Angeles. That was a relatively quick trip and I was there for one reason, which was to get a settlement with the community and get the homeless veterans off the streets of skid row in Los Angeles. But I will come to Ventura county and get together with you and perhaps this would be a good topic to talk.

As Deputy Secretary Gibson goes through and looks at our construction leasing process, I am hoping that the kind of time we have seen in the past to get something like Oxnard going will be

shortened, and we will work together with you on that. Right now I don't have any estimates, but we will get together with you and we will work on that, and I want to meet the needs of the veterans in Ventura County.

Ms. BROWNLEY. Very good.

And just as a follow-up, could you just describe, briefly, what the process will be in terms of—are stakeholders, are veterans being included in this process?

Secretary MCDONALD. Absolutely. Absolutely.

Just like I have done everywhere else I have gone, I bring together all of the stakeholders, members of Congress, veteran service organizations, mayors. Because as I said earlier, and I really do mean this, this really is a team sport.

And, particularly, in the case of homelessness as an example, we can't do the right thing unless—we can have all the HUD house vouchers we want, but if there is not a landlord in the City of Los Angeles willing to rent at that rate, we are still going to have a homeless veteran. So, for me, what we did in Los Angeles is going to be a prototype of what I hope to do everywhere else in the country, which is VA can be the lightning rod to call the community together with the local mayor and work to improve the situation. In this case, we will work with you on the Oxnard facility.

Ms. BROWNLEY. Thank you very much.

And I think we are making progress on the VHA side, and I think there is more progress to be done on the benefits side. This year is 2015. I was just curious to ask—we set an ambitious goal, your predecessor set an ambitious goal in terms of the backlog—just your comments in terms of meeting that goal?

Secretary MCDONALD. As Allison said earlier, we think the goal is doable, so we are not changing the goal. But one thing that is really clear is we do need more people. Even though the productivity is up, the inflow is so great, the inflow has grown so much and the repetitive appeals has created a workload issue, that we have had to work mandatory overtime. Mandatory overtime is a prescription for disaster with a workforce—I do have some experience leading large organizations—and as a result of that, we have got to get more people or find either further productivity improvements, which we are working on.

But going to the entire digital record has been a big, big improvement, and one of the nice things about it is we don't need any more space. We can hire additional people and all the space that used to be taken up with paper can now be people working on digital files.

Ms. HICKEY. In fact, Congresswoman, I want to thank the entire committee for increasing VBA's budget. We would not have been able to accomplish this without the support of this committee and every person on it.

You saw the growth in the requirement from 2000, so thank you, Chairman, and thank you Ranking Member for being here long enough to really see us through that growth. I really appreciate that.

But one of the things I wanted to tell you is there is a savings implication to this, we are not yet ready to be able to realize because we have got—working through the agreements with DoD on

what we do with half a million cubic feet of paper we no longer touch, and that is 5,000 tons, and equal to ten Mt. Everests and 200 Empire State Buildings, just to give you a visual. We don't touch that anymore. Ninety-five percent of what we are doing now is in a paperless environment. We are working with DoD on a solution to get that out of the buildings. When we do, we have some potential lease savings in the tune of \$30 million a year that we can bring back to you and say, "This is what the benefit is by our not needing to house all of those cabinets and all those things anymore."

We are already realizing a \$2.4 million savings in simply shipping costs of not moving all that paper around on a regular basis.

Ms. BROWNLEY. Thank you.

And my time is way out, and I yield back.

The Chairman. Mr. Huelskamp.

Dr. HUELSKAMP. Thank you, Mr. Chairman.

I appreciate the opportunity to visit with you, Mr. Secretary, particularly last week, and I would like to ask you a few questions and discuss the Choice Program, which is very important to me.

As we discussed last week, my district includes 63 counties; it touches four different VISNs, and that creates some problems. But distance is the main problem and access; there is no VA hospital in the district. I just had an email contact from a veteran who drives 340 miles one way for cardiology. If the VA Choice Program can't provide something closer for him, then we need to relook at how we are implementing that.

One thing I would like to ask you, and there is some concern, particularly with providers, with veterans that are looking into taking advantage of that, is the fact that it is only a temporary program. Are you and the Administration committed to making this a permanent option for our veterans?

Secretary MCDONALD. As you know, we have had an external program, and so I think an external program is necessary as we look forward to a future where the network is both VA care and outside care. We are also going through an analysis right now—given the relatively low take rates, but, again, I don't want to assume that is going to continue, we are talking about how can we do a better job marketing it, and also, should we look at that 40 miles and change the interpretation of it, get CBO to score something differently so we can make sure the program is robust.

Dr. HUELSKAMP. And your thoughts on making the Choice Program permanent, Mr. Secretary?

Secretary MCDONALD. I am all for it. I am all for whatever it takes to satisfy veterans, to aid veterans.

Dr. HUELSKAMP. And I appreciate and thank you for that. I appreciate the 40-mile discussion, because that creates problems. If you were in a place, for instance, that a CBOC was implemented sometime in the last 20 years, all of a sudden, that keeps you out of the Choice Program. And as I understand, the interpretation is even if the services aren't provided at the CBOC, that restricts that access.

So for the gentleman in Dodge City, Kansas, that is asked to drive to Kansas City, again, 340 miles one way, it is only because there is a CBOC there and they are never going to provide the car-

diology services that we need. So is that something that you are willing to look at interpretation or you are going to require us to pass some changes in the law? Because I think that can be interpreted that you would have that flexibility to make that determination.

Secretary MCDONALD. Actually, it is pretty straightforward in the law, at least that is what we have heard from CBO and from others.

But we are going to work on different options. Each option will have a different estimated price and we will come back to you and let you know what those options are and together we will decide what is the best thing to do. I agree with your point of view that distance from a place you can't get the service seems like a relatively weak measure, but that is what has resulted in the current appropriations. So we have got to work with CBO to score all of those opportunities and decide together.

Dr. HUELSKAMP. And I can follow some of that, but as the crow flies versus as a real person drives, I think that is an interpretation that can be changed.

But even with the 40 miles that is in the Choice Program, there is nothing that would prohibit you from using a fee-for-service approach in this exact same situation, which has created many of these problems.

Secretary MCDONALD. Correct.

And that is the marketing that we have to do, too; we have got to get the word out that that is possible.

Dr. HUELSKAMP. Well, the word, I think needs to go with the folks answering the phone at the VA Regional Medical Center, because that is not what they are told, that you could get your cardiologist services and drive a hundred miles to Hays, no. You can go to Wichita, which by the way is only 157 miles, but he wanted services that were a little bit better, and so they said you can drive 340 miles when he probably could have gotten those right in his own hometown.

The answer always should be, Yes, we can, we are going to look at a way. And if it is not the Choice Program, we have got the fee-for-service that we should be using—should have been using all along. And I know it varies if you are in an urban area, but, again, when I am in a rural area, I actually have 70 community hospitals that are coming to my office and say, Tim, we would like to serve those veterans and we are not able to. And the Choice Program, if we can make that permanent and then expand our understanding of the fee-for-service approach to that, I think we are going to serve veterans better and give them access to the care they deserve.

So I appreciate your efforts on that, Mr. Secretary. Appreciate your commitment to making these programs permanent, because I think they are critical to making sure that the VA works long-term, so thank you.

I yield back, Mr. Chairman.

The Chairman. Ms. Rice.

Ms. RICE. Thank you, Mr. Chairman.

So, Mr. Secretary, I wanted—as everyone here has thanked you, I thank you for spending time with me yesterday. I think it is in-

credibly informative, and I, personally—all the brave men and women that work so hard to protect our freedoms deserve the help right now. But what they don't—and I know that is what you are working towards and your whole team is working towards—but what they don't deserve is a “knee-jerk, try to Band-Aid on a gaping wound fix,” and so I appreciate, as I am sure everyone on this committee does, the thoughtful way that you are approaching all of these reforms. Because I think that they are going to serve the brave men and women that protect us in the long run.

So I just have a couple quick questions. You mentioned the 22 veterans who commit suicide every day. I think you said 17 of them had not accessed any service within the VA. How are you going to—and we had spoken briefly about this yesterday—but how are you going to reach out to them?

Secretary McDONALD. There are a number of things we have to do. Number one, we have to eliminate the stigma in this country, but it exists across the world, around mental health care. I am thinking that this is a fortuitous moment in time because American Sniper, the movie, the largest-selling war movie, is starting to do that. That is why I went on the Charlie Rose show last night was to talk about this.

When Congressman O'Rourke and I were together in El Paso—I will never forget it—we were looking at a private sector hospital and there was a neon sign at the top of this one building that said mental health clinic, and there wasn't a car in the parking lot. And I turned to him at the time and I said, well, of course, there is not—it wasn't his hospital; it wasn't our hospital—but, of course, there is not a car in the parking lot.

What we do is we take our veterans, through the primary care physician, into the mental health treatment, and as a result of that, the stigma doesn't exist, and they may not even know that they are talking to a psychiatrist. So we have got to get rid of the stigma.

Number two is we have to reach all of the veterans. We have the ability to put on the TV, a public service campaign that the Ad Council is working with us pro bono to get people signed up, but I don't feel, yet, that we are ready for that. That our capacity is so strained that if we were to get a lot more people into the system not for mental health, that we might have issues.

And, third, we have to train the American public. If you see somebody who you think has an issue—we have an algorithm or not an algorithm—an acronym called SAV. S is about seeing and recognizing that the individual may have an issue. We have a hotline, a 1-800 hotline that you can call to get that person help and then we go immediately into action.

Those are some of the things we are doing. It is not everything. The medical exam when you leave DoD is also a big help, but we have got to get our arms around the 17 veterans and care for them.

Ms. RICE. Now, I know that there is discussion in terms of the facilities in California that are vulnerable to earthquakes. The VA is just outside my district, but I still claim it as my own, obviously, on behalf of the veterans that live in my district and have to travel out there.

Superstorm Sandy hit my congressional district harder than any other place in New York state, and I was wondering if part of your construction plan included—I mean I understand the focus on earthquakes in places like California, but in similarly fragile and vulnerable areas like Long Island, is there a plan to have some emergency preparedness to prevent any—

Secretary MCDONALD. Yes.

Ms. RICE [continuing]. Interruption in services?

Secretary MCDONALD. When we do our construction management process, we call it SCIP; it is another acronym. I owe you that acronym dictionary.

Ms. RICE. We need an encyclopedia of acronyms in Washington.

Secretary MCDONALD. But safety is number one, and we consider seismic and other natural disasters as safety, so that is always the first priority.

In the case of Sandy, for example, we have a facility near the Battery, near Battery Park in Lower Manhattan, and it was devastated. The entire first floor was water. I visited the facility.

We are now building a wall that can help us keep out higher levels of water should another storm occur. So express safety is always number one—and I don't have the specific facts on the facility in Long Island, but we can get together with you, and we can go through that.

Ms. RICE. I would appreciate that.

Again, thank you so much, Mr. Secretary and to your entire team.

Secretary MCDONALD. You're welcome. Thank you.

Ms. RICE. And I yield back my time.

Thank you, Mr. Chairman.

The Chairman. Dr. Benishek.

Dr. BENISHEK. Thank you, Mr. Chairman.

Thank you, Secretary Vilsack [sic], for being here with your team. I think a lot of the members this morning, we asked a lot of great questions and touched upon a lot of the issues that I want to talk about. I want to commend Dr. Wenstrup there for bringing up the costs of care.

And that is something that I am very concerned about, and I wanted to ask a few more questions about when you think that you are going to have an idea of when that is going to be or is this independent review of the VA system, is that going to help look at that number? Because I know I am very concerned about it in continuing to implement access to care locally.

Can you just elaborate on that a little bit?

Ms. HICKEY. Sure. In addition to the external independent assessments, which we anticipate will be here around August or before then, we are also commissioning some internal work, internal contracts and so forth from some of the leaders in industry just to figure out how do we get to some of the questions that you raised in your recent hearing when Dr. Tuchs Schmidt presented and so forth.

One of the issues that we struggle with in terms of cost is this reliance factor, you know, where some veterans use VA for some of their needs, but they go outside for others. My uncle recently proudly told me he got his hearing aid, but by and large, given

where he lives, does not actually go to VA for most of his care; he goes closer to home. So that is part of the issue that we have got to work through, as well as this issue of fixed and variable costs.

And, again, I think this is why the secretary raising this issue of fixed costs that are kind of a drag on the budget in terms of getting to the issues of access and veteran experience are so important.

Dr. BENISHEK. I think that is what Dr. Wenstrup was talking about, is that, you know, the cost of these half-a-billion-dollar hospital overruns, that all adds to the costs of taking care of a patient who walks into the clinic. I just want to make sure that all of these costs are included in that because we are supporting a bureaucracy that—are we supporting way too much of a bureaucracy for the care that we are getting out of it. I mean that is my concern.

Ms. HICKEY. That is a fair question and it is one that—

Dr. BENISHEK. Let me just ask another question here, and this is something else that we have talked about in our subcommittee as well, is this management of pain within the VA. Because I know it has been over a year that we have talked about this in my subcommittee and this opioid medication and the high doses and the number of prescriptions written, and then this recent troubling incident with the IG in Tomah. What has been going on in the VA recently to try to address pain management; is there a better pain management system? Is there a referral to a pain management specialist?

Tell me a little bit more about what is happening more recently, and how are we going to put an end to this, you know, the practice of using opioids on a chronic basis for people with chronic pain.

Secretary McDONALD. I will ask Dr. Clancy to give you the specifics, but one of the things that I wanted to say at the beginning is we take this opioid use very, very seriously, and we track it very closely.

And one of the things that I am very proud of that we do in the VA that I don't see as much of in the private sector is we use a lot of alternative approaches, alternative medicines. We use acupuncture. We use yoga. We have used electronic devices that have shown to be effective amongst some of our veterans. Anything we can do to get that veteran off of opioids is something we want to do. And we are developing quite a broad array of tools that we can use that allow us to reduce the opioid use.

Dr. BENISHEK. Well, I mean that sounds great, Mr. Secretary, but I think if you look at the numbers of people who are not on the alternate treatment versus the opioids, you would find that there are a lot of people on opioids compared to the number of people that are getting alternate therapies.

Secretary McDONALD. There are.

Dr. BENISHEK. And it is great that you mentioned those things, but it seems like there should be a lot more people having access to pain management specialists than are being treated by their family physician or their primary care physician with narcotics.

Dr. CLANCY. So, really an incredibly important and serious issue. I think, as you know from your prior hearing—and we, again, would be happy to brief you in more detail—we actually track opioid use per facility. Each facility has a dashboard, and nation-

wide since we launched this safety initiative, we have seen the trend line go down, which is a good thing. But we are also looking at the prescribing patterns of individual physicians to see—to make sure that an overall positive trend that is going down isn't masking some practices that we would consider suboptimal.

We are supporting a lot of research in this area as well, because the combination of non—

Dr. BENISHEK. Well, again, that is great, but it is unfortunate that apparently the situation in Tomah sort of contradicts what you are saying here today, and we just want to make sure that we maintain a high vigilance on this problem.

So, I am out of time, but I certainly appreciate your efforts.

Dr. CLANCY. Thank you.

The CHAIRMAN. Thank you very much.

Members, Ms. Brown has one final question.

Ms. BROWN. Thank you, Mr. Secretary, and thank you for your service.

I have one question. Just a few minutes ago, the congressional audit came out, and I don't know whether you have seen the article, VA health care is at high risk, and I guess they do this audit every two years. In reading it, it seems like they were rehashing a lot of the stuff that is going on.

You know, I appreciate you going on television, I just think we need to respond in our town hall meetings. You know, we see about seven million people a year that once they get in the system, they are happy with the service.

So, can you speak to the article that is just coming out today and whether or not you would be willing to do an updated piece to USA TODAY, because I think it is important that veterans are not sidetracked. We are definitely headed in the right direction.

Secretary McDONALD. Yes, ma'am.

I actually met with the comptroller general, and we were talking about whether or not he should put VA on the high-risk list. I actually encouraged him to, and the reason I did that is because we are a healthcare system, and we are going through a large amount of change right now. And during the time that any organization goes through a large amount of change, we need to make sure that we have the appropriate oversight, the leadership, as well as those responsible for it.

So while I think the VA system is absolutely essential to American medicine—we train 70 percent of U.S. doctors. We have developed innovations that are absolutely critical for American medicine, the first liver transplant, first implantable pacemaker, nicotine patch, first time bar code is used to connect patients with medicine. We have got to make sure we have a robust VA.

And so as we go through this change, I am thankful that you in your oversight role and others will be helping us get through this change and develop this robust system that this country and our veterans need.

Thank you.

Ms. BROWN. I want to, again, thank you all for your service.

The CHAIRMAN. Mr. Secretary and everybody at the table, thank you for being here today. You are excused.

If we could go ahead and have the second panel come to the table, we need to continue.

I invite the second panel to the table and welcome Mr. Carl Blake, Associate Executive Director of Government Relations at Paralyzed Veterans of America who is going to be testifying to the committee on behalf of the co-authors of the Independent Budget. Accompanying Mr. Blake is Mr. Joe Violante, National Legislative Director, DAV; Mr. Ray Kelley, Director, National Legislative Service, Veterans of Foreign Wars; Ms. Diane Zumatto, national legislative director, AMVETS, and we are also going to be having testimony from Mr. Ian de Planque, Legislative Director, The American Legion.

Mr. Blake, you are now recognized for five minutes.

STATEMENTS OF MR. CARL BLAKE, ASSOCIATE EXECUTIVE DIRECTOR, GOVERNMENT RELATIONS, PARALYZED VETERANS OF AMERICA, ON BEHALF OF THE CO—AUTHORS OF THE INDEPENDENT BUDGET, ACCOMPANIED BY MR. JOSEPH A. VIOLANTE, NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; MR. RAY KELLEY, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS; MS. DIANE M. ZUMATTO, NATIONAL LEGISLATIVE DIRECTOR, AMVETS, AND MR. IAN DE PLANQUE, LEGISLATIVE DIRECTOR, THE AMERICAN LEGION

STATEMENT OF CARL BLAKE

Mr. BLAKE. Thank you, Mr. Chairman, Members of the Committee.

On behalf of the co-authors of the Independent Budget seated here at the table, I would like to thank you for the opportunity to testify today on the VA's fiscal year 2016 and 2017 budget. I ask that our report, the Independent Budget for the Department of Veterans Affairs for fiscal year 2016 and fiscal year 2017, be admitted into the official hearing order.

The CHAIRMAN. Without objection.

Mr. BLAKE. Thank you, Mr. Chairman.

Let me begin by saying we believe this is probably the best VA budget we have seen in my many years of being up here on the Hill. That being said, recent media reports have pointed out that the VA has had hundreds of millions of dollars in unspent resources carried over in recent years. The IB does not dispute that fact. In fact, the VA has done a questionable job of managing the insufficient resources it has been given in the past. We believe that the access problems and the long waiting lists identified over the last year clearly affirm that point.

However, we also believe that the VA, prior to this year, has continuously requested insufficient funds to adequately provide healthcare and benefit services to veterans. Yes, Congress has given the Administration virtually everything it has requested yearly, but that certainly does not mean that the VA has requested what it truly needs. Perhaps the Office of Management and Budget would have something to say about this.

This does not mean that the VA should not be properly scrutinized for what it spends or does not spend; in fact, we whole-

heartedly support this notion. But it should be scrutiny grounded in facts, not in rhetoric or poorly formulated assumptions.

The Independent Budget recommendations represent our view of the actual resource needs of the VA to provide services across the entire spectrum of programs. Our views are not clouded by a particular agenda or by politics. Despite the closeness of our recommendations, the IB is an independent assessment of the VA budget requirements developed before the Administration even released this most-recent budget request.

It is not bloated with unnecessary resources and administrative support. I would call your attention to the clear differences between our recommendations for such line items as medical support and compliance, general of administration and IT to affirm that point. Our recommendations focus on the areas where service is the linchpin: medical services, major/minor construction, the Veterans Administration, the National Cemetery Administration, and other key areas. A couple of those key areas were recently identified in our policy agenda that we released back in January. Those include women veterans programs and Caregiver Support Programs. We appreciate the emphasis this Committee has put on these two areas. We certainly appreciate the fact that the Committee held a hearing back in December to review the Caregiver Support Program; it is a high priority for many of our members. Those two issues are particularly critical issues in this year's Independent Budget.

Clearly, there are wide-ranging opinions about how the VA manages its capital infrastructure. We have no doubt that VA construction and contract management has been a disaster. The only people to suffer the consequences of these failures are veterans seeking care, particularly in the Denver area. But none of this changes the fact that the VA has a huge backlog of valid building projects that are in various stages from initial planning to near completion.

Nevertheless, we believe the VA has not shown the level or degree of commitment in its request for resources to get all of these projects moving in the right direction or to complete them. We stand with the Committee to resolve these VA construction management problems and we hope that that will be done quickly.

Lastly, I would just like to comment on a couple of points that have been raised here. With regards to the question about cost for care, we are certainly not experts, but I would suggest that in all of the briefings I have received about the VA's Enrollee Health Care Projection Model, that if one wanted to know how much it cost to do a particular procedure in any region in the United States, that that model would produce a number, at least that is what we have been told over the years when we have been briefed on this.

So what I would expect that if the Committee wanted to know how much it cost to do a colonoscopy which came up over and over again in the cost for care hearing, that the VA can probably produce a number. We appreciate the fact that the VA is committed to providing better information with regards to the cost for care. We look forward to having an opportunity to review that information, as well.

And then lastly, the question about the Choice Program, which the VA has brought right out into the light of day, I think the Independent Budget probably agrees with the principle that the secretary has laid out, that, you know, you shouldn't be obligated to spend the money you have been given for one singular purpose. I thought the secretary's analogy he used about gas versus food is a perfect way to describe the need to be able to shift money around.

That being said, I'm not sure that we also agree with taking money from a program right now that is clearly in its infant stage. I think that program clearly has to be given time to flush itself out and see what actually occurs. Three months is certainly not enough time to do a thorough evaluation of utilization of the Choice Program. So until there has been more time to really fully evaluate what will happen, I'm not sure that we fully support what the Administration is requesting.

With that, Mr. Chairman, I would like to thank you again for the opportunity to testify, and I would be happy to answer any questions that you or the members of the committee may have.

[THE PREPARED STATEMENT OF CARL BLAKE APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Blake.
Mr. de Planque.

STATEMENT OF IAN de PLANQUE

Mr. DE PLANQUE. Good afternoon, Chairman Miller, Ranking Member Brown, Members of the Committee.

I would also like to thank Secretary McDonald and his staff for their words today.

I am very fortunate to sit here and speak on behalf of The American Legion for our National Commander Mike Helm and the 2.4 million members in over 14,000 posts across the country, who make up the backbone of the world's—the nation's largest wartime service organization.

We are focused on getting things right, not just for our over two million members, but for over twenty million members beyond that who are veterans, people who have worn this. I was struck by something that Secretary McDonald said earlier today, "This is a team sport; we can't do it by ourselves." I think everyone agrees that the country owes a great service to the veterans, that the country owes a lot of things to the veterans. The country is not just the federal government. The VA is a piece of that, but I think everyone here, everyone here at this table, everyone here in this room is also a piece of that. We all have to work together on this.

I spent two of the last four weekends out at various grassroots events for The American Legion in Nebraska and Kansas out there with blue cappers like myself, you know, who were there, actually out there wanting to go out and go into VA hospitals and help out in whatever way they can. We had over 7,000 legionnaires donating almost a million hours of volunteer service to the VA. This only works if we are all on the same page, if everyone is on the same page.

And, Ranking Member Brown, you mentioned earlier that you wished H.R. 216 was the law of the land, as an important resource and tool that would help with that. I think we agree very much,

and I know in the legislative hearing earlier when it was discussed, I think there was a lot of agreement on both sides of the aisle on that. We have to be able to look back and forth and compare these things.

I was speaking with a colleague of mine about VA's Strategic Capital Investment Plan and whether or not they are putting enough money into these things. The American Legion about four years ago was talking about looking at VA's construction figures. It was going to take them 60 years to complete the 10-year plan in SCIP if they went forward with those numbers. But trying to compare the figures together and what are still there, you are pulling up a budget from one year and you are trying to hold it next to another—having it all laid out there, right for you where all stakeholders can participate in that—I know, Chairman Miller, when that bill was up in a legislative hearing, you spoke about the importance of the transparency for it and how you had seen in Armed Services that they are transparent with that. We need to have that same kind of transparency with the planning for the VA budget so we can maximize the resources that everyone is putting into this.

We have a lot of great organizations. We have a lot of great veterans who are out there trying to make this a better system. We believe in a VA system. We believe the Choice card is important because we have to get access to care for veterans, but we want to make sure that the veterans still have access to that system.

It is there because Secretary McDonald talked about the demand expanding beyond VA's capability to meet that. Well, we need to make sure the resources are allocated to meet those demands, but we can't lose sight of the focus that it is the VA that we want to be needing that. The VA that we want to be the leader that is pioneering medicine, that is the utmost expert in so many conditions. You look at a traumatic brain injury, you look at post-traumatic stress disorder, you look at amputation injuries, there is no reason that the VA should not be the world's leading authority on that and we need that to happen, and that comes from everybody working together, and that comes from everyone being on the same page.

The American Legion is absolutely devoted to that. We need to be able to look at these pieces. I think VA's request for an additional 700, 770 full-time employees to work on the claims backlog, it is important. I think there is a very good point that they have been given more staff and that they were supposed to have been increasing their productivity, but you can't deny the fact that they have been on mandatory overtime for four years. Going through four weeks on mandatory overtime says you might have a little bit of a problem. Going through four years on mandatory overtime says you might not have enough people to do that. Now, we don't know exactly how many people we need in every office, and that is why we all need to be able to look at these figures on the same page together.

I think working together we can do that. We are very committed to being a major partner in that and helping to drive that. We want this system to be the best system that can be for veterans. I think the Committee has been very generous in giving budgets

to the VA to work with, we just need to keep everyone working on the same page and I think we can accomplish that.

Again, I thank you for having The American Legion here to speak on this. Thank you for having all the veterans' groups to speak on this, and I look forward to any of your questions.

[THE PREPARED STATEMENT OF IAN DE PLANQUE APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much for your testimony. I would like to ask either of you, if you would, kind of one of the critical components and probably one of the toughest things that the secretary is confronted with is going to be closing outdated, old substandard, or particularly underutilized facilities. It is not easy politically. It is not easy, as the secretary has already alluded, but I would like to know if you feel like that is an important step that the secretary has to look at.

Mr. BLAKE. Mr. Chairman, I am going to defer to my colleague, Crandall Construction, for the IB.

Mr. KELLEY. Mr. Chairman, absolutely.

If VA is holding property that it no longer uses or is underutilized, they need to find out how to get rid of that property. But in the process of figuring out how to get rid of it, they also need to have that conversation with the community to ensure that those veterans understand there are going to be services still there.

That is the fear in the community, is my hospital is going away, therefore, my services are going away. They need to understand that full continuum of care is still going to be in the community and it is just going to be right-sized for that community. There is no need to spend three dollars per square foot to maintain a building that is no longer being used, just to keep it mothballed.

Mr. DE PLANQUE. If I could dovetail onto that, the thing that comes to mind is Hot Springs which The American Legion has been very involved in, and that community desperately wants to keep their medical center. I can absolutely understand if you have an underutilized building and it is just taking up empty money that is not serving any veterans in the community. And certainly there are probably regions where it is just not effective, but we have to make sure that those veterans are included as a part of that planning process and that they are being listened to.

I know there has been a tremendous amount of frustration in Hot Springs, that the community is adamant, it is vehement, and it has been organized and has tried to voice its opinion at every step along the way, that we need this facility here, this is serving the veterans in this area, and they are very concerned that that is not being heard.

So, yes, I think that it is important to be able to open up to some possibilities with that, but let's make sure that we are also still serving the veterans.

The CHAIRMAN. Any other comments?

Mr. BLAKE. Mr. Chairman, I would only add, too, one thing we would caution as they make a determination of where facilities are underutilized or unused, that they be innovative also. You know, we have talked for years about using some of these underutilized spaces for the homeless veterans issue.

You know, one of the challenges of homelessness is having supportive housing that allows them to then transition into finding a job and being able to sort of become a productive member of society again. So before they choose to close a facility, I would hope that they would think outside the box in some of these areas where these facilities can serve a purpose.

That doesn't mean that some facilities shouldn't just be closed, especially if they are sitting empty and have been sitting empty too long.

The CHAIRMAN. Mr. Blake, where, specifically, do you think the administrative costs within VA could be reduced and where could those funds be reallocated? And, specifically, I guess we are talking about page 3 in your testimony.

Mr. BLAKE. Well, I would suggest, Mr. Chairman, from the perspective of the recommendations we have made, we have sort of stuck to the same principle over the last couple of years, that we directed most of our recommendations at the medical services line where the rubber meets the road for providing healthcare.

There has been some discussion about plussing up staff like in the general administration line items, which are a lot of the offices here in Washington, DC. We have also had some conversations with the Committee staff on the VHA side about the administrative costs that exist at the VISN level and across the various layers that exist within VHA. We were interested to see the plan to seemingly transition the regional framework of VA. What we would certainly hope to see—or hate to see, I should say, is we transition to a five-region alignment and where we go from 22 VISNs with 125 to 150 staff to five regions that are just those people shifted into a regional alignment and you didn't streamline your administrative support at all.

The CHAIRMAN. If I could, the secretary asked Mr. Coffman to ask a question of the VSOs, and since Mr. Coffman is no longer here in the room, I will ask the question on behalf of the secretary: Have you seen a difference in the VA?

Mr. VIOLANTE. Mr. Chairman, the fact that the secretary and his leadership team are still here I think answers that question. I think we have all been impressed of what he and Deputy Secretary Sloan Gibson have done in the short time that they have been here. So I would have to say that, yes, we appreciate what he is doing and what he is trying to do and hope that you will work with him to make sure that these changes happen.

The Chairman. Mr. Kelley.

Mr. KELLEY. Yes, we see a difference in spots. There are going to be areas that are slower to change than other areas, but we are seeing pockets of improvement.

Just solving the problem in West LA, that land-management issue in a very short time, something that has been around for years, is indication that he is hands-on, he is going to get things done, and he expects people at all levels to do the same thing.

The CHAIRMAN. And if I could—my time has expired, but could I just get a yes or a no, Mr. Blake?

Mr. BLAKE. I will give a yes.

The Chairman. Mr. de Planque.

Mr. DE PLANQUE. Definitely a yes, and they are starting to own problems, too, which is a big change.

The Chairman. Ms. Zumatto.

Ms. ZUMATTO. I would agree with my colleagues.

The CHAIRMAN. Okay. Very good. Thank you.

I agree, too. There is a difference, and I would also say that Ms. Brown's H.R. 216 is scheduled to be marked up tomorrow, and so we would expect to see that pass very quickly.

Ms. Brown.

Ms. BROWN. Thank you.

I would like to associate myself with the remarks of the gentleman from Florida. I absolutely think there is a change in VA and it is headed in the positive direction.

And when you talk about VA, I remember going to LA, and we had four brand new units sitting for over two years that we had built those units, 400 units, four separate buildings that stood vacant for two years because we built them, but the State of California did not have the money to operate it. We have got to make sure that that does not happen in the future, and I am very pleased that he was able to go in and resolve those issues.

For the first time we have forwarding budget in all of the categories. Can you give me a response as to how you feel about how this is going to help VA move forward. I just want to hear from all three.

Mr. BLAKE. Well, I would say Ms. Brown that, you know, we offered our support for the legislation at the legislative hearing a couple of weeks ago. I think Mr. de Planque hit on an important point, that this would allow for more transparency as they develop their needs going forward.

I would also suggest that, you know, the secretary—what I appreciate seeing is I believe this is the first time that I have seen the VA take serious, this requirement, as part of the advanced appropriations process. You know, for the last several years since this was passed, one of our chief complaints has been that the Congress passes an advance appropriation, as requested by the VA, and then the next year, there is no real adjustment or no consideration given to how that should be adjusted.

And this is certainly the first year that I can remember where a substantial analysis review and re-estimate for its need has taken place. So we appreciate the fact that this leadership team in particular seems to have taken this requirement far more seriously than in the past.

Mr. DE PLANQUE. I also want to note I think the forward funding, you are not going to have veterans who are worried about not getting their checks if, for some reason, there is some friction between the Congress and they can't get a budget passed. I am not as worried about that immediately, but I mean that is an important guarantee for them down the road, but I also think that that planning component that is going along with your legislation is a critical, like handshake with that bill. The ability to plan is critical as we are forward-funding things and to be able to look down the road and see the anticipated results beyond that. So I think they are kind of hand in hand with each other and very helpful.

Ms. BROWN. One other thing. Let me mention that when I first came here, we were going through a bright process and, of course, we support closing some of the VA facilities, but keep in mind as meant, just as long as you don't close any in Florida. But that is kind of the mentality of the members of Congress. So as we work through it, we have to keep in mind it is a team effort and that those communities need to have input and involvement as we evolve as to what we want the VA to look like. Because we are sitting up here saying, This is the right thing. This is the best thing for the country.

But when we go to some little place in, what, high springs—Hot Springs?

Mr. DE PLANQUE. Hot Springs.

Ms. BROWN. Hot Springs.

You know, that community feels that they are going to be disenfranchised, so the question is: How do we have these other communities and everybody involved in those decisions?

And don't think that politics doesn't play a part, because when you get ready to close that, when the senators weigh in and, you know, some senators say, We don't do that, we are just interested in what is best for the country. That is not always the case, as experienced it with brack.

So I want to thank you all for your service and for your presentation. Any closing remarks? I have thirty seconds.

Mr. BLAKE. I would say this, Ms. Brown, we have also—it has been nice to see that some of the folks in central office have been more open to deal with us on a regular basis. I have already had two briefings on VHA's model and their cost for care since the cost for care hearing, which was two weeks ago.

Prior to that, the last hearing or last meeting we had with VA employees on the healthcare model was back in 2009. So they are clearly more in tune with the concerns of the Committee, the concerns we raised and trying to get us more involved in the discussion so we know what they are doing. Whether we necessarily wholly support it or not, at least we have a better idea of where they are going and what they are doing.

Ms. BROWN. Well, I feel the same way.

I think I have been over there about four times at 8:00 in the morning or 7:00-something, and I want to get the entire committee over there to review like the town hall and the discussion so that we have a better feel as to what is going on over there, because I think it is very exciting to have the employees involved in what we are doing and it is not from top down, but it is the input of the employees, too. And one-third of them, I often see are veterans or more.

So, thank you, Mr. Chairman. Thank you for the hearing, and I yield back the balance of my time.

The CHAIRMAN. Thank you very much.

Dr. Abraham.

Mr. ABRAHAM. As a new Congressman and fortunately a new member of this Committee, I am very honored to be here. And just six weeks ago I was a practicing physician that was privileged to see veterans in my clinic. I am jumping up and down with joy for this Choice Program.

And my question is, on these guys' levels, are you, Members, are ya'll getting feedback on the implementation of the Choice? Is it working? Is it fairly seamless? Where does it stand from ya'll's Members perspectives?

Mr. KELLEY. The VFW commissioned a survey through our membership to get feedback and we are doing a two-part survey. We cut it off at the beginning of this month, so for a two-month period. We found that a good portion of veterans who called for an appointment to VA, when they interacted with VA to get an appointment, were not told that they had a choice.

But now that we are in the second phase of this survey, we are finding more of those veterans are understanding that they have a choice, and VA employees are being educated to provide that choice. So we are seeing that trend of access go up, but at the same time, early on, the perception of choice was very positive or the experience of choice was very positive; there seems to be a trend that now that it has more people in it, that there is a slight down-tick in people's opinion of it, of the care that they received.

It is something that we are going to continue to monitor. We will have a report very soon that weighs out those analytics.

Mr. ABRAHAM. Fair enough.

Mr. DE PLANQUE. Likewise, I wanted to touch on that because, again, I just recently talked to a number of people. One of the biggest earlier concerns was there was a lot of confusion over whether or not people were eligible. There was a lot of confusion among the access. I mean we get calls in the office in DC all the time about this, as well, and so we have been working hard and I know that VA has been working hard as well to try and educate better about that.

There is a lot, particularly the 40-mile straight line when you are in a rural area where the roads aren't that accessible, the, well, I am close to a clinic, but the clinic doesn't offer the services I need, as was mentioned I believe by Mr. Huelskamp in Kansas. You know, when you are driving 340 miles to get to something. So there was a lot of concern about that and we have heard a lot of bad feedback from the members.

As far as, you know, whether they want to use the Choice Program or whether they want to use the VA, it has been mixed. We have some people that have been very happy with the care that they got at the VA, they just couldn't get access to it and they were frustrated by that and they want to get back into the VA; on the other hand, some people were very excited about the options of looking out.

So we are continuing to monitor that. The biggest part that we noticed early on has been a little bit of the confusion about eligibility, particularly with that sort of 40-mile circle and whether or not—how that interacted with facilities that didn't treat the condition they had.

Mr. ABRAHAM. Gotcha.

Mr. BLAKE. I think the playing field is a little unlevel in trying to evaluate it right now, too, when you consider that, one, the VA doesn't have the capacity to meet all the demand as we see it, and at the same time, we don't know for sure that the private sector

truly has the capacity to meet the demand that might come from the Choice Program. I think that is a great unknown.

I think we forget that private healthcare is a business and they maximize their revenue for their business by not operating with excess capacity, and so it would stand to reason that when people try to access the private healthcare system that they might find challenges. I mean we find challenges using private insurance now. If I try to get an appointment for specialty care at George Washington University Hospital right here in town, it could be six months.

So there are challenges. So the field is not level on the VA side or the private sector side yet. Until we have had a little more time to let the program itself even out, allow the VA to get its footprint more firmly planted by expanding its capacity, I am not sure that we can do a real thorough analysis.

Mr. VIOLANTE. From DAV's standpoint, we are getting ready to go out with a survey of our members to see what they are hearing, and we are not really hearing complaints. There is some confusion, as has been said, and I get X amount of miles for beni-travel, but then when I apply for this, they are telling me that I am not that far away and that is because of the way the law was written.

But early on, our people were more concerned of being forced out of the system, thinking that if they lived more than 40 miles away or had to wait longer than 30 days that they wouldn't be able to come into VA, and that concerned them greatly.

Mr. ABRAHAM. But that has been dispelled, certainly—that misinformation has certainly, hopefully been dispelled.

I think what we all envision here is that the veteran, when he needs primary care, such as a bronchitis—and I don't mean to minimize a simple bronchitis—he can go maybe to a Choice doctor, and certainly if he needs specialty, he has the option to go to any VA facility he wants. We just want it as seamless for the veteran.

And I guess my question was, are we slowly obtaining that goal?

Mr. DE PLANQUE. I think right now it is a little early and that is why in terms of making an analysis of what utilization of the program is, and I understand that the secretary stated before that, you know, it wasn't so much about what the utilization was right now, he was kind of trying to give a warning light that they might need to reappropriate things.

For us, you know, it is a little bit early to make any decisions about that because people are just starting to get their feet wet with the program, but it is something that I know we are, and I know that all the other groups up here are watching very closely to see how this interacts and how this works—

Mr. ABRAHAM. Okay. Thank you.

I am out of time. I just wanted to get ya'lls take. Thank you.

The Chairman. Mr. O'Rourke.

Mr. O'ROURKE. Thank you, Mr. Chairman.

Mr. Violante pointed this out earlier, that the secretary and his team are here, and I really appreciate you saying that. I just want to make sure that it is noted for the record, because if we are going to be successful in this team approach, it is going to take all of us literally being in the same room and listening to each other. So I thought that was important that you pointed it out.

I wanted to ask you, any person at the table to respond to this, that the secretary also mentioned working collaboratively in terms of how we build and offer medical care, beyond this question of the Choice Act. An example that we talked about last week in a hearing was this hospital in Aurora, Colorado, you know, \$604 million now to \$1.1 billion, originally supposed to be affiliated with an academic institution. That affiliation is broken. I couldn't help but get the sense that veterans in that area and perhaps VSOs were insistent that that be flagged solely as a VA facility, and that might have had some cost and some consequences to that.

What is your openness or what are your thoughts on this idea of working collaboratively and involving other non-VA institutions in the provision of healthcare or the development of facilities or organizing how we deliver that healthcare in a community like El Paso where I don't know that we need a hospital—I don't know that we are going to get a \$1.1 billion facility, so we may have to work collaboratively. So, if I could start with you, Mr. Violante and work rightwards down the table, I would love to get your response.

Mr. VIOLANTE. Sure. We have mixed feelings. I mean we have seen other facilities, particularly DoD facilities where VA and DoD have gone in together and sometimes there are problems because the troops that are stationed there get deployed and then the services really start lacking. But I think some of the facilities up in Great Lakes may be working fine with a federal VA kind of emphasis, so it just depends on the area and how it is structured.

Mr. KELLEY. We have to look at every option. We have to look at building standalone VA hospitals. We need to look at public-private partnerships. We need to look at intergovernmental partnerships. We just have to. It has to be right-sized and the services need to be in place for veterans. And so every avenue, not just with university hospital partnerships, but with county hospitals, with city hospitals. I think that as they start planning what they are going to replace for their need, if there is room for VA at that same campus and it is purchased, it is a co-purchase, it is co-owned, and services are interoperable, then it is a smart move.

Mr. O'ROURKE. To include, you mentioned city, county. To include private sector, potentially, if there is a capacity and expertise and a center of excellence in a particular area where there is a gap in VA care?

Mr. KELLEY. Absolutely.

Mr. O'ROURKE. Great.

Mr. Blake.

Mr. BLAKE. I think it would be unreasonable to think that they shouldn't take advantage of affiliate opportunities and partnerships if it maximizes opportunity for healthcare. That being said, you mentioned Aurora, you know, part of the problem with that over the years was figuring out—I can remember a time when the vision for that was sort of a joint facility that had a mix of veteran patients and non-veteran patients, civilian patients, and you ran into challenges with something as simple as, you know, identification of two. And then you got into more complicated issues with like governance and priority of access and service.

And so you have to be careful when you get into that sort of concept. The Denver issue is clearly—you know, I think it is even

more unique than the problems that existed in Las Vegas and New Orleans that are still going on and Orlando. The Denver project has been going on for 20-plus years now and if nothing else, veterans are being unsatisfied there because there are many promises that have been made and still no access to healthcare there and that is a clearly under-served population.

Mr. O'ROURKE. Thank you.

Mr. DE PLANQUE. I think it clearly is a team sport. I think, clearly, it is a country that takes care of veterans, and we have certainly seen in the past, teaching hospitals working in conjunction with VA facilities and I think there are some great partnerships that can be achieved there. Obviously, the VA has to be the core of that and the taking care of veterans. There is a reason that a lot of our veterans like to go to the VA and that is because it is something that understands them.

But at the same time, if they are going to be innovative, if they are going to be leading the way, like I was saying, you know, the leading authorities on TBI, PTSD, et cetera, that is beginning to involve partnerships. That is going to involve finding the best people out there, and I think it is absolutely within their grasp to be able to do that.

Mr. O'ROURKE. Thank you.

Mr. Chair, could I have 30 seconds for Ms. Zumatto to answer? Thank you.

Ms. ZUMATTO. Thank you.

I would say that while VA certainly has many fine doctors and experts, they don't corner the market. There are lots of people in the civilian community who could bring new ideas, research and other possibilities. So to say that we shouldn't be considering public-private partnerships I think would be a serious mistake.

Mr. O'ROURKE. Thank you.

Thank you all for your answers and for your work.

The CHAIRMAN. Thank you very much.

Ms. Brown, do you have additional comments or questions?

Ms. BROWN. No, sir.

Thank you very much for this hearing.

The CHAIRMAN. Thank you very much for being here. Thank you for presenting the Independent Budget; we appreciate that. Expect questions to the second panel post-hearing questions and to the first panel. There are some issues that we were not able to bring up, given the time.

But, Mr. Secretary, thank you, sir, for staying through the entire budget hearing, and with that, I request that all Members have five legislative days with which to revise and extend their remarks.

Without objection, so ordered.

This hearing is adjourned.

[Whereupon, at 1:12 p.m., the committee was adjourned.]

APPENDIX

PREPARED STATEMENT OF CHAIRMAN JEFF MILLER

Good morning. This hearing will come to order. We are here to discuss the President's Fiscal Year 2016 budget request for the Department of Veterans Affairs (VA). Mr. Secretary, welcome. I understand that your testimony will be a bit different than what the Committee is accustomed to, with references to charts to help us better understand what you're seeing in terms of the challenges ahead. That's a welcome change. So, too, is the openness that you have had with me, Members of this Committee and the Congress about your plans to change the culture at VA.

As your testimony illustrates you've been extremely active in visiting VA facilities, talking with employees, veterans groups, and your private sector colleagues with one aim in mind ... putting everyone's focus squarely on the needs of veterans. Thank you for your willingness to take the job of Secretary, and thank you for putting everything you have in to it.

Turning now to the business of examining the VA budget request, I see some very positive things but also some areas with considerable question marks. The Committee's task will be to learn as much as possible in order to inform our "Views and Estimates" letter to the Budget Committee due next Friday.

On the positive side, Mr. Secretary, you have boldly tackled the sensitive issue of VA's aging infrastructure. Coupled with a more realistic budget request for VA's major construction program, addressing the closure of unsafe, vacant, or underutilized facilities begins an important conversation about the future alignment of VA's infrastructure. I have long argued that we needed a strategic reassessment of VA's construction program. That is, in part, what the independent assessment and the Veterans Healthcare Commission, established in last summer's Choice Act, were tasked with examining. You have my commitment to work with you as this conversation begins in earnest.

I do have several areas of concern that I hope that you and our second panel can address.

First, and I will be frank, the proposal to reallocate any portion of the \$10 Billion appropriated for the Veterans Choice Program is a non-starter. I understand there is a great degree of uncertainty about the program's utilization. In appropriating the money, the Congress had to work with the best estimates we had at the time to stretch those dollars, including limiting eligibility criteria for veterans. If there is to be any reallocation it will be to further improve and strengthen the program itself and not to address other, unspecified needs.

Second, the budget requests an additional \$1.3 billion for VA medical care on top of the advance appropriation for Fiscal Year 2016, bringing the total proposed increase to 7.4%. At a threshold level, I do not understand how this request interacts with the \$15 Billion Congress provided last summer for non-VA care and infrastructure as part of the Veterans Access, Choice and Accountability Act. It would appear that there are considerable unknown variables in this area, such as the degree to which the Choice Program alleviates workload and resource pressure on VA, the productivity standards VA should expect from its clinical workforce, and the ability for VA to hire medical professionals in the face of an already large vacancy rate and a national shortage of healthcare professionals. I hope to expand on this a bit more in questioning.

Third, I note the 6.5% increase for the Veterans Benefits Administration, principally to hire additional staff to address the workload. Mr. Secretary, there are several of us on the Committee who have a long memory on this issue. We know that disability claim staffing has doubled in 10 years and nearly tripled since when I first arrived in Congress. We've invested over a half-a-billion dollars in the VBMS system and millions more in other systems. And we've provided tools to encourage veterans to file fully-developed claims which, in turn, enables a quicker decision.

All of these investments were made with the promise that productivity would markedly improve and shift the department away from the usual trend of relying on an ever-increasing workforce and overtime to deal with the workload. Although I note the production improvement in the backlog over the last two years, it is a far cry from seeing individual worker productivity improve given the resources that have already been provided. Again, this is another area I hope to address in questioning.

Finally, a big lesson learned last year is that veterans are better served with constant and aggressive oversight. Ms. Brown and I have asked for a larger Committee budget toward that end. I believe the Office of Inspector General, too, needs more than a .3% increase. The proposed amount is not even enough to cover inflationary costs, let alone the increased oversight we all rely so heavily upon.

Again, I look forward to hearing your testimony, Mr. Secretary. I also look forward to hearing the views of our VSO panel. The VA system is for them and those they represent, so their input on budgetary matters is critical to inform the Committee and the Congress on VA's budget request.

PREPARED STATEMENT OF RANKING MEMBER CORRINE BROWN,

Thank you, Mr. Chairman.

Secretary McDonald, I want to welcome you this morning. I look forward to hearing how this budget request will meet the needs of our veterans.

The President has proposed a large increase for VA. For FY 2016 the President has proposed nearly an 8 percent increase in funding for VA health care, personnel, construction, research, and claims processors.

Given this large request, I look forward to our discussion today, and how it will assist our work as a Committee to make sure that this proposed budget gives you the dollars you need, but also assures us here in Congress that every dollar you receive will be spent wisely.

I certainly wish that my bill, H.R. 216, the Department of Veterans Affairs Budget Planning Reform Act of 2015, was the law of the land. It is an important tool to assist us, and you, in matching resources to the needs of our veterans and ensuring we are planning for the future to make sure we don't let down our veterans.

Mr. Secretary, the first question I will ask is does your proposed budget give you all the dollars you need to fix the problems you face, meet the goals of the initiatives the Department has laid out?

Keeping in mind the funding provided by the Choice Act, I hope that we can discuss whether you have enough resources to ensure that veterans do not face intolerable delays in getting access to health care. I hope we can discuss how you are looking down the road to ensure that veterans have access to VA care in the future.

I always hear from my veterans how they prefer VA care when it is available—I hope that we are going to all work together to make sure that this health care our veterans prefer is available to them when they need it.

This is the first year that VA benefit programs are to be funded under advance appropriations. Now veterans won't have to worry as much if we here in Congress can't do our job.

Finally, I want to hear about your reform and reorganization efforts, and how this budget request will support these efforts. I also want to hear about how you are making progress in your efforts to reform and reinvigorate the VA.

Too often, all we hear about is the problems VA is having—I would like us to also consider what we can do to fix these problems and to point out what VA is getting right.

I am pleased with this budget request, and hope that these dollars can fix what is wrong and strengthen what is right with the VA.

Thank you Mr. Chairman and I yield back the balance of my time.

**STATEMENT OF THE HONORABLE ROBERT A. MCDONALD
SECRETARY OF VETERANS AFFAIRS**

**FOR PRESENTATION BEFORE THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS**

BUDGET REQUEST FOR FISCAL YEAR 2016

FEBRUARY 11, 2015

Chairman Miller, Ranking Member Brown, Distinguished Members of the House Committee on Veterans' Affairs:

Thank you for the opportunity to present the President's 2016 Budget and 2017 Advance Appropriations (AA) requests for the Department of Veterans Affairs (VA). This budget continues the President's staunch, unwavering support for Veterans, their families, and survivors. We value the support to VA that Congress has demonstrated in providing the resources and legislative authorities needed to honor our Nation's Veterans.

This is a critical moment for VA. We are emerging from one of the most serious crises the Department has ever experienced. But with this crisis, VA also has before it perhaps the greatest opportunity in its history to enhance care for Veterans and build a more efficient and effective system. We are listening hard to what Veterans, Congress, employees, Veterans Service Organizations (VSOs), and other stakeholders are telling us. Since my nomination on June 30, 2014, I have made 96 visits to VA field sites -- including 26 visits to VA Medical Centers, seven visits each to VA Community-Based Outpatient Clinics and Homeless Veteran program sites. I participated in the Los Angeles Point-in-Time Homeless Veterans count. I've made six visits to VA Regional Offices and five visits to VA cemeteries. I have witnessed first-hand the operations at VA polytrauma centers, a Veterans community living center, a hospice, an insurance center, and a domiciliary. I have attended nineteen Veteran engagements through partnerships and sixteen stakeholder events. I have visited twelve medical schools and universities to recruit newly minted clinical professionals for VA's healthcare system. All of these visits are influencing the way VA is moving forward. We are implementing an historic department-wide transformation, changing VA's culture, and making the Veteran the center of everything we do. We aspire to make the VA a model agency that is held up as an example for other government agencies to follow with respect to customer experience and stewardship of the taxpayer's resources. We strive to be comparable to the very best private sector businesses, with efficient and effective operations.

The President's 2016 Budget will allow VA to operate the largest integrated healthcare system in the country, including over 1,900 VA points of healthcare and approximately 9.4 million Veterans enrolled to receive care; the tenth largest life insurance provider, covering both active duty Servicemembers and enrolled Veterans; a compensation and pension benefits program serving over 5.2 million Veterans and survivors; an education assistance program serving 1.2 million students; a home mortgage program with a portfolio of over 2 million active loans guaranteed by VA; and the largest national cemetery system that leads the Nation as a high-performing organization, with projections to inter 129,200 Veterans and family members in 2016. VA's 2016 budget request is essential to begin to address the resource requirements necessary to move VA into the future, address the crisis we are in, and meet our obligation to provide timely, quality health care and services to Veterans.

The 2016 Budget for VA requests \$168.8 billion -- \$73.5 billion in discretionary funds, including medical care collections, and \$95.3 billion in mandatory funds for Veterans benefits programs. The discretionary request reflects an increase of \$5.2 billion (7.5 percent) above the 2015 enacted level. The budget also requests a 2017 AA for Medical Care of \$63.3 billion and a first-time AA request of \$104.0 billion for three mandatory accounts that support veterans' benefit payments (i.e., Compensation and Pensions, Readjustment Benefits, and Insurance and Indemnities). These investments, together with the 2016 Budget, will provide authorities, funding, and other tools to enhance service to Veterans in the short term while strengthening the underlying VA system to better serve Veterans in the future. However, more resources in certain areas will be required to ensure that the VA system can provide timely, high-quality health care into the future. In the coming months, the Administration will submit legislation to allow the VA Secretary to reallocate a portion of Veterans Choice Program funding to best meet Veteran needs. This will allow the Secretary to make essential investments in VA system priorities in a fiscally responsible, budget-neutral manner.

MyVA -- Driving Reforms and Improving Efficiency

In order to transform VA into an organization of which Veterans, employees, and Americans can be proud, we are beginning with a commitment to critically assess ourselves. Transformation must start with organizational reforms to better unify the Department's efforts on behalf of Veterans. These reforms will take time, but will center around the ICARE values and provide Veterans the services and benefits they have earned and deserve.

The goal of MyVA is to reorient the Department around the needs of Veterans. MyVA will create a VA that eliminates barriers to putting customers first; measures success by the outcomes to Veterans as opposed to our internal processes; and integrates across programs and organizations to optimize productivity and efficiency. MyVA focuses on five major themes:

- Improving the Veteran experience
- Improving the employee experience, and achieving “people excellence” so we can better serve Veterans
- Establishing a culture of continuous improvement
- Improving our internal support services
- Enhancing strategic partnerships

The overarching principle is our focus on the Veteran experience. We want every Veteran to have a seamless, integrated, and responsive customer service experience every time. We are taking the first step towards better integration of the Department by moving from nine separate regional maps to one. This realignment will align VA's disparate organizational boundaries into a single framework, easing internal coordination and collaboration between business lines, and allowing VA to provide customer service training and capabilities across the agency. This will make the department more seamless to Veterans, who will begin to perceive their interactions with one VA, rather than individual organizations. The new organizational framework will have five geographically-named regions, and we are working with Veteran stakeholders to develop names for the regions.

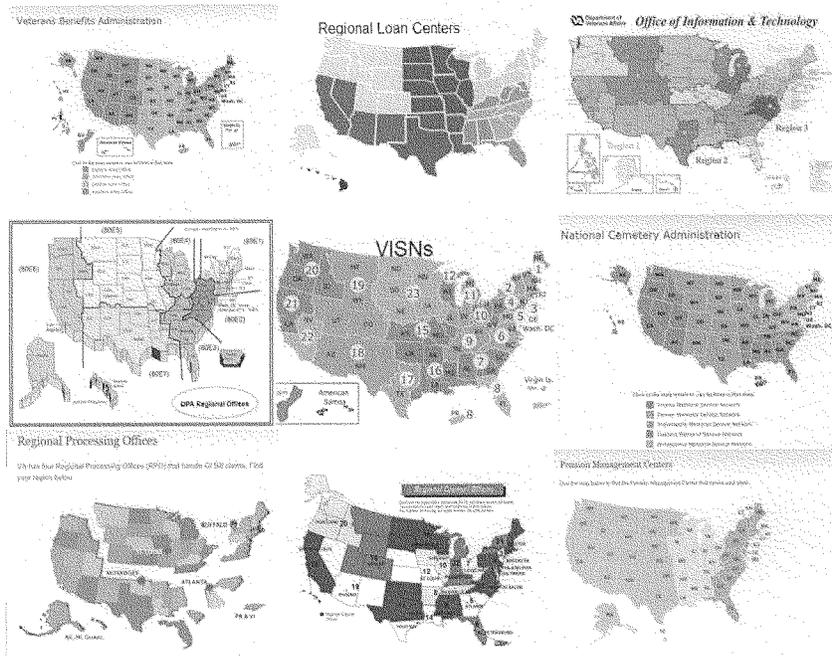
MyVA will empower employees with the tools they need to better serve Veterans, and will revolutionize VA's culture by emphasizing continuous improvement, setting conditions at the local level for issues to be raised, addressed, and solutions replicated across as many facilities as needed to achieve enterprise level results.

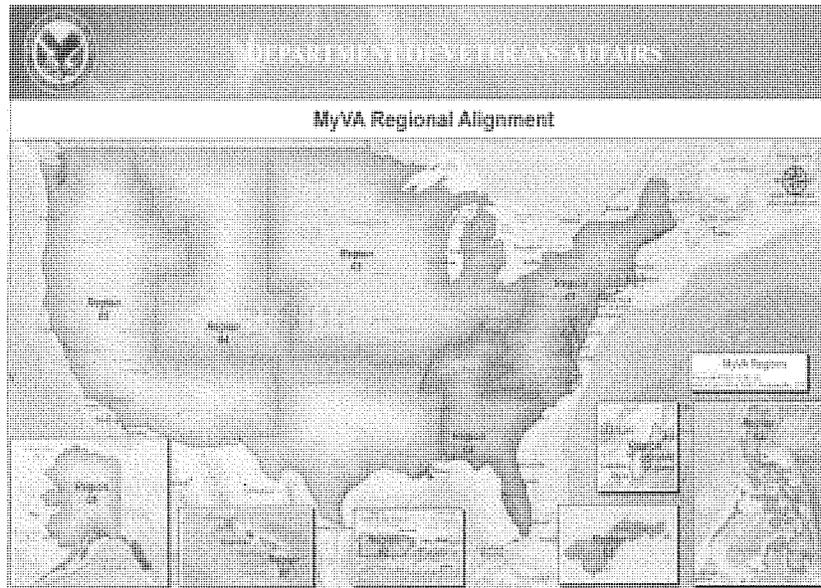
MyVA is also about ensuring that VA is a sound steward of the taxpayer dollar. By improving our internal support services, we will ensure that our processes support VA employees serving Veterans and that we effectively balance exceptional Veteran-centric service with operational efficiency. We are using a business lens to assess all aspects of VA operations and will pursue changes to allow VA to deliver care and services more efficiently and effectively while delivering the highest value to Veterans and taxpayers. By exploring opportunities to enhance Strategic Partnerships, we will ensure the best and most effective organizations—public, private, non-profits, and volunteer—work with VA to best serve Veterans.

In addition, we are creating a new Digital Services Team, comprised of the country's best developers, designers, and digital product managers, who will work across VA to design and deploy world-class digital services for America's Veterans. Our digital services experts will help the Department achieve the MyVA vision through improved electronic access to VA services that works across Veterans' computers, tablets, kiosks, and mobile devices.

We anticipate this will be the largest department-wide transformation in VA's history. It will be the product of ideas and insights shared by Veterans, employees, members of Congress, VSOs, and other stakeholders.

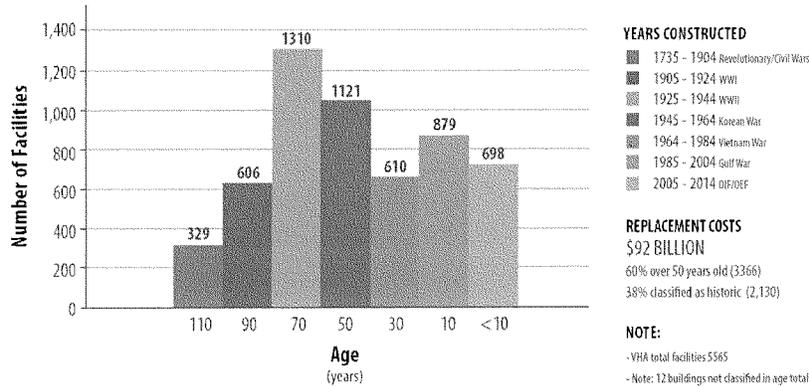
Before: VA's Nine Organizational Maps



After: A Single, Coordinated Framework**Closing Unsustainable Facilities**

VA cannot be a sound steward of the taxpayer's resources with the asset portfolio it is carrying. No business would carry such a portfolio – and our Veterans deserve better. It is time to close VA's old, substandard, and underutilized facilities. Of 5,565 VA medical facilities – which include hospitals, clinics, warehouses, and other assets that support medical operations – more than 900 facilities are over 90 years old, and more than 1,300 facilities are over 70 years old. Overall, 60 percent of VA facilities are more than 50 years old.

VHA's Aging Infrastructure
68% of VHA facilities more than 50 years old



We need to move forward with closing locations that are not economically sustainable and old, outdated buildings that are challenging to maintain and provide little or no value to our customers. VA currently has 336 buildings that are vacant or less than 50 percent occupied, which are excess to our needs. This means we have to maintain over 10.5 million square feet of unneeded space – taking funding from needed Veteran services. For example, we estimate that it costs VA \$24 million annually to maintain and operate vacant and underutilized buildings. These funds could be better used to hire roughly 200 Registered Nurses for one year; pay for 144,000 Veteran primary care visits; provide Veterans 13,500 bed days of inpatient care; or support 41,900 days of nursing home care for Veterans in Community Living Centers. The President's 2016 Budget includes two legislative proposals that would aid VA in disposing of these unnecessary assets. The first is the government-wide Civilian Property Realignment Act, which would enable Federal agencies to pursue consolidation and disposals in a streamlined way. The second proposal would authorize VA to pursue Enhanced-Use Lease (EUL) agreements for purposes beyond the currently authorized purpose of creating supportive housing. Our existing EUL authority does not allow VA to enter into a wide range of innovative agreements that could benefit Veterans.

VA faces many obstacles to rightsizing our capital asset portfolio. For example, under an Enhanced Use Lease project, VA and a third-party developer tried to demolish the vacant building shown below in order to provide land for the development of housing for homeless Veterans, but the state historic preservation office prevented VA from

taking action. I have met with National Historic Building advocates to discuss repurposing the buildings we close, and look forward to a spirited, positive dialogue on this issue.

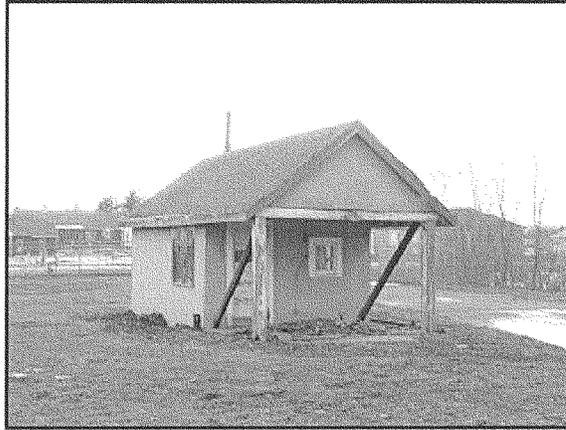


Photo: Minneapolis, Minnesota vacant building, quartermaster gas station, built in 1932.

As the Veteran population has migrated, VA's capital infrastructure has not kept pace. We continue to operate medical facilities in legacy locations, in places where the Veteran population is small or shrinking. We do this at the expense of creating new access and right-sized capacity for larger numbers of Veterans in the locations where the Veteran population is growing. For example, in one hospital with an operating capacity of ten medical beds, the average daily patient census is 5 patients or less. At this facility, VA is required to maintain adequate infrastructure such as lab, x-ray, and other support in place continuously, regardless of the facility's low utilization rate. The cost per patient to maintain a small operation such as this one is higher than the cost in some of our large, highly complex facilities. Additionally, the patient volume and complexity of care make it difficult, if not impossible, for physicians and nurses to maintain clinical skills and competencies. This example is not an anomaly – there are many others in VA.

VA needs to better align its health care facilities to meet today's health care delivery models, which are shifting away from long inpatient stays to greater outpatient care. We also need to modernize our facilities to ensure they provide ready access to women, who now comprise 11 percent of all Veterans and 20 percent of our military. Where hospitals no longer make sense, due to a declining Veteran population or

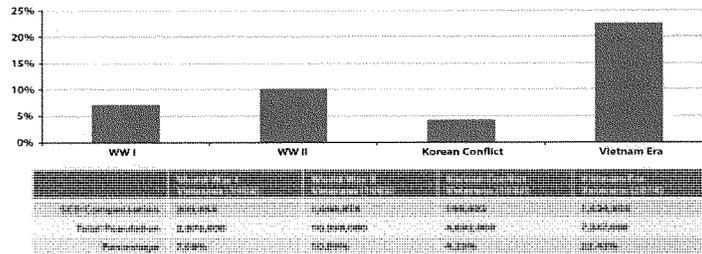
demographic shifts, VA must look for ways to partner with local hospitals and health care systems to serve Veterans. Much of health care today is about creating partnerships and interdependencies to better serve patients and to contain costs. VA must be part of that.

We know that it is difficult for Members of Congress to contemplate the closing of a facility in their own District, even when that facility is underutilized and wasteful. Yet, given the current and future demands on the VA system, we cannot afford to waste scarce resources on an inefficient system. We would like to work with Members of Congress to do the harder right, rather than the easier wrong. We ask for your help to realign our Medical facilities to best serve our Veterans and shed facilities that are not economically viable and no longer provide value.

Veterans' Demand for Services and Benefits

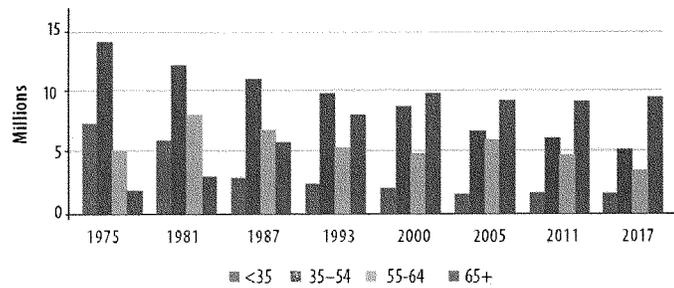
We know that Veterans' demand for services and benefits continues to rise for decades after conflicts end. And we know that the Veteran population is aging. In 2017, 9.8 million, or 46 percent of the 21.1 million Veteran population will be age 65 or older. This compares with 2.2 million, or 7.5 percent, in 1975. Veterans' care often occurs many years after they served in uniform, so this is a long-term issue for VA. Just since 2002, the number of Veterans receiving outpatient services has grown by more than 76 percent.

Veterans Receiving Service Connected Disability Compensation
40 years after conflict ends

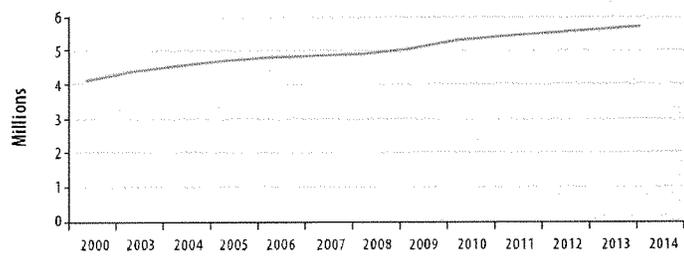


Note: Date in parentheses is the date of data used in the chart
 Data Source: 1956 VA Annual Report; 1985 VA Trend Data 1961-1985;
 1993 VA Trend Data 1969-1993; 2014 VBA OPIA and Veteran Population Model

Number of Living Veterans
by Age Groups, 1975-2017

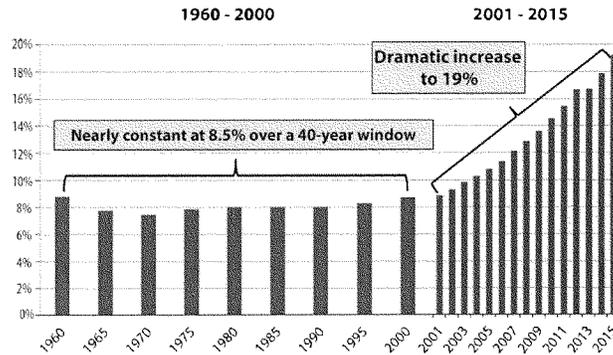


Number of Veterans Unique Outpatients
2002-2014 (in millions)

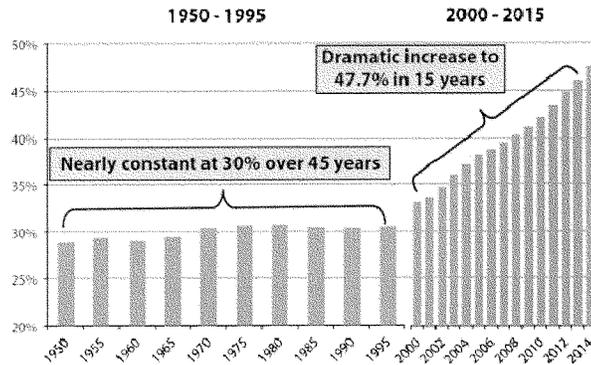


Fueled by more than a decade of war, Agent Orange-related disability compensation claims, an complex, non-linear claims appeal process, demographic shifts, increased medical claims issues, and other factors, Veterans' demand for services and benefits has exceeded VA's capacity to meet it. VA has worked with the Ad Council on a pro bono advertising campaign to encourage more Veterans to sign up for their benefits, but we are reluctant to launch the campaign at a time when our capacity is stretched to its limit.

Percent of Veterans Receiving Disability Compensation



Average Degree of Disability



We must ensure that demand for services and benefits does not outstrip our capacity to provide them. VA must build the capacity now to meet future demand. We

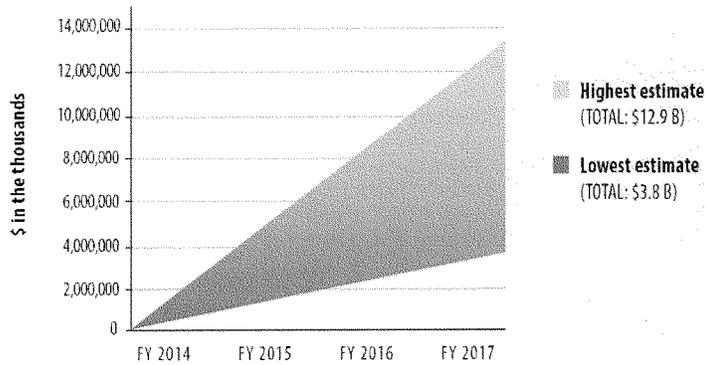
look forward to working with you to identify and prioritize spending to best serve the interests of Veterans and our Nation.

The Veterans Access, Choice, and Accountability Act of 2014

The funding provided in the Veterans Access, Choice, and Accountability Act of 2014 (Veterans Choice Act) was an important step in moving VA on the path to improved access to care for Veterans. VA greatly appreciates these additional resources provided by the Congress - \$15 billion to allow Veterans additional access to health care within the community and address current access and capacity shortfalls that are inherent within VA. While it is clear that purchased care plays an important role, it should not be seen as a replacement for a strong and vital Veterans' healthcare system.

The emergency resources provided in the Veterans Choice Act are not permanent, but are being used to address the current access crisis, but do not fully address VA's longstanding capital infrastructure requirements. Because VA has limited experience with the new Veterans Choice Program, it is difficult to predict Veterans' use of the program, or its interaction with the medical care base budget. Our estimates of the total health care costs for the Choice Program range from a low of \$3.8 billion to a high of \$12.9 billion over the three-year program.

Cone of Uncertainty Surrounding Cost of Veteran Participation in Veterans Choice Program



Data source: VA Office of the General Counsel, Economic Impact Analysis for RIN 2900-AP24, "Expanded Access to Non-VA Care through the Veterans Choice Program"

The variance is the result of significant uncertainty surrounding eligible Veterans' participation and utilization of non-VA medical services. Two categories of Veterans are eligible to participate -- those living outside the Act's 40-mile distance from a VA facility, and those who are on a waiting list for more than 30 days. Each eligible Veteran must make his or her own decision about care in the community. For example, a Veteran may prefer to be seen at the VA by his or her regular doctor, even though there is a waiting period, rather than see a new private sector physician in a shorter time period. Also, wait times may be high in the community for specialty appointments, and Veterans may elect to receive their specialty care from VA.

Ensuring Veterans Access to Care

Veterans are demanding more services from VA than ever before. The number of Veterans who are seeking VA medical care continues to grow steadily. Compared to FY 2009, the number of patients is projected to increase by 20 percent by FY 2016. We now serve a population that is older, with more chronic conditions, and less able to afford care in the private sector. And, as Veterans see the results of the positive changes we are making, we are confident that the number of Veterans utilizing VA services will rise. Currently, 11 million of the 22 million Veterans in this country are registered, enrolled, or use at least one VA benefit or service. Our 2016 budget requests the necessary resources to allow us to serve the growing number of Veterans who selflessly served our Nation.

In 2016, the number of Veterans enrolled in VA medical care will be nearly 9.4 million, an increase of 1.6 percent from 2015. Also, VA expects to provide more than 101 million outpatient visits in 2016, an increase of 2.8 million visits from 2015. Workload will continue to rise as the military downsizes and Veterans regain trust in the VA. In addition, 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.

The 2016 Budget requests \$60.0 billion for medical care, an increase of \$4.2 billion (7.4 percent) over the 2015 enacted level. The increase in 2016 is driven by Veterans' demand for VA health care as a result of demographic factors, and 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 2016 request supports programs to end Veteran homelessness; continue implementation of the Caregivers and Veterans Omnibus Health Services Act; provide for activation requirements for new or replacement medical facilities; and invest in strategic initiatives to improve the quality and accessibility of VA healthcare programs. The 2016 appropriations request includes an additional \$1.3 billion above the enacted 2016 AA for Veterans medical care. This is

the first year VA will be seeking additional funding in all three medical care accounts that are funded by advance appropriations. The request includes approximately \$3.3 billion annually in medical collections in 2016 and 2017.

For the 2017 Advance Appropriations for medical care, the current request is \$63.3 billion. This request reflects great uncertainty surrounding the impact of the Veterans Choice Act on VA operations in 2017. This estimate will be revised as VA gains greater experience with implementation of the Veterans Choice Act.

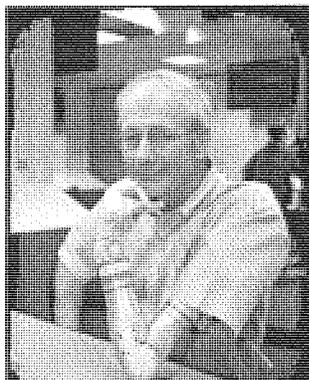
Ending Veteran Homelessness

As President Obama has said, too many of those who once wore our nation's uniform now sleep in our nation's streets. The Administration has made the elimination of Veteran homelessness a national priority. In 2009, we set an ambitious plan to end veteran homelessness by the end of 2015. We have made substantial progress toward this goal — as of January 2014, overall Veteran homelessness is down 33 percent since 2010, and we have achieved a 42 percent decrease in unsheltered veteran homelessness. Through unprecedented partnerships with 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. As a result of these investments, in fiscal year 2014, more than 260,000 homeless or at-risk Veterans (including formerly homeless Veterans) received VA specialized services.

In 2016, VA will continue to focus on prevention and treatment services. The Budget requests \$1.4 billion for VA homeless-related programs, including case management support for the HUD-VASH voucher program, the Grant and Per Diem Program, the Supportive Services for Veteran Families program, and VA justice programs. The 2016 Budget supports VA's plan to end Veteran homelessness by emphasizing rescue for those who are homeless today, and prevention for those at risk of homelessness.

Medical and Prosthetic Research

VA has a legacy of innovation and cutting-edge research that is as broad and historically significant as it is profound—and often unrecognized. Few are aware that VA research developed the cardiac pacemaker, the first successful liver transplant, the nicotine patch, and the world's most advanced prosthetics—including VA's revolutionary "Braingate" breakthrough that makes it possible for totally



paralyzed patients to control robotic arms using only their thoughts.

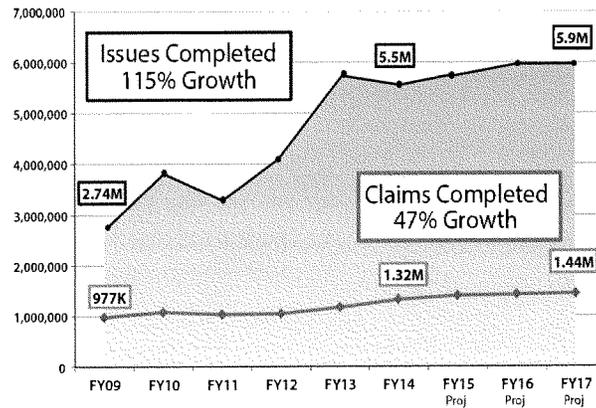
VA research also has led to major breakthroughs and advances in medical science and care—Posttraumatic Stress Disorder, or PTSD, and Traumatic Brain Injury, or TBI, being only two of many. In 2016, Medical Research will be supported through a \$621.8 million direct appropriation, and an additional \$1.2 billion from VA's medical care program and grants. Total funding for Medical and Prosthetic Research will be over \$1.8 billion in 2016.

The 2016 Budget includes a \$10.2 million strategic initiative to support improvements in VA medical care through research focused on a "Learning Health Care System." A learning health care system is one that is responsive to new information, adapts to implement more effective clinical practices, and is committed to an ongoing mission of excellence, supported by a culture of self-reflection and continuing education. Through five interlocking research streams – measurement science, operations research, point-of-care research, provider behavior, and randomized program implementation – this initiative proposes to broaden existing research by systematically capturing, assessing, and translating the lessons from each care experience into improved methods of delivering care to Veterans.

Continuing the Transformation of the Veterans Benefits Administration

Improving quality and reducing the length of time it takes to process disability compensation claims is integral to our mission of providing the care and benefits that Veterans have earned and deserve in a timely, accurate, and compassionate manner. The disability rating claims workload continues to increase, due to the reduction in military forces, Servicemembers returning from wars, and the aging of the Veteran population. Also, the complexity of the workload continues to grow because Veterans are claiming greater numbers of disabling conditions and the nature of disabilities -- such as PTSD, combat injuries, diabetes and related conditions, and environmental diseases -- is becoming increasingly complex.

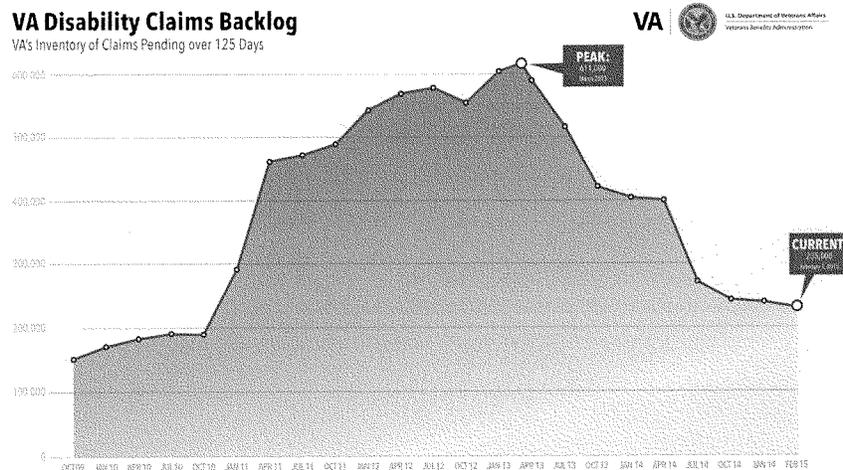
Claims and Medical Issues Completed



Despite these challenges, VBA has decreased the disability claims backlog by more than 60 percent as of January 31, 2015, since its peak in March 2013 (from 611,000 to 235,000), and we are on track to meet the President's goal to eliminate the disability claims backlog by processing all claims in 125 days by the end of 2015. VBA's success in reducing the backlog has occurred, in part, because of its strong reliance on mandatory overtime by claims processors. However, this strategy is unsustainable. It strains employee-management relations and is inconsistent with our goal to improve the employee experience so they can be empowered to better serve Veterans. We must right size VBA's workforce and more effectively manage the use of management practices such as the use of mandatory overtime and continue progress toward eliminating the disability claims backlog.

VA Disability Claims Backlog

VA's Inventory of Claims Pending over 125 Days



We are taking the lessons learned in eliminating the disability claims backlog and applying them to transform business processes supporting the fiduciary program, the delivery of non-rating benefits, and the appellate workload.

For 2016, VA requests \$2.7 billion for VBA for general operating expenses, an increase of \$165.8 million (6.6 percent) over the 2015 enacted level. These resources will support 21,871 Full-Time Equivalent (FTE) employees and allow VA to administer disability compensation and pension benefits totaling \$83.1 billion to over 5.2 million Veterans and survivors; education benefits and vocational rehabilitation and employment benefits and services to nearly 1.3 million participants; VA guaranty of more than 431,000 new home loans; and life insurance coverage to 1.1 million Veterans, 2.3 million Servicemembers, and 3.1 million family members.

As VBA continues to receive and complete more disability rating claims, the volume of appeals, non-rating claims, and fiduciary field examinations increases correspondingly.

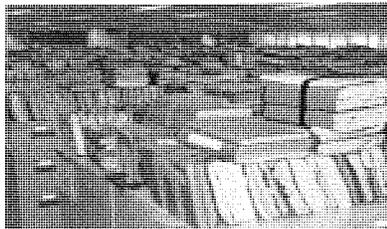
- **Appeals.** Over the last 20 years, appeal rates have continued to hold steady at between 11 and 12 percent of completed claims. As VBA continues to receive and complete record-breaking numbers of disability rating claims in recent years (1.3 million claims completed in 2014), the volume of appeals increases concomitantly. VBA currently has approximately 290,000 pending appeals.

- **Non-rating claims.** VBA's success in completing rating decisions has driven an increase in non-rating claims. In 2015, VBA expects to receive 2.9 million non-rating claims and review actions, an increase of 7.4 percent over 2014 (2.7 million) and 12.5 percent over 2013 (2.4 million).
- **Fiduciary program.** In 2014, VA's fiduciary program protected more than 173,000 beneficiaries, which is a 42 percent increase in the number of beneficiaries from 2011 (122,000). Primary drivers of the growth in this program are the increase in the total number of beneficiaries receiving VA benefits and an aging beneficiary population. In 2014, fiduciary personnel conducted over 86,000 field examinations, and VBA anticipates field examination requirements to exceed 117,000 in 2016.

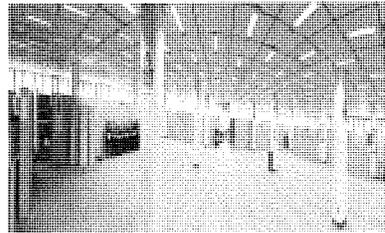
To ensure all aspects of the claims process are improved for Veterans, VBA is requesting additional claims processors and field examiners. VBA is requesting \$85 million to fund 200 appeals processors, 320 non-rating claims processors, 85 fiduciary field examiners, and 165 support personnel (including 13 FTE for the National Work Queue (NWQ)), for a total of 770 additional FTE. VBA employees – over 50 percent of whom are Veterans – are leading advocates for Veterans, Servicemembers, their families, and Survivors and are key to our success. With the additional 770 employees, VA will provide Veterans with more timely decisions on their appeals and non-rating claims, and conduct thousands more vital fiduciary home visits.

VBA is able to accommodate additional staff within existing space requirements by efforts underway to digitalize Veterans claims folders, building on success to date. One example is the VBA office in Winston-Salem, North Carolina, which is shown below before and after VBA digitized Veterans' paper records.

Winston-Salem Regional Office: Before and After Transformation



Spring 2012



Fall 2013

The VBA request includes \$140.8 million for continued investment in the Veterans Claims Intake Program (VCIP), which converts paper claims into an electronic format and enables the electronic transfer of medical and personnel records. This

electronic transfer is critical to creating the necessary digital environment that supports end-to-end electronic claims processing for each stage of the claims lifecycle. As of December 2014, over 28,000 users of the Veterans Benefits Management System (VBMS) could access over one billion electronic images converted from paper.

The Budget request for the 2017 Advance Appropriations for the Compensation and Pensions appropriation is \$87.1 billion; the Readjustment Benefits advance appropriation request is \$16.7 billion; and the Veterans Insurance and Indemnities advance appropriation is \$91.9 million. These amounts reflect the current estimates for the resources that would be necessary to continue these benefit programs in 2017, and will be revised as necessary in the mid-session review of the 2016 Budget, as VA monitors workload and monthly expenditures.

Enhanced Focus on Information Technology Solutions

Funding for IT infrastructure and services is at the heart of VA's mission, because IT affects every aspect of VA's ability to serve Veterans by providing easily accessible, quality health care and benefits. To offer a view of the scope of VA's IT dependency, VA IT systems support operations at every VA location, with over a million devices on the network. VA's current challenges present a unique opportunity to employ innovative Information Technology (IT) solutions to accelerate changes that will better serve Veterans. Veterans and their families of all ages are increasingly more comfortable using leading-edge technology to communicate and access health care and benefits. Our IT challenge is to safely and securely deliver Veterans that leading-edge experience—fluid mobile solutions, creative apps, and user-friendly websites that rival the best in technology outside VA.

The \$4.1 billion request represents an increase of \$230 million (6 percent) above the 2015 enacted level. The request consists of \$505 million for development of new IT products; \$2.5 billion for sustainment, \$892 million for more than 7,615 staff and administrative support, and \$223 million for related support services. The request will sustain our infrastructure while making necessary investments in IT support for critical business processes, such as streamlining benefits processing, enhancing and modernizing VA's electronic health record, enhancing data security, and achieving health data interoperability with the Department of Defense.

The 2016 request funds key development projects for Veterans' access (\$192 million), disability claims backlog elimination (\$105 million), and VistA Evolution (\$82 million). The request of \$2.5 billion for IT sustainment will fund the replacement of the oldest hardware that has fallen beyond its useful lifespan; the development of registries to track homeless Veterans; communications systems, wireless, and mobile solutions; software license procurement; and information security.

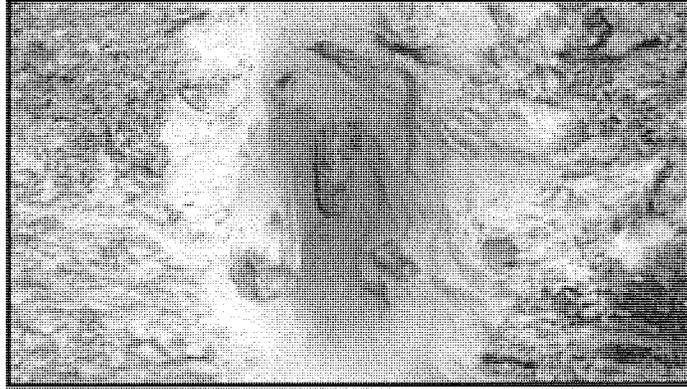
Investing in VA's Infrastructure

The 2016 Budget requests \$1.6 billion for VA's major and minor construction programs, an increase of \$493 million (47 percent) above the 2015 enacted level. Providing access to care and ensuring that Veterans are safe when they are in a VA facility, drive our capital requirements. The capital asset budget 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, secure, sustainable, and accessible facilities for Veterans. The request enables VA to invest in our facilities to fulfill VA's mission to deliver timely and high quality care and services to our Veterans. The request also reflects the current fiscal climate and the great challenges VA faces in order to close the gaps identified in our Strategic Capital Investment Planning (SCIP) process.

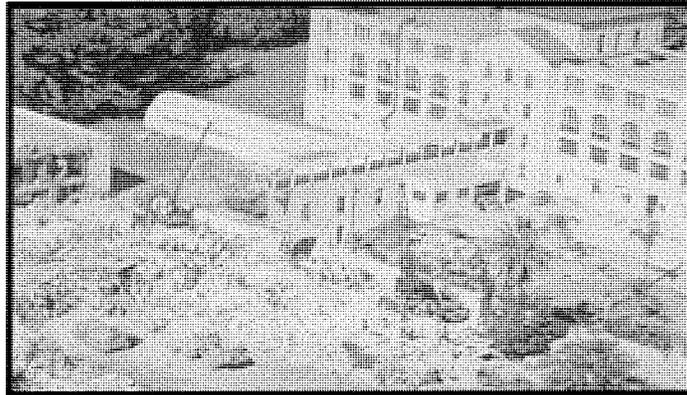
Major Construction

VA acknowledges the challenges we have experienced in building the Denver Replacement Medical Center facility in Aurora, Colorado. We are committed to doing what is right for the Veterans in Denver and completing this major construction project without further delay. VA is dedicated to getting the project back on track in the most effective and cost efficient manner possible.

The 2016 Budget requests \$1.144 billion for major construction, an increase of \$582 million from the 2015 enacted level. The request provides funding for nine on-going VHA major medical facility projects. Correction of seismic deficiencies is a primary focus of our 2016 Major construction request. The request includes funds to address seismic problems in facilities in America Lake, WA; and in San Francisco, West Los Angeles, and Long Beach, CA. These projects will correct critical safety and seismic deficiencies that pose a risk to Veterans, VA staff, and the public. The photograph below shows a known seismic deficiency at the San Francisco Medical Center -- built in 1933 -- wherein the rebar does not extend into the "pile cap."



We must prevent the devastation and potential loss of life that occurs because our facilities are vulnerable to earthquakes – such as occurred in 1971 in San Fernando, California. As shown below, 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.





The Major construction request also includes funds for medical facility improvements and cemetery expansion project in St. Louis, MO (Jefferson Barracks); new medical facility project in Louisville, KY; construction of a new outpatient clinic and a columbarium in Alameda, CA; realignment and closure of the Livermore Campus in Livermore, CA; and construction of a replacement Community Living Center in Perry Point, MD. New, replacement, and renovated medical space will provide additional capacity to treat Veterans through more efficient configurations, with the implementation of Patient-Aligned Care Teams, and the establishment of multi-exam rooms per provider – similar to the private sector. Once the projects are completed, Veterans will be served in modern and safe facilities.

The major request also includes funding for four cemetery gravesite expansion projects at: Puerto Rico National Cemetery; Willamette National Cemetery in Portland, OR; Riverside National Cemetery in Riverside, CA; and Barrancas National Cemetery in Pensacola, FL. These projects offer VA the ability to provide access to burial services through new and expanded cemeteries and prevent the closure to new interments in existing cemeteries.

Minor Construction

In 2016, the minor construction request is \$406.2 million. The requested amount would provide funding for ongoing and newly identified projects that renovate, expand and improve VA facilities, while increasing access for our Veterans. VA continues to focus on a balance between continuing to fund minor construction projects that can be implemented quickly to maintain and repair our aging infrastructure, while using major construction funding to address life-threatening safety and seismic issues that currently exist at multiple VA medical facilities.

Leasing

The 2016 Budget includes a request to authorize 18 major medical leases to provide access to Veterans and enhance our research capabilities nationwide. The proposed major medical lease projects are to replace, expand, or create new outpatient clinics and research facilities. The request includes resubmission of five leases that were originally submitted in 2015, but have not yet been authorized.

Since the inception of the EUL program, VA has entered into approximately 100 EUL projects, leveraging approximately 5.8 million square feet and over 1,000 acres of excess property to repurpose in support of Veterans, VA, and local communities across the country. VA needs the support of Congress for our proposed amendments to expand our current EUL authority beyond supportive housing projects so we can better leverage our excess space for Veterans. In addition, this proposed enhancement would allow VA to monetize unneeded assets to raise capital to address needed investments in VA's system.

Legislation

In addition to presenting VA's resource requirements, the 2016 President's Budget proposes legislative action that will benefit Veterans. VA's most critical legislative request is for a significant update to VA's authorities for purchase of non-VA healthcare. The Administration is proposing a streamlined process for purchasing health care needed for Veterans in those circumstances where it cannot be purchased through existing contracts or sharing agreements. The proposal takes care to preserve important features and protections found in traditional contract vehicles. Current law is simply not adequate to support the continued level of access to health care we need to secure for our Veterans. We look forward to detailed engagement with the Committee and your staff.

Other important proposals include adjustment for VHA personnel authorities, one of which will greatly help in having employee scheduling flexibility that will both make hospital operations more efficient, and help attract the most qualified medical professionals to work for VA, especially for critical round-the-clock operations. VA in this budget also again proposes changes in disability claims processes, an area where reform is greatly needed, for the benefit of all Veterans who are frustrated with the time it takes to resolve claims and appeals. We are open to all ideas from the Committee and from VSO's to modernize this process, and make it work for Veterans. Our increased manpower and great strides in automation are helping, but these cannot replace statutory changes to modernize the process.

As mentioned earlier, VA will propose a measure that would allow a portion of the Veterans Choice Act funds to be used for essential operational requirements. In addition, the legislative proposals would allow for better coordination of care when a Veteran also receives other care at a non-VA hospital, by streamlining the exchange of patient information. Additionally, we propose allowing the CHAMPVA to cover children

up to age 26, to make that program consistent with benefits conferred under the Affordable Care Act.

To continue our priority to end Veteran homelessness, VA proposes increased flexibility in the Grant and Per Diem program to focus on the transition to permanent housing. Also among our proposals is a measure that would allow VA to speed payment of Dependency and Indemnity Compensation and other benefits to surviving spouses by eliminating the need for a formal claim when there already is sufficient evidence for VA to act. We are proposing legislation to eliminate the requirement for quarterly conference reporting. This requirement has impacted essential VA training and has taken a massive staff effort to produce the mandated reports. Since the beginning of fiscal year 2013, VA has spent \$2.4 million to prepare these reports. These resources are better spent providing health care and benefits to Veterans. We greatly appreciate consideration of these and other legislative proposals included in the 2016 Budget and look forward to working with the Congress to enact them.

Closing

Veterans are VA's sole reason for existence and our number one priority. In today's challenging fiscal and economic environment, we must be diligent stewards of every dollar and apply them wisely to ensure that Veterans—our clients—receive timely access to the highest quality benefits and services we can provide and which they earned through their sacrifice and service to our Nation.

We also acknowledge the responsibility, accountability, and importance of showing measurable returns on that investment. You have my pledge that VA will do everything possible to 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. We are proud to be part of this VA team and feel privileged to be here serving Veterans at this key time in history. The work we do continues and grows for decades after the end of America's conflicts. Thank you for the opportunity to appear before you today and for your steadfast support of Veterans.

Appendix 1
Response to HVAC Hearing Questions

Question 1. What portion of the \$5 billion internal funding provided under P.L. 113-146, the Veterans Access, Choice and Accountability Act of 2014 (the "Choice Act") has been obligated and for what purpose? Please detail the major allocations and what is the anticipated timeline for obligating the remainder of the funds?

Answer: Through January 2015, obligations totaled \$56.4 million, of which \$29.7 million was for expenses associated with hiring 738 FTE, \$17.6 million was for NRM, and \$9.1 million was for Minor Construction. The table below provides VA's funding plan for the Section 801 funds.

Section 801 Funding			
(\$ in millions)			
Purpose	<u>2015</u>	<u>2016</u>	<u>Total</u>
Hire Medical Staff	669.0	1,384.2	2,053.2
Other Cost (Equipment and Supplies)	50.5	109.3	159.8
Non-Recurring Maintenance Projects	759.2	532.6	1,291.8
Emergency Leases	31.2	9.5	40.7
Leases in the Pipeline	132.8	139.6	272.4
Legionella Eradication Projects	93.4	73.3	166.7
Other Costs (Sec 301 & 302)	32.2	95.4	127.6
Total VHA	1,768.3	2,343.9	4,112.2
Information Technology Support			
Development	107.5	43.9	151.4
Sustainment (Hardware/Activations)	82.7	103.5	186.2
Staffing Support	13.0	26.0	39.0
Total IT	203.2	173.4	376.6
Minor Construction	383.2	128.0	511.2
Total, Section 801	2,354.7	2,645.3	5,000.0

Question 2. What portion of the \$10 billion for non-VA health care funding provided under P.L. 113-146, the Veterans Access, Choice and Accountability Act of 2014 (the "Choice Act") has been obligated? Please detail the major allocations; i.e., what portion has been spent on administrative expenses vs. provider payments?

Answer. As of January 28, 2015, \$438.3 million has been obligated. Of the total, \$300 million was obligated for administrative expenses to fund the costs of two contracts to administer the Veterans Choice Program.

Question 3. What is the total funding requested for all VA homeless programs and what is the amount allocated to each program for Fiscal Year 2016 and the Fiscal Year 2017 Advanced request?

Answer: See table below.

	2015		2016		2017 Advance Approp.	2015-2016 Increase / Decrease	2016-2017 Increase / Decrease	
	2014 Actual	Budget Estimate	Current Estimate	Advance Approp.				Revised Request
Total Medical Care Obligations (\$000)								
Homeless Veterans Treatment Costs	\$4,799,108	\$5,782,000	\$5,038,828	\$6,397,595	\$5,269,667	\$5,406,909	\$230,839	\$227,242
Programs to Assist Homeless Veterans:								
Permanent Housing/Supporting Services								
HUD-VASH case management - Initiative 1/	\$248,276	\$321,000	\$321,000	\$182,500	\$321,000	\$321,000	\$0	\$0
HUD-VASH - Sustainment 2/	\$92,530	\$52,668	\$52,668	\$54,670	\$52,668	\$52,668	\$0	\$0
Subtotal	\$340,806	\$373,668	\$373,668	\$237,170	\$373,668	\$373,668	\$0	\$0
Transitional Housing								
Grant & Per Diem 1/	\$214,468	\$214,990	\$214,990	\$145,000	\$171,094	\$171,094	(\$43,896)	\$0
Grant & Per Diem Lodging 1/	\$29,820	\$37,863	\$35,010	\$25,000	\$30,000	\$30,000	(\$5,010)	\$0
Other - Sustainment 2/	\$46,835	\$35,561	\$35,561	\$36,912	\$35,561	\$35,561	\$0	\$0
Health Care for Homeless Vets (HCHV) 1/	\$130,714	\$155,000	\$157,853	\$122,500	\$155,000	\$155,000	(\$2,853)	\$0
Subtotal	\$430,837	\$443,414	\$443,414	\$329,412	\$391,655	\$391,655	(\$51,759)	\$0
Prevention Services								
Supportive Services Low Income Vets & Families 1/	\$299,902	\$500,000	\$300,000	\$375,000	\$300,000	\$300,000	\$0	\$0
National Call Center for Homeless Veterans (NCCHV) 1/	\$4,464	\$5,568	\$5,568	\$5,568	\$5,568	\$5,568	\$0	\$0
Justice Outreach Homelessness Prevention - Initiative 1/	\$24,504	\$35,224	\$35,224	\$32,152	\$35,224	\$35,224	\$0	\$0
Justice Outreach Homelessness Prevention - Sustainment 2/	\$4,173	\$3,155	\$3,155	\$3,275	\$3,155	\$3,155	\$0	\$0
Subtotal	\$333,133	\$543,947	\$343,947	\$415,995	\$343,947	\$343,947	\$0	\$0
Treatment								
Donatary Care for Homeless Vets - Sustainment 2/	\$233,980	\$183,362	\$183,362	\$190,328	\$183,362	\$183,362	\$0	\$0
Donatary Care for Homeless Vets - Initiative 1/	\$12,269	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Telephone/Homeless Chronically Mentally Ill - Sustainment 2/	\$33,074	\$13,194	\$13,194	\$13,096	\$13,194	\$13,194	\$0	\$0
Substance Abuse/Mental Health Enhancement 1/	\$4,020	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Expansion of Homeless Dental Initiative 1/	\$8,426	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Subtotal	\$291,778	\$196,556	\$196,556	\$204,024	\$196,556	\$196,556	\$0	\$0
Employment/Job Training								
Homeless Veterans Supported Employment Program 1/	\$17,412	\$15,000	\$0	\$10,000	\$0	\$0	\$0	\$0
Homeless Veterans Community Employment Program 1/	\$4,174	\$0	\$15,000	\$0	\$15,000	\$15,000	\$0	\$0
Homeless Ther. Empl. CWT & CWT/TR - Sustainment 2/	\$91,055	\$60,565	\$60,565	\$62,867	\$60,565	\$60,565	\$0	\$0
Subtotal	\$112,641	\$75,565	\$75,565	\$72,867	\$75,565	\$75,565	\$0	\$0
Administrative								
Getting to Zero	\$532	\$532	\$532	\$532	\$532	\$532	\$0	\$0
Supportive Services Low Income Vets & Families Admin	\$7,647	\$4,860	\$8,619	\$4,000	\$8,619	\$8,619	\$0	\$0
National Homeless Registry	\$3,760	\$2,458	\$2,458	\$1,000	\$2,458	\$2,458	\$0	\$0
Subtotal	\$11,888	\$7,850	\$11,609	\$5,532	\$11,609	\$11,609	\$0	\$0
VA Requote Total								
Obligations (Grand Total)	\$1,520,783	\$1,641,000	\$1,444,759	\$1,265,000	\$1,393,000	\$1,393,000	(\$51,759)	\$0
Specific Purpose total	\$1,019,127	\$1,292,495	\$1,096,154	\$903,252	\$1,044,495	\$1,044,495	(\$51,759)	\$0
General Purpose total	\$501,656	\$348,505	\$348,505	\$361,748	\$348,505	\$348,505	\$0	\$0

4. Deputy Secretary Gibson signaled that this spring, VA will likely hit the \$880 million cap (\$800 million in statutory authorization under P.L. 113-163, plus the 10 percent variance permitted under Section 8107(c) of title 38 U.S.C.) on the Denver project and it will require legislation to increase the cap to allow construction to continue uninterrupted. Also, if the cap is increased, VA intends to shift funding from other construction projects and eventually request funding to replace those "borrowed" funds.

Question a. How much will VA request as an increased interim cap on the Denver project and when will that request be made?

Answer: VA anticipates submitting a request to Congress for an increase in the interim funding authorization cap for the Denver project and a request to reprogram about \$200 to \$240 million in funding from other VA outyear projects in the next few weeks.

Question b. From which construction projects will VA "borrow" funds to continue the Denver project and how much funding will be "borrowed" from each of those projects?

Answer: Details will be provided once our reprogramming request is completed. In general, we are looking at requesting for reprogramming from outyear projects, with the understanding that these funds will need to be replenished as quickly as possible.

Question c. What will be the final amount needed to complete the Denver project?

Answer: VA staff do not know the final amount yet. We will share the projected cost to complete the facility as soon as we have this estimate from the Army Corps of Engineers (COE). In the interim, we intend to reprogram, with appropriate Congressional notification, existing funds to continue work on the project until the COE provides a final cost estimate to complete the project.

Question d. When do you anticipate requesting the additional funds to complete the Denver project and replenish the funds "borrowed" from other construction projects?

Answer: We will submit this request once we have the estimate from the COE, which is anticipated in late spring.

STATEMENT OF CARL BLAKE
ASSOCIATE EXECUTIVE DIRECTOR FOR GOVERNMENT RELATIONS
PARALYZED VETERANS OF AMERICA
ON BEHALF OF
THE CO-AUTHORS OF THE INDEPENDENT BUDGET
FOR THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
CONCERNING
THE INDEPENDENT BUDGET
AND THE DEPARTMENT OF VETERANS AFFAIRS BUDGET
FOR FISCAL YEAR 2016

FEBRUARY 11, 2015

Chairman Miller, Ranking Member Brown, and members of the Committee, on behalf of the co-authors of *The Independent Budget* (IB)—AMVETS, DAV (Disabled American Veterans), Paralyzed Veterans of America (PVA), and Veterans of Foreign Wars (VFW), I am pleased to present the views of *The Independent Budget* (IB) regarding the funding requirements for the Department of Veterans Affairs (VA) for FY 2016 and advance appropriations for FY 2017. The IB veterans service organizations (IBVSO) released our report *The Independent Budget* for the Department of Veterans Affairs for FY 2016 and FY 2017 just last week. We would ask to make that complete report part of the official hearing record.

The IBVSOs believe that the VA's budget request is largely a very good budget. We appreciate the fact that VA appears to have made an honest assessment and revision to the medical care accounts for FY 2016. We have continuously stressed our belief that the amounts provided through advance appropriations would be insufficient to meet full demand for health care services. We encourage the Committee to give serious consideration to these revisions and we will be calling on the House Committee on Appropriations to address the shortfall that was previously approved through advance appropriations.

With this in mind, the IBVSOs recommend approximately \$63.3 billion for total medical care for FY 2016. The VA has revised its estimated resource need for total medical care for FY 2016 from \$61.9 billion to now approximately \$63.2 billion. We believe the VA's recommendation is a very sound recommendation based on projected demand for health care services inside the VA while also allowing veterans to access necessary services outside of the VA when appropriate.

The IBVSOs also believe that the FY 2017 advance appropriations recommendation reflects a more accurate view of the resource needs in the future. For too long, we have complained that the VA has underestimated projected utilization and overprojected medical care collections and efficiencies in order to hold down its funding requests. The long term result of such a policy is the massive access problems and the long waiting lists that have come to light in the last year. The VA's budget recommendations for FY 2017 finally begin to correct those failures.

For FY 2017 the IBVSOs recommend approximately \$66.4 billion for total medical care. Meanwhile, the VA has recommended approximately \$66.6 billion. We believe the VA's recommendations validate the position that the IB has taken for many years on the need for sufficient resources to provide timely, quality care without concern for political agendas or posturing. Despite the closeness of our recommendations, the IB is an independent assessment of the VA budget requirements developed before the Administration released its Budget Request.

The IBVSOs are also pleased to see that the Administration has committed significant new resources to other program accounts of the VA. Notably, the VA recommends an increase in Medical and Prosthetic Research to approximately \$622 million. This recommendation actually

exceeds the recommendation of the IBVSOs—\$619 million—for research. The VA research program is a jewel within the VA that we support without hesitation or reservation. Research is a vital part of veterans' health care, and an essential mission for our national health care system. This significant increase in research dollars has been long-needed, and we applaud the Administration for taking this step.

The Independent Budget also includes significant increases in funding for the Veterans Benefits Administration (VBA)—approximately \$2.8 billion, more than \$250 million over FY 2015—and for the Board of Veterans Appeals (Board)—approximately \$118 million, nearly \$20 million more than FY2015. The Administration has recommended approximately \$2.7 billion for VBA and approximately \$108 million for the Board. Our recommendations include significant increases in additional full-time equivalent employees (FTEE) for the Compensation program, the Vocational Rehabilitation & Employment program, and the Board. These staff increases are critical to continue to work towards a long-term reduction in claims for benefits and to address the ever-growing number of appeals being brought before the Board. We would note that under the Administration's budget proposal for FY 2016, the Board would be required to decrease the number of employees working on appeals because the apparent increase in funding results from an accounting change, not increased resources. At a time when the appeals backlog is growing, it is imperative that the Board be provided increased resources to begin to address that backlog and resolve appeals in a timely manner.

The IBVSOs would also offer some concerns that we see with the Administration budget. *The Independent Budget* recommendations focus on recommendations at the point of service, but we believe that administrative costs across the board must continue to be reined in. We would highlight the clear differences between our recommendations for such line items as Medical Support and Compliance, General Administration and Information Technology (IT) to affirm this point. These line items focus a great deal of resources on administrative support, and all three of these accounts reflect significant increases in resources for FY 2016 and in the FY 2017 advance appropriations for Medical Support and Compliance. We encourage the Committee to do a thorough analysis of those accounts specifically to ensure that dollars appropriated for those accounts are allocated efficiently and effectively.

Without question, the area of the VA budget that is under perhaps the greatest scrutiny, and deservedly so, is the infrastructure accounts. This includes large portions of the Medical Facilities account, Major and Minor Construction, Grants for State Extended Care Facilities (State Homes) and Grants for State Veterans Cemeteries. There is no doubt that VA construction and contract management has been a disaster. And the only people to suffer the consequences of these failures are veterans seeking care. But none of this changes the fact that the VA has a huge backlog of projects that are at various stages from initial planning to near completion.

The areas that concern the IBVSOs the most are funding for Non-Recurring Maintenance (NRM) as a part of the Medical Facilities account as well as funding for the massive project backlog in the Major and Minor construction accounts. With regards to NRM, the VA projects a resource need of approximately \$700 million for FY 2016. While we appreciate that this is a substantial increase over the original projection (\$460 million), this amount does not go far enough to address NRM needs. Recent performance shows that the VA has averaged approximately \$1.3 billion for actual NRM expenditures despite requesting only about one third of this amount over the previous three fiscal years. This fact suggests that VA is taking money from other medical care accounts (or other discretionary appropriations) to meet NRM requirements. This is completely unacceptable. We strongly urge the Committee to ensure that this problem is addressed in its Views & Estimates.

In 2004, the VA health care system operated at 80 percent capacity for access to services; today that operating capacity stands at 115 percent. There are currently 38 Major construction projects that are partially funded, with a price tag of \$5 billion to complete work on those projects. In order to close all Major construction funding gaps, the VA estimates that it will need to invest between \$11 billion and \$13 billion over the next 10 years. The IB believes that the VA absolutely must request and Congress must fund the Major construction account at a level that will close all existing and identified future gaps in access, utilization and safety in a timely manner.

Similarly, the VA has identified more than 600 unfinished projects that will need minor construction funding to complete. In order to close these gaps and unidentified future gaps, the

VA will need to invest between \$7.5 billion and \$9 billion for Minor Construction. The majority of veterans enrolled in VA health care receive their care at VA facilities. A VA budget that does not adequately fund facility maintenance and construction will most certainly reduce the timeliness and quality of care veterans receive.

We also want to highlight our concern about the funding level proposed by the Administration for State Home Construction Grants, which is a federal-state matching grant program. The number of pending grant requests by State Homes rose again this fiscal year to almost \$1 billion, with more than \$400 million in Priority Group List 1, which includes those addressing life and safety issues and those which have already secured the required state matching funds. Yet the Administration requests only \$80 million for FY 2016, an 11% decrease from last year's \$90 million, and less than half what the program received just five years ago. With State Homes providing more than half of all long term care beds for veterans, we urge Congress to consider our recommended funding level of \$200 million, which would cover just about half of the pending Priority Group 1 projects.

We encourage the Committee to scrutinize the VA's budget with vigor. However, we believe that honest analysis will show that these are the resource needs of VA. As such, we believe that the real focus of the Committee should be on scrutinizing how the VA spends these critically needed resources. It is imperative that these dollars ensure that veterans receive timely, quality health care and claims decisions that are right the first time.

Mr. Chairman, I would like to thank you once again for the opportunity to testify. We would be happy to answer any questions that you might have.

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2014

No federal grants or contracts received.

Fiscal Year 2013

National Council on Disability — Contract for Services — \$35,000.

Disclosure of Foreign Payments

Paralyzed Veterans of America is largely supported by donations from the general public. However, in some very rare cases we receive direct donations from foreign nationals. In addition, we receive funding from corporations and foundations which in some cases are U.S. subsidiaries of non-U.S. companies.

William Carl Blake
Associate Executive Director for Government Relations
Paralyzed Veterans of America
801 18th Street NW
Washington, D.C. 20006
(202) 416-7708

Carl Blake is the Associate Executive Director for Government Relations for Paralyzed Veterans of America (PVA) at PVA's National Office in Washington, D.C. He is responsible for the planning, coordination, and implementation of PVA's National Legislative and Advocacy Program agendas with the United States Congress and federal departments and agencies. He develops and executes PVA's Washington agenda in areas of budget, appropriations, health care, and veterans' benefits issues, as well as disability civil rights. He also represents PVA to federal agencies including the Department of Defense, Department of Labor, Small Business Administration, the Department of Transportation, Department of Justice, and the Office of Personnel Management. He coordinates all activities with PVA's Association of Chapter Government Relations Directors as well with PVA's Executive Committee, Board of Directors, and senior leadership.

Carl was raised in Woodford, Virginia. He attended the United States Military Academy at West Point, New York. He received a Bachelor of Science Degree from the Military Academy in May 1998.

Upon graduation from the Military Academy, he was commissioned as a Second Lieutenant in the Infantry in the United States Army. He was assigned to the 2nd Battalion, 504th Parachute Infantry Regiment (1st Brigade) of the 82nd Airborne Division at Fort Bragg, North Carolina. He graduated from Infantry Officer Basic Course, U.S. Army Ranger School, U.S. Army Airborne School, and Air Assault School. His awards include the Army Commendation Medal, Expert Infantryman's Badge, and German Parachutist Badge. Carl retired from the military in October 2000 due to injuries suffered during a parachute training exercise.

Carl is a member of the Virginia-Mid-Atlantic chapter of the Paralyzed Veterans of America.

Carl lives in Fredericksburg, Virginia with his wife Venus, son Jonathan and daughter Brooke.

STATEMENT OF
IAN de PLANQUE, DIRECTOR
NATIONAL LEGISLATIVE DIVISION
THE AMERICAN LEGION
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
"U.S. DEPARTMENT OF VETERANS AFFAIRS BUDGET REQUEST FOR FISCAL
YEAR 2016"

February 11, 2015

Chairman Miller, Ranking Member Brown, and Members of the Committee:

On behalf of National Commander Michael Helm and the 2.4 million members of The American Legion, we welcome this opportunity to comment on the federal budget, and specific funding 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.

The American Legion comes before this committee in a unique state of military affairs, as for the first time in over a decade; this country is not officially engaged in combat operations in Afghanistan or Iraq. Though combat operations in Afghanistan may have officially ceased on December 28, 2014, there is no doubt the effects of these wars will continue to be felt in the veterans' communities for many decades, as has been the case with every previous war. The cost of war does not end when the guns fall silent. To paraphrase Winston Churchill this is not the beginning of the end, but rather the end of the beginning.

We cannot allow focus and resources to be diverted from the VA because the limelight fades and the news cameras have gone away. The President's proposed budget would offer an increase of 7.5 percent over the enacted level of Fiscal Year 2015 funding, a healthy increase even as other agencies are forced to tighten belts under the effects of sequestration. However, we cannot think that just because the numbers go up that all of the money is being directed to the proper places. Here is where the importance of true transparency from VA becomes critical. This is where the importance of open and freely available planning reports, such as those proposed in Ranking Member Brown's "Department of Veterans Affairs Budget Reform Planning Act of 2015" (**H.R. 216**) would be helpful to the entire community of stakeholders. Many of the questions we will

raise delve into matters that would be more clear if VA was more open and straightforward with stakeholders.

This process only works if everyone can see all the pieces on the board. Taking care of veterans is the nation's responsibility. That includes not only the federal government, but state and county governments, veteran and military service organizations, and the citizens themselves. We have to all see how the pieces fit together and we have to all be on the same page if this is going to work and we're all going to maximize our efforts together.

There are areas of concern within the budget proposed by VA, but all of these areas can be worked out if everyone is open and above board.

The Veterans Benefits Administration:

This year, 2015, is to be the year the Veterans Benefits Administration finally "breaks the back of the backlog." To that end, the budget request includes requests to add 770 additional full time employees (FTEs) as claims processing workers and fiduciaries for the pension program. Adding additional workers is an important and needed step. VA employees have been directed to put in mandatory overtime work dating back to at least 2011¹. Mandatory overtime may provide a useful boost to push an organization through a tough patch, but four straight years of mandatory overtime indicates an organization that's not going through a tough patch, it's an organization that's clearly understaffed.

How many additional employees are appropriate? This is where it's difficult to tell and where a study of VA's resource allocation models would be helpful. At VA's budget roll out, Undersecretary for Benefits Allison Hickey indicated some of this would be represented in making the Decision Review Officer (DRO) process more robust, something The American Legion strongly supports. 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.

Whatever the case may be, better communication from VA to indicate how they intend to use staffing levels to effectively combat the backlog of claims is a must.

The American Legion strongly supports additional FTEs to improve the VBA workforce.

The Veterans Health Administration:

One of the key lessons learned through last year's health care access is that VA's reporting must be crystal clear to avoid the problems that occur when things are hidden from the stakeholders. Had VA employees not manipulated the wait time data a more bleak picture of the ability to serve veterans would have been painted, but the key stakeholders – veterans and Congress –

¹ <http://www.stripes.com/va-workers-say-mandatory-overtime-won-t-solve-benefits-backlog-1.221294>

would have known that additional resources were needed and where. Ensuring proper distribution of resources throughout VA depends on accurate reporting that is free from fear of reprisal for not meeting goals. We cannot create an environment where VA employees fear to report problem areas, for discerning where those problem areas are occurring is the critical factor in determining where resources need to go.

To be fair, Secretary McDonald has expressed a renewed interest in openness and The American Legion believes VA is making a good faith effort to increase honesty, although we would like more clarity regarding the Secretary's request for more flexibility in use of the funds designated for the Choice card program. VA's budget request announces that they will be seeking more flexibility to retarget some of the \$10 billion allotted to the Choice card program with last year's legislation to provide more choice and access in care.

Without an extremely specific accounting, which was not forthcoming in initial presentations of this budget, it would be difficult to support this request. The Choice program, which The American Legion believes is an important temporary measure to address shortfalls in VA's ability to treat veterans, needs to be properly funded to succeed. To reprogram monies designated for this program so early into the program, barely six months into a three year pilot, seems short sighted. It would be the preference of The American Legion to see the program implemented as intended, and if funds remain at the end of the allotted time, then it would be appropriate to address what use those funds could best be put to. If there is money left over, great; that would mean VA was meeting their goal of addressing veterans' needs with their in house resources, to include VA care as well as other assets in their arsenal such as the PC3 program or ARCH, the very successful rural health initiative.

Regarding other important VHA funding, The American Legion notes that VA's budget for medical research is relatively consistent, but positively notes the acknowledgement of the importance of additional areas of Posttraumatic Stress Disorder (PTSD) research including alternative therapies such as yoga, meditation and other treatments alongside cognitive processing therapy (CPT) and prolonged exposure therapy. The American Legion continues to devote extensive focus to the treatment of PTSD and Traumatic Brain Injury (TBI) through the PTSD and TBI Committee of the Veterans Affairs and Rehabilitation (VA&R) Commission. The Commission's work included the production of "The War Within"² and a survey conducted in conjunction with the Data Recognition Corporation which presented results last year at a June 24th symposium entitled "Advancing Care and Treatment for Veterans with TBI and PTSD."³ Through that survey, it was reported that nearly 60% of veterans undergoing treatment for PTSD and TBI reported feeling no improvement or felt worse after the traditional treatments.⁴ Clearly, there is still much room for improvement in this area.

The American Legion supports VA becoming a robust leader in complementary and alternative medicine for Posttraumatic Stress Disorder and Traumatic Brain Injury.

Construction and Facilities:

² <http://www.legion.org/sites/legion.org/files/legion/publications/war-within.pdf>

³ <http://www.legion.org/veteranshealthcare/222891/legion-survey-ptsdtbi-care-not-working>

⁴ <http://www.legion.org/veteranshealthcare/222891/legion-survey-ptsdtbi-care-not-working>

All stakeholders are aware of the much publicized struggles VA has gone through with major construction projects, particularly in Colorado, Florida, Louisiana and Nevada. VA recently came to an agreement with the contracting firm in Colorado and work was able to resume on the VA hospital project in Aurora. That work will likely cost at least \$234 million, and the budget for the project has spiraled from approximately \$600 million to over \$1 billion⁵. The money for these overages has to come out of VA's construction budget, yet where the money to backfill that budget and provide for future projects will come from is still unclear.

In February of 2012, The American Legion presented the following warning about insufficient funding in VA's construction budgets and capital investment plans:

The SCIP planning process develops data for VA's annual budget requests. These infrastructure budget requests are divided into several VA accounts: Major Construction, Minor Construction, Non-Recurring Maintenance (NRM), Enhanced-Use Leasing, Sharing, and Other Investments and Disposal. The Fiscal Year (FY) 2012 VA budget identified more than 5,000 capital projects needed to close all the identified infrastructure gaps over the ten year period. The VA estimated costs were between \$53 and \$65 billion.

The American Legion is very concerned about the lack of funding in the Major and Minor Construction accounts. In FY 2012 The American Legion recommended to Congress that the Major Construction account be funded at \$1.2 billion and the Minor Construction account be funded at \$800 million. However, Congress only appropriated \$589 million and \$482 million respectively to those accounts. Based on VA's SCIP plan, Congress underfunded these accounts by approximately \$4 billion in FY 2012. Clearly, if this underfunding continues VA will never fix its identified deficiencies within its ten-year plan. Indeed, at current rates, it will take VA almost sixty years to address these current deficiencies.⁶

Even before the setbacks in Colorado and Florida created holes in the construction budgets, there were already grave concerns about the ability to meet the needs that had been identified. Now that the struggling major projects are depleting funds at a greater rate than previously anticipated, the danger to future projects is even more severe.

The American Legion urges Congress and VA to get on the same page about fixing these budget holes before it's too late. We must act now. Whether this will require supplemental appropriations to make the troubled major construction projects whole again without jeopardizing the rest of VA's construction needs, or whether this can be built into the budget is still a topic for discussion. What is clear is that this is going to present a major hurdle to ensuring VA's facilities are able to handle the load. This is a problem that needs a solution.

The hospitals are not the only area of concern in terms of facilities. Last year's Veterans Access, Choice and Accountability Act (VACA) provided a respite for 27 Community Based Outreach

⁵ <http://kdvr.com/2014/12/17/va-announces-deal-to-start-work-on-aurora-hospital/>

⁶ American Legion testimony before HVAC on the VA Budget, February 15, 2012

Centers (CBOCs). The CBOCs have been an effective tool in reaching veterans, particularly in rural areas where a full scale hospital might not be feasible. Changes in how the leases for these facilities were scored by the Congressional Budget Office (CBO) jeopardized the future of CBOCs within the VHA health care system.

VACA provided relief for the 27 identified CBOCs, but in a sense it has only kicked the can a little further down the road. A long term solution to the CBOC lease conundrum will be required.

*The American Legion urges Congress to provide an annual or permanent exemption for the Department of Veterans Affairs leases from the Congressional Budget Office's scoring process, so as to give VA the flexibility it needs to meet the health care needs of veterans.*⁷

Conclusion:

The past year has made it clear that 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. The American Legion has been a strong and active supporter of the Department of Veterans Affairs Voluntary Service (VAVS) since 1946 and today over 7,000 volunteers provide 900,000 hours of volunteer service at VA medical centers, CBOCs, Vet Centers, state veterans' homes, and nursing homes every year.⁸ With nearly a million hours of service provided, imagine the cost savings to VA in terms of additional FTEs they do not have to provide.

That kind of coordination only works with open transparency. The American Legion urges VA to adopt an open and freely accessible planning process such as the quadrennial review proposed by Ranking Member Brown and endorsed by many members on both sides of this committee.

Secretary McDonald has a daunting task ahead of him as he continues to reform the VA and rebuild from the failures that led to last year's crises. There is no reason to go it alone. Congress has long displayed a willingness to provide VA with resources, increasing their budget nearly 75 percent since 2009 alone, and The American Legion has already gone out and conducted a dozen Veterans Crisis Centers and Veterans Benefits Centers in the field to help link VA and veterans up to make the system work. To be truly effective though, we all have to be reading from the same page. This is something that can and will be accomplished, and The American Legion looks forward to making that happen.

Questions concerning this testimony can be directed to The American Legion Legislative Division (202) 861-2700, or ideplanque@legion.org

⁷ Resolution 282: Congressional Budget Office Scoring on Department of Veterans Affairs Leasing – AUG 2014

⁸ <http://www.legion.org/vavolunteers>

The Independent Budget
for the Department of Veterans Affairs



Budget Recommendations for FY 2016 and FY 2017

Introduction

The co-authors of *The Independent Budget (IB)*—AMVETS, DAV (Disabled American Veterans), Paralyzed Veterans of America, and Veterans of Foreign Wars—recognize that Congress and the Administration continue to face immense pressure to reduce federal spending. However, we believe that the ever-growing demand for healthcare and benefits services provided by the Department of Veterans Affairs (VA) certainly validates the continued need for sufficient funding. We understand that VA has fared better than most federal agencies with regard to budget proposals and appropriations.

In the past couple of years, as many federal agencies have faced immense pressure to hold down spending, the Administration has continued to request increases to discretionary funding for VA. At the same time, Congress has continued to provide increases in actual appropriated dollars. However, the serious access problems in the healthcare system identified in 2014 and the continued pressure being placed on the claims-processing system raise serious questions about the resources being provided and how VA chooses to spend the resources it is given. In fact, Deputy Secretary Gibson affirmed our concerns last year when he testified before the House Committee on Veterans' Affairs that for too long VA has been "managing to budget, not to need." This is an unacceptable practice for an agency charged with meeting the needs of the men and women who have served and sacrificed for this country.

For the first time, *The Independent Budget* veterans service organizations (IBVSOs) are jointly releasing a stand-alone report that focuses solely on the budget of VA and our projections for the VA's funding needs across all programs. This report is not meant to suggest that these are the absolute right answers for funding these service lines. However, in submitting our recommendations the IBVSOs are attempting to produce an honest assessment of need that is not subject to the politics of federal budget development and negotiations that inevitably have led to insufficient requests.

Our recommendations include funding for all discretionary programs for FY 2016 as well as advance appropriations recommendations for medical care for FY 2017. We hope that the House and Senate Committees on Veterans' Affairs as well as the Military Construction and Veterans' Affairs Appropriations Subcommittees will be guided by these estimates in making their decisions for ensuring sufficient, timely, and predictable funding for VA.

VA Accounts for FY 2016 and FY 2017 Advance Appropriations

	FY 2015 Appropriation	FY 2016* Admin	FY 2016 <i>IB</i>	FY 2017 Adv Approp	FY 2017 <i>IB</i> Adv Approp
<u>Veterans Health Administration (VHA)</u>					
Medical Services	45,224,716	47,603,202	51,593,505	51,673,000	54,183,411
Medical Support & Compliance	5,879,700	6,144,000	5,972,489	6,524,000	6,241,506
Medical Facilities**	4,739,000	4,915,000	5,703,763	5,074,000	5,926,353
Subtotal Medical Care Discretionary	55,843,416	58,662,202	63,269,757	63,271,000	66,351,270
<i>Medical Care Collections</i>	3,065,000	3,248,000		3,299,954	
Total, Medical Care Budget Authority (including Collections)	58,908,416	61,910,202	63,269,757	66,570,954	66,351,270
Medical & Prosthetic Research	588,922	621,813	619,000		
Total, Veterans Health Admin.	59,497,338	62,532,015	63,888,757		
<u>General Operating Expenses (GOE)</u>					
Veterans Benefits Admin.	2,534,254	2,697,734	2,796,650		
General Administration	321,591	346,659	330,436		
Board of Veterans Appeals	99,294	107,884	117,853		
Total, General Operating Expenses (GOE)	2,955,139	3,044,393	3,244,939		
<u>Departmental Admin. and Misc. Programs</u>					
Information Technology	3,903,344	4,133,363	3,974,781		
National Cemetery Admin.	256,800	266,220	260,970		
Office of Inspector General	126,411	126,766	128,412		
Total, Dept. Admin. & Misc. Programs	4,286,555	4,526,349	4,364,163		
<u>Construction Programs</u>					
Construction, Major	561,800	1,143,800	1,930,000		
Construction, Minor	495,200	406,200	575,000		
Grants for State Extended Care Facilities	90,000	80,000	200,000		
Grants for State Vets Cemeteries	46,000	45,000	48,000		
Total, Construction Programs	1,193,000	1,675,000	2,753,000		
Other Discretionary	162,372	166,090	165,132		
Total, Discretionary Budget Authority (Including Medical Collections)	68,094,404	71,943,847	74,415,991		

*Amounts for health care for FY 2016 reflect the FY 2015 Consolidated and Further Continuing Appropriations Act approved in December 2014. However, the Administration has revised its FY 2016 estimated need for the three medical care accounts. The Administration projects need for an additional \$1.1 billion for Medical Services, \$70 million for Medical Support and Compliance, and \$105 million for Medical Facilities. The new total includes Medical Services (\$48.7 billion), Medical Support and Compliance (\$6.2 billion), and Medical Facilities (\$5 billion). This results in a new total Medical Care estimate of \$63.3 billion.

**The *IB* Recommendation for Medical Facilities includes \$900 million over the baseline for Non-Recurring Maintenance for both FY 2016 and FY 2017.

Veterans Health Administration

Total Medical Care

FY 2016 <i>IB</i> Recommendation	\$63.3 billion
FY 2016 Revised Administration Request	\$63.2 billion
FY 2016 Enacted Advance Appropriations	\$58.7 billion
<i>Medical Care Collections</i>	<i>\$3.2 billion</i>
Total	\$62.0 billion
FY 2017 <i>IB</i> Advance Appropriations Recommendation	\$66.4 billion
FY 2017 Administration Advance Appropriations Request	\$63.3 billion
<i>Medical Care Collections</i>	<i>\$3.3 billion</i>
Total	\$66.6 billion

The IBVSOs appreciate the fact that the Administration continues to present budget recommendations for the overall Medical Care accounts that address veterans' growing demand for healthcare services. Unfortunately, we believe the advance appropriations amount for FY 2016 provided for by Congress in the "FY 2015 Consolidated and Further Continuing Appropriations Act" approved in December 2014 is not sufficient to meet the full demand for services being placed on the system. For FY 2016, the *IB* recommends approximately \$63.2 billion for total Medical Care. However, Congress recently approved only \$62 billion for total Medical Care (based on an assumption that includes approximately \$3.3 billion for medical care collections).

Of particular concern is the fact that VA continues to over-project and underperform with its medical care collections estimates. Overestimating medical care collections affords Congress the opportunity to appropriate fewer discretionary dollars for the healthcare system. However, when VA fails to collect what VA estimated, it is left with insufficient funding to meet the actual demand by veterans. As long as this scenario continues, VA will find itself falling farther and farther behind in its ability to care for those men and women who have served and sacrificed for this nation. In fact, we believe this to be the precise situation now occurring.

Similarly, we are concerned that the Administration has not adjusted the baseline for medical care funding to account for the additional resources targeted at expanding the capacity of the system. Congress approved approximately \$5.0 billion in additional funding to expand the capacity of the VA healthcare system in P.L. 113-146, the "Veterans Access, Choice and Accountability Act (VACAA)." We believe that it will be critical moving forward for VA to adjust its baseline for total Medical Care expenditures to account for the infusion of these new resources and the resultant expansion of capacity, including new permanent employment authorized by the act.

The Independent Budget also recommends approximately \$66.1 billion for total Medical Care for FY 2017. This reflects an increase of approximately \$4.1 billion over the amount advance-appropriated by Congress in December 2014.

Medical Services

Appropriations for FY 2016

FY 2016 <i>IB</i> Recommendation	\$51.6 billion
FY 2016 Revised Administration Request	\$48.7 billion
FY 2016 Enacted Advance Appropriations	\$47.6 billion

For FY 2016, *The Independent Budget* recommends approximately \$51.6 billion for Medical Services. This recommendation is a reflection of multiple components. These components include the following recommendations:

Current Services Estimate.....	\$49,468,647,000
Increase in Patient Workload.....	\$1,489,858,000
Additional Medical Care Program Costs.....	\$635,000,000
Total FY 2016 Medical Services.....	\$51,593,505,000

The current services estimate reflects the impact of projected uncontrollable inflation on the cost to provide services to veterans currently using the system. The estimate also assumes a 1.5 percent increase for pay and benefits across the board for all VA employees.

Our estimate of growth in patient workload is based on a projected increase of approximately 148,000 new unique patients. These new unique patients include priority group 1–8 veterans and covered nonveterans as well as additional new users as a result of veterans being removed from the extended waiting lists and those whose decisions on healthcare enrollment eligibility are made. We estimate the cost of these new unique patients to be approximately \$1.2 billion. The increase in patient workload also includes a projected increase of 71,500 new Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) enrollees, as well as Operation New Dawn (OND) veterans at a cost of approximately \$282 million. The increase in utilization among OEF/OIF/OND veterans is supported by the average annual increase in new users from FY 2002 through the 3rd quarter of FY 2014.

The Independent Budget believes that there are additional projected medical program funding needs for VA. Specifically, we believe there is real funding needed to address the array of long-term-care issues facing VA, including the shortfall in institutional capacity; to provide additional centralized prosthetics funding (based on actual expenditures and projections from the VA's prosthetics service); as well as funding necessary to improve the Comprehensive Family Caregiver program; and funding to address needed improvements in programs directed for women veterans.

The Independent Budget recommends \$325 million directed toward VA long-term-care programs. In order to support the continued rebalancing of VA long-term care in FY 2016, \$125 million should be provided. Additionally, \$95 million should be targeted at the VA's Veteran Directed-Home and Community Based Services (VD-HCBS) program. The remainder of the \$325 million (\$105 million) should be dedicated to increasing the VA's long-term-care

average daily census (ADC) to the level mandated by Public Law 106-117, the “Veterans Millennium Health Care and Benefits Act.”

In order to meet the increase in demand for prosthetics, the *IB* recommends an additional \$150 million. This increase in prosthetics funding reflects an increase in expenditures from FY 2014 to FY 2015 and the expected continued growth in expenditures for FY 2016. Our additional program costs recommendation includes investing \$70 million in the Comprehensive Family Caregiver program in accordance with the deficiencies identified during the hearing held by the House Veterans’ Affairs Subcommittee on Health in December 2014.

The Medical Services appropriation should be supplemented with \$90 million designated for women’s healthcare programs, in addition to those amounts already included in the FY 2016 baseline. 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 these facilities where women seek care. The new funds would also aid the VHA in making its cultural transformation to embrace women veterans and welcome them to VA healthcare services, and provide means for VA to improve specialized mental health and readjustment services for women veterans.

Advance Appropriations for FY 2017

FY 2017 <i>IB</i> Advance Appropriations Recommendation	\$54.2 billion
FY 2017 Administration Advance Appropriations Request	\$51.7 billion

The Independent Budget once again offers baseline projections for funding through advance appropriations for the Medical Care accounts for FY 2017. While we have previously deferred to the Administration and Congress to provide sufficient funding through the advance appropriations process, we remain concerned that this responsibility is not being taken seriously.

For FY 2017, *The Independent Budget* recommends approximately \$54.2 billion for Medical Services. Our Medical Services recommendation includes the following recommendations:

Current Services Estimate.....	\$51,937,260,000
Increase in Patient Workload.....	\$1,576,151,000
Additional Medical Care Program Costs.....	\$670,000,000
Total FY 2017 Medical Services.....	\$54,183,411,000

Our growth in patient workload is based on a projected increase of approximately 150,000 new unique patients. These new unique patients include priority group 1–8 veterans and covered nonveterans. We estimate the cost of these new unique patients to be approximately \$1.3 billion. This recommendation also reflects an assumption that more veterans will be accessing the system as VA expands its capacity and services and we believe that reliance rates will increase as veterans examine their healthcare options as a part of the option for choice. The increase in patient workload also includes a projected increase of 74,225 new OEF/OIF, as well as OND veterans at a cost of approximately \$301 million.

Last, as previously discussed, the IBVSOs believe that there are additional medical program funding needs for VA. *The Independent Budget* recommends \$325 million directed toward VA long-term-care programs. In order to support the continued rebalancing of VA long-term care in FY 2017, \$125 million should be provided. Additionally, \$95 million should be targeted at the VA's Veteran Directed-Home and Community Based Services (VD-HCBS) program. The remainder of the \$325 million (\$105 million) should be dedicated to increasing the VA's long-term-care average daily census (ADC) to the level mandated by Public Law 106-117, the "Veterans Millennium Health Care and Benefits Act." In order to meet the increase in demand for prosthetics, the *IB* recommends an additional \$165 million. Our additional program costs recommendation includes continued reinvestment of \$75 million in the Comprehensive Family Caregiver program in accordance with the deficiencies identified during the hearing held by the House Veterans' Affairs Subcommittee on Health in December 2014. Finally, we believe that VA should invest a minimum of \$105 million as an advance appropriation in FY 2017 to expand and improve access to women veterans' healthcare programs.

Medical Support and Compliance

FY 2016 <i>IB</i> Recommendation	\$5.972 billion
FY 2016 Revised Administration Request	\$6.214 billion
FY 2016 Enacted Advance Appropriations	\$6.144 billion
FY 2017 <i>IB</i> Advance Appropriations Recommendation	\$6.242 billion
FY 2017 Administration Advance Appropriations Request	\$6.524 billion

For Medical Support and Compliance, *The Independent Budget* recommends approximately \$6.0 billion for FY 2016. Our projected increase reflects an increase in current services based on the impact of inflation on the FY 2015 appropriated level. Additionally, for FY 2017 *The Independent Budget* recommends approximately \$6.2 billion for Medical Support and Compliance. This amount also reflects an increase in current services from the FY 2016 advance appropriations level.

Medical Facilities

FY 2016 <i>IB</i> Recommendation	\$5.704 billion
FY 2016 Revised Administration Request	\$5.020 billion
FY 2016 Enacted Advance Appropriations	\$4.915 billion
FY 2017 <i>IB</i> Advance Appropriations Recommendation	\$5.926 billion
FY 2017 Administration Advance Appropriations Request	\$5.074 billion

For Medical Facilities, *The Independent Budget* recommends approximately \$5.7 billion for FY 2016, nearly \$800 million more than the enacted advance appropriations in December 2014. Our Medical Facilities recommendation includes the addition of \$900 million to the baseline 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 on average approximately \$1.3 billion yearly for NRM, the Administration has requested only approximately \$460 million for NRM. This is clearly insufficient. This decision means that VA is forced to divert funds designated for another purpose to meet this need.

The Independent Budget also recommends approximately \$5.9 billion for Medical Facilities for FY 2017. Our FY 2017 recommendation also includes the addition of \$900 million to the baseline for NRM. Last year the Administration’s recommendation for NRM reflected a projection that would place the long-term viability of the healthcare system in serious jeopardy.

Medical and Prosthetic Research

FY 2016 <i>IB</i> Recommendation	\$619 million
FY 2016 Administration Request	\$622 million
FY 2015 Enacted Final Appropriation	\$589 million

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

Investing Taxpayers’ Dollars Wisely

Despite documented success of VA investigators across many fields, the amount of appropriated funding for VA research since FY 2010 has lagged far behind annual biomedical research inflation rates, resulting in a net loss over these years of nearly 10 percent of the program’s overall purchasing power. As estimated by the Department of Commerce, Bureau of Economic Analysis, and the National Institutes of Health, for VA research to maintain current service levels, the Medical and Prosthetic Research appropriation should be increased in FY 2016 by 2.5 percent over the FY 2015 baseline—about \$15 million.

Numerous meritorious proposals for new VA research cannot be funded without an infusion of additional funding for this vital program. Research awards decline as a function of budgetary stagnation, so VA may resort to terminating ongoing research projects or not funding new ones, and thereby lose the value of these scientists’ work, as well as their clinical presence in VA healthcare. Denied research funding, many of them simply resign and move their research work to affiliated universities or to corporate platforms.

Program Growth

In addition to covering uncontrollable inflation, the IBVSOs believe Congress should appropriate an additional \$15 million for FY 2016, for expanding research on conditions prevalent among newer veterans, as well as continuing VA’s inquiries in chronic conditions of aging veterans from previous wartime periods. These additional funds would support ongoing research on

chronic conditions of aging veterans and provide funds for new and emerging research on conditions prevalent among younger veterans of our most recent overseas wars. For example, VA research is uniquely positioned to advance genomic medicine through the “Million Veteran Program” (MVP), an effort that seeks to collect genetic samples and general health information from 1 million veterans over the next five years. When completed, the MVP will constitute one of the largest genetic repositories in existence, offering tremendous potential to study the health of veterans.

Additional funding will also help VA support emerging areas that remain critically underfunded, including:

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

General Operating Expenses (GOE)

Veterans Benefits Administration

FY 2016 <i>IB</i> Recommendation	\$2.797 billion
FY 2016 Administration Request	\$2.698 billion
FY 2015 Enacted Final Appropriation	\$2.534 billion

The Veterans Benefits Administration account is comprised of six primary divisions. These include Compensation; Pension; Education; Vocational Rehabilitation and Employment (VR&E); Housing; and Insurance. The increases provided for these accounts primarily reflect current services estimates with the impact of inflation representing the grounds for the increase. However, two of the subaccounts—Compensation and VR&E—also reflect a substantial increase in staffing. The explanation for those increases is included below.

The *IB* recommends approximately \$2.797 billion for the Veterans Benefits Administration (VBA) for FY 2016. This amount reflects an increase of approximately \$263 million over the recently enacted FY 2015 appropriations level. Our recommendation includes approximately \$159 million additional in the Compensation account above current services and approximately \$42 million additional in the VR&E account above current services to provide for new full-time equivalent employees (FTEEs).

Compensation Service Personnel	1,700 New FTEEs	\$158.9 million
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Over the past two years, the VBA has made significant progress in addressing the backlog of pending claims for compensation, reducing the number of pending claims and increasing the accuracy rate for claims decisions. Some of this progress can be attributed to the development and deployment of a new organizational model and new information technology (IT) systems, including the Veterans Benefits Management System (VBMS), e-Benefits, and the Stakeholder Enterprise Portal (SEP). However, much of the increased productivity is the result of putting more resources into processing claims. Recognizing that rising workload, particularly claims for disability compensation, could not be addressed without additional personnel, Congress provided the VBA with more than 3,000 FTEEs between 2008 and 2013, primarily in Compensation Service. However, relative to the VBA's total workload, to include appeals, these increases have not been significant enough to keep pace with or reduce backlogs in the claims and appeals pipelines as evidenced by VBA's own resource allocation and personnel decisions.

Over the past couple of years, VBA's largest increases in productivity—periods where the backlog declined most markedly—occurred while the VBA enforced a policy of mandatory overtime for its workforce. During holiday periods at the end of the year, when mandatory overtime was curtailed, production fell off measurably. Furthermore, over the past couple of years many VA Regional Offices (VAROs) have diverted some of their senior employees from both quality review and appeals work to focus on claims- processing work in order to drive down the backlog. Specifically, both Decision Review Officers (DROs) and Quality Review Specialists (QRSs) have been performing development and rating duties during both regular and

medical separations through the Department of Defense and VA's joint Integrated Disability Evaluation System.

These additional functions of VR&E personnel are undoubtedly beneficial; however, staffing levels throughout VR&E services must be commensurate with current and future demands. At the end of FY 2013, VR&E had a total of 1,343 FTEEs. The VBA projected an increase in FY 2014 and was authorized 1,442 FTEEs. In the FY 2015 budget request, the VBA did not recommend increasing this staff and was again authorized 1,442 for FY 2015, despite an increasing workload.

In order for VR&E to keep pace with demand, the IBVSOs project the total number of VR&E participants at roughly 165,000 for FY 2016, nearly 10 percent in participant growth. At present there are roughly 974 VR&E counselors managing an active client caseload of roughly 140,000 participants, which averages out to a counselor-to-client ratio of roughly 1:135.

Ideally, a reasonable client-to-counselor ratio would consist of one VR&E counselor for every 125 veterans as has been advocated by the IBVSOs for the past several years. However, the average can be somewhat misleading as there are higher and lower averages throughout VAROs. As an example, the Cleveland VAROs counselor to client ratio was 206 cases for every one VR&E counselor, and in the Fargo VARO, 64 cases for every one VR&E counselor.

In order to achieve the 1:125 counselor to client ratio in FY 2016, VR&E would require an additional 382 FTEEs, of which 277 would be dedicated as VR&E counselors and the remaining 105 employees dedicated toward support services bringing VR&E's total FTEE strength to 1,824.

While increased staffing levels are required to provide efficient and timely services to veterans utilizing VR&E services, it is also essential that these increases be properly distributed throughout all of VR&E to ensure that VR&E counselors' caseloads are equitably balanced among VAROs.

General Administration

FY 2016 <i>IB</i> Recommendation	\$330 million
FY 2016 Administration Request	\$347 million
FY 2015 Enacted Final Appropriation	\$322 million

The General Administration account is comprised of nine primary divisions. These include the Office of the Secretary; the Office of the General Counsel; the Office of Management; the Office of Human Resources and Administration; the Office of Policy and Planning; the Office of Operations, Security and Preparedness; the Office Public and Intergovernmental Affairs; the Office of Congressional and Legislative Affairs; and the Office of Acquisition, Logistics, and Construction. For FY 2016, the *IB* recommends approximately \$330 million, an increase of nearly \$8.0 million over the FY 2015 appropriation level. This increase reflects only an increase in current services based on the impact of uncontrollable inflation across all of the General Administration accounts.

Board of Veterans' Appeals

FY 2016 IB Recommendation	\$118 million
FY 2016 Administration Request	\$108 million
FY 2015 Enacted Final Appropriation	\$99 million

The Independent Budget recommendation for the Board of Veterans' Appeals (Board) reflects two considerations. The baseline of the Board recommendation represents an increase in current services based on inflation. Our recommendation then includes funding for additional FTEEs for the Board. For FY 2016, the IBVSOs recommend \$118 million to fully fund the operations of the Board and increase its staffing level by 120 FTEEs.

Board of Veterans' Appeals Personnel 120 New FTEEs \$17 million

After several years of declining workforce, the Board has significantly increased its FTEE levels over the past two years, rising from an average of 510 FTEEs in FY 2012 to an authorized 640 FTEEs in FY 2015. Since approximately 18 months of training and orientation are required for a new Board attorney to reach full productivity, and given the time taken away from existing staff to train and mentor new staff, there will still be some expected increases in productivity to be made this year even without future increases in staffing. Over the past five years, the Board has averaged approximately 90 appeals dispositions per FTEE, producing a record 55,532 decisions in FY 2014. However, with the inventory of pending appeals now topping 360,000 in various stages at both the VBA and the Board, there are simply not enough hands to do all the work that will be required, even with further efficiencies gained through technology and other reforms. Furthermore, as the number of claims processed annually continues to rise with increased productivity by the VBA, the number of appeals is also expected to rise, even accounting for increased accuracy in rating board decisions.

In order to meet current and future workload requirements, the Board will need to continue adding new attorneys and veteran law judges, as well as sufficient support staff. For FY 2016, the IBVSOs recommend an increase of 120 new FTEEs, a 20 percent increase over the FY 2015 authorized level. This increase represents a balance between the total requirement for staffing at the Board, which is likely even higher, and the ability of the Board to absorb new personnel without undue disruption in a single year.

Departmental Administration and Miscellaneous Programs

Information Technology

FY 2016 <i>IB</i> Recommendation	\$3.975 billion
FY 2016 Administration Request	\$4.133 billion
FY 2015 Enacted Final Appropriation	\$3.903 billion

In contrast to significant department-level IT failures, the Veterans Health Administration (VHA) over more than 30 years successfully developed, tested, and implemented a world-class comprehensive, integrated electronic health record (EHR) system. The current version of this EHR system, based on the VHA's self-developed VistA public domain software, sets the standard for EHR systems in the United States and has been publicly praised by the President and many independent observers. However, VistA is aging and is in urgent need of replacement. One of its component parts, the outdated scheduling module, contributed to VA's recent access to care scandal, and is being replaced on an expedited basis.

Meanwhile, the VBA has completed implementation of a new organizational model and system in order to fix the broken veterans benefits claims-processing system. For more than five years, the VBA has been engaged in a comprehensive transformation process designed to transition from paper-based processing. The initiative is working and merits continued support for the current transformation efforts.

For FY 2016, the IBVSOs recommend approximately \$4.0 billion for the administration of the VA's IT program. This recommendation does not include any new funding above the planned current services level. Significant resources have already been invested into VA's IT programs in recent years, and we believe proper allocation of existing resources can allow VA to fulfill its missions while modernizing its systems. However, we do believe a portion of the IT appropriation should be directed specifically at acceleration of the VBMS and at modernization of the BVA IT system. A detailed explanation of those recommendations is included below.

VBMS Acceleration **\$60 million**

The most critical and dramatic elements of the VBA's claims-processing transformation have been the new IT systems—the VBMS, e-Benefits, and SEP—built over the past five years. These three systems have led the way in moving claims processing from an outdated, paper-based system to a modern, automated digital system. Despite some early challenges, the VBMS program has proven to be an effective platform for processing claims in a digital environment, but more must be done.

Because of budget constraints, current planning at the VBA calls for some critical elements of the claims process, including major new modules to allow electronic transmission of examinations and service treatment records from the Department of Defense, other government agencies, and private businesses and organizations, to be slowly phased in over the next several years. The VBMS has also yet to fully address veterans service organization stakeholder

requirements to enhance the ability of certified service officers to fully represent veterans in the claims process.

The IBVSOs recommend increasing the amount of IT funding allocated to the VBMS program in FY 2016 by \$60 million to support the specific IT enhancements referenced above, which are already planned, but have been pushed forward to future years solely due to budget constraints.

Board of Veterans’ Appeals IT Modernization \$15 million

Similarly, the extension and adaptation of the VBMS for the Board’s use has also been pushed back to future years due to limited budgets made available to the VBMS program. While the Board has access to e-Folders to review claims records, they do not have the ability to process appeals within a fully electronic environment. With the inventory of pending appeals at both VBA and the Board growing, it is imperative that IT modernization at the Board move forward. The IBVSOs recommend that \$15 million be allocated in FY 2016 to move forward as expeditiously as feasible with the Board’s IT modernization.

National Cemetery Administration

FY 2016 IB Recommendation	\$261 million
FY 2016 Administration Request	\$266 million
FY 2015 Enacted Final Appropriation	\$257 million

The National Cemetery Administration (NCA), which receives funding from eight appropriations accounts, administers numerous activities to meet the burial needs of our nation’s veterans, including:

- interring veterans and their eligible family members in national cemeteries;
- maintaining the graves and cemetery grounds as national shrines;
- providing aid to individual states and tribal organizations in establishing, maintaining, and expanding existing veteran cemeteries;
- furnishing headstones and markers for eligible individuals in national, state, or tribal veterans cemeteries and private cemeteries;
- furnishing commemorative medallions to be affixed to privately purchased headstones;
- issuing Presidential Memorial Certificates to the families of deceased veterans in recognition of their loved ones service to the nation;
- providing outer burial receptacles or partial reimbursement for privately purchased receptacles for each new gravesite in NCA-administered cemeteries;
- initiating and confirming all information necessary for the interment process in the NCA system, to including recording First Notice of (Veterans) Death; requests for flags, headstones, or markers; burial applications; and entering insurance information into VA IT systems.

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 need expansion of the national cemetery system will help to facilitate the projected increase in annual veteran interments and will simultaneously increase the overall number of graves being maintained by the NCA to 3.7 million in 2018 and 3.9 million by 2020.

Even as the NCA continues to add veteran burial space to within 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 capacity and will be closed to first interments, though they will continue to accept second interments.

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

- continue developing new national cemeteries;
- maximize burial options within existing national cemeteries;
- strongly encourage the development of state veteran cemeteries; and
- increase burial options for veterans in highly rural areas.

Additional areas of growth within the NCA system include:

- an increase in the issuance of Presidential Memorial Certificates, which is expected to increase from approximately 654,000 in 2013 to more than 870,000 in 2017;
- the expected increase in the burial of indigenous veterans; and
- the possible increase, thanks to local historians and other interested stakeholders, in requests for headstones or markers for previously unidentified veterans.

Budgetary Resources for NCA Programs

With the above considerations in mind, *The Independent Budget* recommends \$261 million for FY 2016 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 decreased from \$33.9 million to \$9.1 million projected in FY 2015. The NCA must continue to invest sufficient resources in the National Shrine Initiative to ensure that this important work is completed.

Office of the Inspector General

FY 2016 <i>IB</i> Recommendation	\$128 million
FY 2016 Administration Request	\$127 million
FY 2015 Enacted Final Appropriation	\$126 million

The Office of the Inspector General (OIG) has been under significant scrutiny over the past year. We believe that the work requirements assigned to this office have placed it under great stress and potentially stretched it beyond its capacity. That being said, the IBVSOs believe that the office does not warrant a staffing increase at this time. The nature of the reporting and the scrutiny that the OIG has faced suggests that internal reform should be considered before significant new resources are appropriated. The *IB* recommends funding based on current services of approximately \$128 million.

Construction Programs

Major Construction

FY 2016 <i>IB</i> Recommendation	\$1.93 billion
FY 2016 Administration Request	\$1.14 billion
FY 2015 Enacted Final Appropriation	\$562 million

Each year the Department of Veterans Affairs outlines its current and future major construction needs in its annual Strategic Capital Investment Planning (SCIP) process. In its FY 2015 report, VA projects it will take between \$18.1 billion to \$22.1 billion to close all current and projected gaps in access, utilization, and safety. Currently, VA has more than 50 major construction projects that are either partially funded or funded through completion, but in which construction is incomplete.

Last year VA requested and Congress appropriated approximately \$562 million to further fund four major construction projects. While these funds will allow VA to begin substantive construction on these projects, many other previously funded sites continue to go unfunded. One of these projects was originally funded in FY 2007, while others were funded more than five years ago but no money has been spent on the projects to date. Of the 49 projects on VA's partially funded VHA construction list, 12 are seismic in nature, with nine of them being in some stage of funding.

It is time for the projects that have been in limbo for years or that present a safety risk to veterans and employees to be put on a course to completion within the next five years. To accomplish this, the IBVSOs recommend that Congress appropriate \$1.93 billion for FY 2016 to fund through completion the 10 highest priority projects. On an urgent basis, Congress must fund the full cost to replace any funds that have been reprogrammed from existing projects to allow construction on the Denver VA Medical Center replacement facility to be concluded.

Research Infrastructure

State-of-the-art research requires state-of-the-art technology, equipment, and facilities. For decades, VA construction and maintenance appropriations have not provided the resources VA needed to maintain, upgrade, or replace its aging research laboratories and associated facilities. The impact of funding shortages was vividly demonstrated in a Congressionally mandated report that found major, systemwide deficits in VA research infrastructure. Nearly 40 percent of the deficiencies found were designated "Priority 1: Immediate needs, including corrective action to return components to normal service or operation; stop accelerated deterioration; replace items that are at or beyond their useful life; and/or correct life safety hazards."

The report cited above estimated that approximately \$774 million would be needed to correct all deficiencies found, but only a fraction of that funding has been appropriated since this report was made public in 2012. The VA Office of Research and Development is conducting a follow-up study of over a dozen key research sites. This update should be available in mid-2015, the results

of which can be used to guide VA and Congress in further investment in VA research infrastructure. Nevertheless, Congress needs to begin now to correct the most urgent of these known infrastructure deficiencies, especially those that concern life-safety hazards for VA scientists and staff, and for veterans who volunteer as research subjects.

The IBVSOs believe that Congress should break this chronic stalemate and designate funds to improve specific VA research facilities in FY 2016 and in subsequent years. In order to begin to address these known deficits, the IBVSOs recommend Congress approve at least \$50 million for up to five major construction projects in VA research facilities.

The full report discussed above is available at www.aamc.org/varpt. The House reports associated with this issue are House Report 109-95, and House Report 111-559.

Minor Construction

FY 2016 <i>IB</i> Recommendation	\$575 million
FY 2016 Administration Request	\$406 million
FY 2015 Enacted Final Appropriation	\$495 million

In FY 2015, VA requested and Congress appropriated \$495 million for 47 minor construction projects. That still leaves more than 600 minor construction projects that need funded 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 healthcare access by increasing medical staffing levels and investing in infrastructure. VA has developed a spending plan that will obligate \$511 million for 64 minor construction projects over a two-year period.

VA plans 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 of, annual appropriations for minor construction projects. To ensure that VA funding keeps pace with completing all current and future minor construction projects, the IBVSOs recommend that Congress appropriate an additional \$575 million above the \$128 million that is provided through VACAA for FY 2016.

Additionally, the IBVSOs recommend \$175 million in non-recurring maintenance and minor construction funding to address needs of facilities identified in the Congressionally requested report on the status of VA research facilities.

Grants for State Extended-Care Facilities

(State Home Construction Grants)

FY 2016 <i>IB</i> Recommendation	\$200 million
FY 2016 Administration Request	\$80 million
FY 2015 Enacted Final Appropriation	\$90 million

The State Veterans Home program is a very successful federal-state partnership in which VA and states share the cost of constructing and operating nursing homes and domiciliaries for America's veterans. Today, State Homes provide over 30,000 nursing home and domiciliary beds for veterans, their spouses, and gold-star parents of veterans. Overall, State Homes provide approximately 53 percent of VA's long-term-care workload, for the very reasonable cost of only about 12 percent of VA's long-term-care budget. VA's basic per diem payment for skilled nursing care in State Homes is approximately \$100, significantly less than comparable costs for operating VA's own long-term-care facilities. On average, the daily cost of care for a veteran at a State Home is less than 50 percent of the cost of care at a VA long-term-care facility. This basic per diem covers about 30 percent of the cost of care, with states responsible for the balance, utilizing both state funding and other sources.

VA also provides states with construction grants to 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 qualify are included in VA's Priority List Group 1 projects, which are eligible for funding. Those who have not yet received assurances of state matching funding are put on the list among Priority Groups 2 through 7.

In FY 2014, the estimated federal share for proposed State Home Construction Grants submitted by states was \$928 million, of which \$489 million had already secured the state matching funds required to put them in the Priority Group List 1. The IBVSOs had recommended \$250 million to provide funding for about half of the Priority 1 projects. The final appropriated funding for FY 2014 was only \$85 million, significantly less than the amount needed to address the current backlog of projects.

In FY 2015, total estimated share of State Home Construction Grant requests rose to \$976 million, of which \$409 million already have state matching funding. For FY 2015, Congress appropriated \$90 million for this program, which does represent a small increase, but again does not begin to seriously address the backlog of pending construction requests to maintain the State Homes infrastructure.

For FY 2016, the IBVSOs recommend \$200 million for the State Home Construction Grant program, which we estimate would provide sufficient funding for approximately half of the projects expected to be on the FY 2016 VA Priority Group 1 List when it is released at the end of this year.

Grants for State Veterans Cemeteries

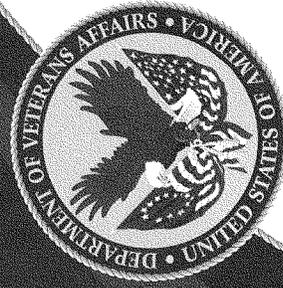
FY 2016 <i>IB</i> Recommendation	\$48 million
FY 2016 Administration Request	\$45 million
FY 2015 Enacted Final Appropriation	\$46 million

The State Cemetery Grant Program allows states to expand veteran burial options by raising half the funds needed to build and begin operation of veterans' cemeteries. The NCA provides the remaining funding for construction and operational funds, as well as cemetery design assistance. As of September 2014, there were 49 projects with state matching funds.

Funding eight projects in FY 2016 will provide burial options for an additional 148,000 veterans. To fund these projects, Congress must appropriate \$48 million.

Department of Veterans Affairs

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**Secure Sharing of
Health Information to
Improve Patient Care**

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Sharing Health Information - DoD and VA (Legacy Systems)

DoD

Data on Shared Patients

- Outpatient pharmacy data
- Inpatient and outpatient laboratory and radiology results
- Discharge summaries (96% DoD sites = 100% of inpatient beds)
- Inpatient consultations, operative reports, history and physical reports, transfer summary notes, initial evaluation notes, procedure notes, evaluation and management notes, pre-operative evaluation notes, and post-operative evaluation and management notes (96% DoD sites - available to all DoD providers and VA providers enterprise wide)
- Allergy data and problem list data
- Theater clinical data (Theater inpatient notes, outpatient encounters, ancillary clinical data)
- Ambulatory encounter, procedures and vital signs
- Family, social, and other history
- **Current Computable and Viewable Data (CHOR)**
- Pharmacy data and medication allergy data - enables drug-drug and drug allergy safety checks and alerts

Data on Separated Service Members

- Outpatient pharmacy data
- Inpatient and outpatient laboratory results and radiology reports
- Allergy information
- Consult reports
- Admission, discharge, transfer information
- Standard ambulatory data record elements (diagnosis, treating physician)
- Pre- and post-deployment health assessments
- Post-deployment health reassessments
- Patient history
- Discharge summaries

Data on OIF/OEF Polytrauma Patients

- Radiology images and scanned medical records
- Walter Reed AMC and Bethesda NMMC merged to form Walter Reed NMMC in September 2011; Malcolm Grow AFMC closed its inpatient beds in September 2011; Walter Reed NMMC closed its inpatient beds when San Antonio MMC (formerly BANG) opened in October 2011.

VA

All VA Medical Facilities

- 5.9 million correlated/shared Patients w/ DoD (includes 2.7 million patients not in FHIE repository thru December 2014)
- 164,170 FHE/BHIE queries, DoDVA combined average weekly (1st Quarter FY 2015)
- 708,928 FHE/BHIE queries, DoDVA combined (Month of December 2014)

- Computable pharmacy and allergy exchange on 2.3 million Active Dual Consumer-registered patients (Cumulative thru December 2014)

Cumulative through December 2014

- 95.1 million laboratory results
- 15.3 million radiology reports
- 96.7 million pharmacy records
- 213.4 million standard ambulatory data records
- 4.2 million deployment-related health assessments on 1.7 million individuals

5 VA Polytrauma Centers

(Tampa, Richmond, Minneapolis, Palo Alto, San Antonio)

- Radiology images for 684 patients
- Scanned records for 804 patients

Two-way on-demand view of health data in real-time

Bidirectional Health Information Exchange (BHIE)

Viewable data exchange between all DoD and VA medical facilities as of July 2007

Live data flow beginning 2004; data from 1999 forward

CHDR

Translated data persists in both systems

Live data flow beginning 2006; data from 1999 forward

Federal Health Information Exchange (FHIE)

One-way monthly transfer of health data

Live data flow beginning 2002; data from 1999 forward

Health data on 5.4 million Service members (3.2 M correlated to VA)

Live data flow beginning March 2007

One-way transfer of health data initiated at time of decision to transfer patient

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DATA ACCURATE AS OF 3 FEBRUARY 2015



Sharing Healthcare Data

- Common Viewing in VA and DoD through JLV

VA

Data on Shared Patients

Viewable Data (JLV v2.2)

Provides an integrated display of:

- o Admissions
- o Appointments
- o Clinical reminders (VA only)
- o Community Health Summaries (C32)
- o Consults
- o Demographics
- o Discharge Summaries/Essentris Notes
- o Encounters (DoD only)
- o Lab Orders

Viewable Data Mapped to National Standard Codes (JLV v2.2)

- o Allergies
- o Immunizations
- o Histories (Social, Family, Other) (DoD only)
- o Lab Results (many types)
- o Medications (Inpatient and Outpatient)
- o Orders
- o Problem List
- o Progress Notes (Standard note type/title)
- o Radiology Reports
- o Vitals

JLV

Provides an integrated real-time view of health records from all VA and DoD sources and VA VLER and VA VLER partners in a common viewer. Newest viewer available to users in both DoD and VA.

Data for 5.9 M correlated patients are accessible by DoD and VA clinicians and benefits professionals via JLV

Available at all VA Medical Centers and VBA Regional Offices on October 1, 2014

JLV in VA (through January, 2015)

- 1,610 Unique Users of JLV
- 30,098 JLV Logins
- 56,649 Records Viewed

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DATA ACCURATE AS OF 3 FEBRUARY 2015



Sharing Healthcare Data - VLER Health Exchange and Direct

Community Partners

VLER Exchange: Total Exchange partners in production - 31

- UC Davis Health System (CA)
- Oregon Health Science U (OR)
- San Diego Health Connect (CA)
- Cornemagh Health Sys (FA)
- Stanford Health Care (CA)
- Medical U of South Carolina (SC)
- Yale New Haven Health Sys (CT)
- South Carolina HIE (SC)
- Mount Sinai Medical Center (FL)
- Texas Health Resources (TX)
- Mount Sinai Medical
- Uah HIN (UT)
- Hawaii Pacific Health (HI)
- Sentara Healthcare (VA)
- Idaho Health Data Exchange (ID)
- MedVirginia (VA)
- Indiana HIE (IN)
- Inland NW Health Services (WA)
- Presbyterian Healthcare (AZ)
- MultiCare (WA)
- HealthLink (NY)
- Gundersen Health System (WI)
- HealtheConnections (NY)
- U Wisconsin Health (WI)
- MetroHealth System (OH)
- Kaiser Permanente (multi-state)
- UnifyPoint (IA)
- CO-HIN (multi-state)
- Novant Health (NC)
- Wageneers (multi-state)

VLER Direct: Total Direct VA partners in production - 10

- Utah Health Information Network (UHIN)
- (Intermountain Health & Harmony Home Health)
- Alaska eHealth Network (AeHN)
- North Carolina Health Info Exchange (HIE)
- Rhode Island Quality Institute (RIOI)
- Missouri Health Connection
- Minnesota Community Health Info Collaborative (CHIC)
- Iowa Henry County Health Center
- Florida Health Information Exchange (HIE)
- MPODirect (vendor/HIE)

The Virtual Lifetime Electronic Record (VLER) Health - Department of Veterans Affairs (VA) Project is being developed to provide a secure, nationwide, interoperable health information infrastructure that will connect with approved healthcare providers, consumers, and others involved in supporting the care and recovery through a secure network, known as an eHealth Exchange.

VLER Health Exchange

Electronic Health Exchange (eHE) Project is to enhance the existing NwHIN Adapter product that provides secure exchange HITSP Summary Document Using HL7 Continuity of Care Document (CCD) Component (C32), as well as a tool front-end that extracts real time patient information

VLER Health Direct Messaging

VA Direct provides a secure messaging system for sharing of medical information between VA and trusted non-VA care providers

VA

VLER Health Exchange

- Cumulative totals (as of January 25, 2015)
 - Sent - 56,092 records retrieved by Partners
 - Retrieved - 30,787 Partner records retrieved by VA
 - Authorized - 98,893 total unique Veterans "Opted in" to share VA health information
 - Correlated - 77,113 patients have matched identities with community partners to share and exchange data
 - 31 Exchange partners
- Fiscal Year 2015 totals (1 Oct 14 - 25 Jan 2015)
 - Sent - 8,038
 - Retrieved - 15,876
 - 2 Exchange partners joined the effort

VLER Health Direct Messages

- Cumulative totals (as of January 28, 2015)
 - Sent - 78
 - Received - 107
- January 1-28, 2015 totals
 - Sent - 8
 - Received - 8
- Total Direct VA users - 41

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DATA ACCURATE AS OF 2 FEBRUARY 2015



Sharing Health Information - between VA and the Veteran

VA

MyHealtheVet (MHV) features based on account type

- Registered (Basic)**
 - Provides limited access to self-entered features in My HealtheVet
 - Cannot see personal information located in VA or DoD systems
 - Use MHV to:
 - Add information to a personal health journal about over-the-counter medications, allergies, military health history, medical events, tests and health insurance
 - Record and track personal information (contacts, health care providers, record and track personal health measurements (blood pressure, blood sugar, cholesterol, heart rate, body temperature, weight, pain level, etc.)
 - Use VA Blue Button to view, save, print or download, save or share self-entered information
- Registered (Advanced)**
 - Only for Veterans and/or VA Patients
 - Provides access to some VA and/or DoD records information
 - VA patient can refill VA prescriptions online
- Authenticated (Premium)**
 - View portions of VA health records
 - VA Admissions and Discharges (including discharge summaries)
 - VA Problem List and VA Notes (written after January 1, 2013)
 - VA Medication History and Allergies
 - VA Appointments (Past two years and Future)
 - VA Immunizations, VA radiology and VA EKGs
 - VA Laboratory Results, Chemistry/Hematology/Microbiology/Immunology
 - VA Pathology Report, Surgical Pathology/Cytology/Electron Microscopy
 - VA Visits and Readings and VA Wellness Reminders
 - VA EHR information such as VA Continuity of Care Document (VA CCD)
 - Department of Defense (DoD) Military Service Information
 - Use VA Blue Button to view, save, print, download, save or share VA health and DoD Military Service Information (VA CCD)
 - Download VA Continuity of Care Document (VA CCD)
 - Use Secure Messaging to communicate online with VA health care team
 - Messages available to VAMC teams including Primary Care, Specialty Medicine, Surgical Care, and Rehabilitation and Prosthetic Services

MyHealtheVet (MHV) Blue Button

Enables Veterans to view, print, and download their personal health information from their VA Personal Health Record

MyHealtheVet (MHV) Online Services

Veterans view and manipulate portions of their personal health information (PHR) downloaded from VISA or self-entered

MyHealtheVet (MHV) Secure Messaging

Patients and healthcare team send non-urgent secure messages directly.

VA Patients

Blue Button (through December 2014)

- Cumulative totals since inception
 - 1.8 Million unique registered users requested downloads
 - 9.4 Million files were downloaded
 - 2.4 Million blue button outputs were viewed in the browser
- Monthly totals
 - 330,864 files downloaded by 88,425 unique users
 - 89,425 unique VA Blue Button users
 - 15,489 unique VA Continuity of Care (CCD) Users

MyHealtheVet (through December 2014)

- 3.2 Million Registered Users
 - 2.7 Million Veterans (87%)
 - 2.5 Million VA Patients (84%)
- 1.70 Million Accounts Identity Proofed as VA Patients
- MHV Visits
 - 142 Million Total Visits since 11/11/2003
 - 2.9 Million Visits in December
- Rx Refill Requests
 - 62 Million total Rx refill requests since 09/2005
 - 3.5 Million requests in FY 2015
 - 9.4% increase over FY 2014 Refill Requests
- Self-Entered Data (SEI)
 - 472,203 Total Unique MHV SEI Users

Secure Messaging (SM)

- 1.15 Million total VA patients Opted in for Secure Messaging since 8/30/2008 (cumulative thru December 2014)
- 859,701 Secure Messages Initiated in December 2014
- Total VA Patients Opt In for Secure Messaging up 34% over December 2013
- Over 18.4 million VA Secure Messages Initiated by VA Patients and their Health Care Teams

DATA ACCURATE AS OF JAN 2015

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QUESTIONS FOR THE RECORD
U.S. House Committee on Veterans' Affairs
FY16 VA Budget Hearing
February 11, 2015

GIBILL

Question 1: In regards to the workload for GI Bill claims, your budget projects the average days to process original education claims will jump from 17 days in FY 2014 to an estimated 28 days in FY 2016 and the average days to complete a supplemental claim will jump from 6 days in FY 2014 to 17 days in FY 2016.

Understanding that many other business lines and programs throughout the department are receiving hefty increases in your budget, even though many of them don't provide direct services to veterans, can you explain your decision to flat line funding for the Education Service as processing times continue to increase?

Response: VBA continues to improve the timeliness and accuracy of GI Bill claims with a majority of the enrollment documents currently being processed within 6 days at a 99-percent accuracy level. The gains have been largely due to the automation of the claims process, which has allowed us to reduce the processing time of original claims by 45 percent, from 31 days in 2012 to 17 days in 2014, and supplemental claims by 65 percent, from 17 days in 2012 to 6 days in 2014. VBA continues to monitor processing times and is optimistic about maintaining improved timeliness. The targets of 28 days for original claims and 14 days for supplemental claims have been consistent goals in recent years with the intent to continuously improve the timeliness of claims processing. VBA is now reviewing these targets to determine if any changes are appropriate.

Question 2: Please tell us how your FY2015 budget will provide funding for the next phase of the GI Bill Comparison tool to update and improve current functionality?

Response: On February 4, 2014, VA launched the GI Bill® Comparison Tool -- a streamlined, web-based tool that allows Veterans and their family members to calculate estimated GI Bill benefits, research certain school attributes, and compare educational institutions. As of April 7, 2015, there were 892,000 unique page views of the Comparison Tool with over one million schools searched.

The next phase of development of the GI Bill Comparison Tool will allow Veterans and family members to view outcome measures along with other school information, such as accreditation information, majors and programs offered, credit transfer policies, and in-state tuition policies. In addition, Veterans and family members will be able to provide feedback on schools. The timeline and funding for the next phase of development will be determined by VA's Chief Technology Officer.

Question 3: Please give us more information regarding VA's partnership with

Student Veterans of America to create the Student Completion Database as well as your plan for releasing the project's data going forward.

Response: VBA, National Student Clearinghouse (NSC), and Student Veterans of America (SVA) completed the initial Million Record Project in March 2014. The goal of the initial project was to collect empirical data to determine the best practices and policies that promote Veterans' success. This initial data set included 500,000 Montgomery GI Bill beneficiaries and 500,000 Post 9/11 GI Bill® beneficiaries.

VBA, SVA, and NSC began developing a second project in August 2014. VBA is currently finalizing new memoranda of agreement with SVA and NSC to obtain post-secondary education enrollment and completion data for up to one million Post-9/11 GI Bill beneficiaries. Additionally, SVA plans to merge institution-level and on-campus Veteran-specific service data, which will help stakeholders understand the effectiveness of on-campus support services for Veterans and enhance the ability to serve them in the future.

Question 4: The Choice Act includes a provision to require states to provide tuition for veterans and their dependents at the in-state rate to qualify for GI Bill benefits, and it included a provision to expand the Fry Scholarship to spouses of servicemembers who die in the line of duty. In multiple meetings and in testimony there has been a concern from VA on its ability to keep up with the fast processing times of education claims once this provision of the law is implemented on July 1 of this year. Even with this concern however, VA has flat lined the Education Service's FTE. Please explain this and how the Department plans to keep up with processing times without increasing the people needed to do so?

Response

Section 702 of VACAA requires VA to disapprove programs of education under the Post-9/11 GI Bill and Montgomery GI Bill—Active Duty at public institutions of higher learning if the school charges qualifying Veterans and dependents tuition and fees in excess of the rate for resident students for terms beginning after July 1, 2015. VA sent a letter to all state Governors to inform them of the requirements and obtain definitive information on the states' ability to meet the requirements of section 702 by July 1, 2015. VA is tracking responses and working with states to understand their positions and intent. Currently, 46 states (AL, AK, AZ, CA, CO, CT, FL, GA, HI, ID, IL, IN, KS, KY, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, and WY) and 3 Territories (GU, PR, VI) are compliant with section 702, and the remaining states and territories are working toward compliance through legislative, regulatory, or policy changes. VA continues to work with these states and territories to achieve compliance.

To avoid disruption to the delivery of Veterans' education benefits, on April 26, 2015, the Secretary of Veterans Affairs exercised his authority to grant a waiver of the requirements of Section 702 of the Choice Act for all non-compliant programs through

the end of calendar year 2015. However, if the remaining states do not achieve full VACAA compliance or receive a waiver extension, then there may be an impact to claims processing timeliness and an increase in the number of claims requiring manual processing. Currently, VA is working to develop functionality to automate claims impacted by Section 702.

Question 5: Looking at the proposed budget, after years of a visible upward trend of participants in the GI Bill, why does the Department expect to see a drop in GI Bill participants between the years of 2016 and 2017?

Response: VBA assumes growth in the number of Post-9/11 GI Bill trainees will begin to stabilize by 2017. While the average increase for the Post-9/11 GI Bill averaged 22 percent annually between 2010 and 2014, the annual increase is diminishing and was down to just five percent from 2013 to 2014. In addition, as more Veterans elect to receive benefits under the Post-9/11 GI Bill, other education programs have experienced a decline in the number of trainees. From 2010 to 2014, Montgomery GI Bill usage decreased by an average of 23 percent annually, and chapter 1607 usage decreased 18 percent annually. From 2016 to 2017, VA is estimating a one percent increase in trainees under the Post-9/11 GI Bill. VA anticipates a continued decrease in participation under other education programs, which, combined with minimal growth under the Post-9/11 GI Bill, results in a decrease of less than one percent for all education programs.

The FY 2016 President's Budget submission was the first budget submission to include an advanced appropriation request for the Readjustment Benefits account. With the advance appropriation for FY 2017, VBA has the opportunity to reevaluate program projections in the FY 2017 President's Budget Submission, if necessary.

VOCATIONAL REHABILITATION AND EMPLOYMENT

Question 6: Please inform the Committee of the performance metrics for the VetSuccess on Campus (VSOC) program? Are you expecting growth of this program in future years?

Response: In 2014, the VSOC Program's 79 counselors assisted nearly 52,000 student Veterans at 94 campuses. Program goals include:

- Contacting 80 percent of new student Veterans on campus during their first semester of attendance;
- Contacting 95 percent of Veterans and beneficiaries who are utilizing VA education benefits and on academic probation to provide support as needed; and
- Conducting 12 campus events per VSOC location per year, such as VA benefits informational workshops, employment workshops, and new student orientations.

VBA expects the VSOC program to grow and is planning to support additional Veterans and campuses in FY 2017 and future years, resources permitting.

Question 7: In your testimony you go into detail about additional funding for VBMS. What is VA's plan to complete the CWINRS program, or provide funding for another IT tool to better track costs and participants in the VR&E program?

Your budget request, however, once again flat lines the number of Voc Rehab counselors to 1,442, same as last year and the year before. VA, however, also recognizes that there will be a 10% increase in participants since 2014, increasing the ratio of veterans to counselor.

Why does this program continue to be flat lined as participation increases? Won't this end up harming disabled veterans that need this program to gain meaningful employment?

Response: VR&E Service is working with the Office of Information Technology (OIT) and VBA's Veterans Relationship Management (VRM) Program Office to develop a new VR&E Case Management System (VR&E-CMS). One of the goals of the new system is to reduce the amount of manual data entry by VR&E staff. VR&E-CMS will integrate with some existing VA systems, and many data fields will be automatically pre-populated from those systems, reducing the opportunity for erroneous data entry. The system will include templates for common data elements, which will improve tracking and reporting of data and allow VR&E counselors to manage their work more efficiently and effectively. VRE-CMS is being developed through the Customer Relationship Management development and sustainment contract.

VA continues to invest in employees by providing training to ensure that they are equipped with the knowledge and skills necessary to provide timely and quality service to Veterans. Training, in conjunction with procedural changes to streamline service delivery, will enable vocational rehabilitation counselors to meet the demands of an increasing workload. In addition, regional offices utilize contract support for VR&E counseling services.

Through collaboration with VHA's Telehealth program, VR&E recently deployed TeleCounseling nationwide using secure video teleconferencing technology to supplement face-to-face counseling with VR&E program participants. The goal of the TeleCounseling initiative is to strengthen outcomes for Veterans and gain efficiency for counselors. TeleCounseling was used by seven regional offices in FY 2014 and reduced travel for Veterans as well as VR&E staff.

Question 8: One of VA's legislative proposals is to remove the cap on funding for Chapter 36 educational counseling. Please explain in greater detail why this cap needs to be removed if it has never been reached? Also, when will the Department make the application for this benefit electronic like almost every other application for benefits that VA administers?

Response: Title 38, section 3697 currently authorizes payments not to exceed

\$6,000,000 in any fiscal year for Chapter 36 educational and vocational counseling obtained by contract. By FY 2016, VA expects a substantial increase in requests for these counseling services as more Servicemembers and Veterans become aware of the benefit as a result of:

- Placement of VR&E counselors on military installations and college campuses.
- Strengthened VR&E content in the Transition Assistance Program (TAP), and
- Outreach to over 60,000 Veterans eligible for VR&E counseling through the White House Office of Science and Technology Policy Behavioral Sciences Team in FY 2014.

Without authority to fund additional contract support, VA will be limited in meeting the needs of this population.

Regarding electronic application for this benefit, VBA is working with OIT to prioritize automation of *VA Form 28-8832: Educational/Vocational Counseling Application* and *VA Form 28-1900: Disabled Veteran Application for Vocational Rehabilitation*. VBA estimates release in the fall of 2015.

ACCOUNTABILITY

Question 9. In the 2016 Budget Request you mention the need to continue driving your top priorities and fulfill the fiscal responsibility of effectiveness, efficiency, and accountability. In fact these were the same three aspects of fiscal responsibility the Department noted in its 2015 and 2014 Budget requests. Last year the Department came under fire for wait lists and data manipulation and you were given enhanced authority by this Congress to remove low performing managers and those managers who oversaw mismanagement and manipulated wait times.

Following the passage of this new authority, the Department continues to be scrutinized for not using this authority to the extent many had assumed. How is the focus of accountability in 2016 going to be any different than it has been in years past? What further tools do you need to increase accountability at the Department? OAR

Response: The Veterans Access, Choice, and Accountability Act of 2014 amended title 38, of the United States Code, by adding in section 713. Section 713 provides the Secretary with additional authority to remove or demote a VA Senior Executive for performance or misconduct. Senior Executives removed or demoted under this authority have substantially fewer appeal rights than their counterparts at other Federal agencies.

The intent of section 713 was to provide the Secretary with greater flexibility to remove Senior Executives if the performance or misconduct of the Senior Executive warrants such an action. Section 713 does not allow VA to remove Senior Executives without evidence or cause, nor does it guarantee that VA's removal of a Senior Executive will be upheld on appeal. Prior to taking a section 713 action, VA must gather evidence to support the action and provide the employee with Constitutionally-required due process, including an opportunity to respond to the proposed section 713 action. Once a section

713 action has been taken, and if the action is appealed, VA must then defend the action before a Merit Systems Protection Board administrative judge, who would examine whether the action is based on merit and whether VA followed the law, prior to taking the action.

With regard to gathering the evidence required for Senior Executive actions and in order to coordinate accountability VA-wide, the Secretary created, the Office of Accountability Review (OAR).

The OAR's primary responsibilities are to ensure leadership accountability for serious misconduct, including whistleblower retaliation, data manipulation related to patient scheduling and access to care, and other matters that impact public trust throughout the Department of Veteran Affairs.

OAR works within current law and policy to reset accountability in the Department. Tracking employee discipline taken throughout VA ensures penalties are appropriate and consistent for comparable behavior. VA will continue to hold its employees accountable and take action as expeditiously as possible. VA will continue to use all available authorities to pursue accountability in FY 2016 and beyond, and does not believe additional statutory authority is necessary.

Question 10. Please provide a job description of the new FTE that is being requested for the Office of Accountability Review (OAR). Are these new employees or are they being transferred from other parts of the agency?

Response: OAR is comprised of a Director, Deputy Director and 25 additional full-time employees (total manpower of 27 full time employees). Twenty-one employees were reassigned or recruited from within VA and 6 positions are in the recruiting or development process. Additional augmentation and support is provided by VA employee details and re-employed annuitants with specialized skills.

The Deputy Director fully shares in the authorities and responsibilities of the Director in all phases of the OAR's programs. The Deputy Director manages and oversees the three divisions within OAR through the direction of the Division leaders

The Employee Relations Division performs or oversees administrative investigations to fully develop a solid evidentiary record on which to take disciplinary actions against culpable senior leaders.

The Employee Relations Director at full staff has 10 investigators and 3 support

personnel. All investigators have been hired and were recruited or realigned from within VA. Three support positions are in the recruiting process.

The Risk Analysis and Compliance Oversight Division tracks data related to oversight investigations and reports from all sources- including but not limited to the VA Office of Inspector General, Government Accountability Office, and Office of Special Counsel to identify trends, address deficiencies in business systems and processes, and assist VA senior leaders in improving accountability and oversight across the Department.

Risk Analysis and Compliance is a division of 4 full time employees. The Director and 2 management analysts were reassigned from elsewhere in VA; a third management analyst is currently being recruited.

The Operations Division supports the other divisions by providing Human Capital and Financial Management. This division has 5 full time employees. All were hired from within VA.

INSPECTOR GENERAL FUNDING

Question 11. The FY 2016 budget once again essentially flat lines the Office of Inspector General's budget at an 0.3% increase compared to FY2015. At the Senate Committee on Veterans Affairs hearing on February 26, 2015 you stated that you believed the flat lining was an "administrative error," and would adjust it, yet your written budget request states otherwise. Page OIG 408 of Volume 3 shows that the Department was very aware of the OIG receiving only a 0.3 percent increase and indicated that this increase would result in a 10 FTE reduction and would, "constrain further expansion of OIG oversight of medical care access, quality, resource allocation, and other high-risk programs, such as disability claims processing and procurement.'

Please explain these inconsistent answers.

Response: The Department supported the full amount of the OIG's 2016 initial budget request, which was submitted in September 2014. After the passage of the 2015 appropriation on December 16, 2014, which added \$5 million to the President's 2015 OIG budget request, the OIG sought a \$5 million increase to its 2016 budget, above its 2016 budget request. Due to the late timing of this event, well after our budget submission, a subsequent, additional increase for the OIG was not included in the final 2016 budget. On February 2, 2015, the President transmitted the 2016 Budget to Congress. The VA 2016 OIG budget request (Volume 3 of 4, page OIG-408), under the topic "Budget Submission Requirements of the *Inspector General Act*", as prepared by the OIG, states:
"This budget request was prepared in accordance with Section 6(f)(1) of the Inspector General Act of 1978. The current 2016 OIG request is

\$126,766,000. OIG's original request forwarded to the Secretary of Veterans Affairs was \$126,567,000, which represented a 4.2 percent increase over the 2015 President's Request of \$121,411,000. However, because the enacted 2015 appropriation subsequently increased OIG funding to \$126,411,000, the current 2016 request of \$126,766,000 now represents only a 0.3 percent increase that will not fully fund current services, the proposed pay raise, or inflation."

Current Status:

As stated by the Secretary at the February 26, 2015 SVAC hearing, the Department is identifying additional resource requirements in coordination with OMB, which will include \$15 million for the OIG budget in 2016. This would be a 12% increase over the enacted 2015 OIG funding level. The timing of this request has not yet been determined.

SPECIALLY ADAPTED HOUSING

Question 12: As more and more servicemembers and veterans are discharged and provided disability compensation, please go into detail as to why you expect the number of SAH grants to go down in FY2016 and FY 2017?

Response: In FY 2014 VA amended regulations to authorize automatic SAH eligibility to beneficiaries with Amyotrophic Lateral Sclerosis (ALS). During this time frame approximately 800 Veterans and Servicemembers with service-connected ALS were found eligible for the Specially Adapted Housing (SAH) grant. The amendment allowed VA to provide SAH benefits without unnecessary delay to disabled Veterans and Servicemembers.

As a result of this sudden increase in the SAH-eligible population, the workload is anticipated to increase by 42 percent from FY 2014 to FY 2015 and then decrease by 18 percent from FY 2015 to FY 2016. The workload is estimated to resume its historical growth rate of three percent from FY 2016 to FY 2017.

Question 13: The budget FY 2016 submission includes a \$5 million request for funding of the Specially Adaptive Housing Technology Grants Program. This program was authorized several years ago but it is my understanding that despite several attempts by VA, the Department has continued to run into self-imposed hurdles and missteps and have yet to provide a single grant. What is going to change this year and how can we help put this well intentioned program back on track?

Response: VA explored several approaches to implement the SAH technology grant program and determined regulations were necessary prior to the program's implementation

The final rule for the SAH technology grant was published on September 17, 2015. VA is working on a notice of funding availability for FY 2016.

OTHER SERVICES FUNDING

Question 14. Please provide the justification for the \$5.8 million increase in the "other services" line item for the Office of Management and the \$43.3 million increase in the same line item for the Office of Human Resources and Administration?

VA Response: The Office of Management (OM) Other Services line item includes both appropriated budget authority and reimbursement funding authority, the majority of which is used for contracts and support agreements. While OM has been able to streamline and reduce Other Services budget authority funding by \$553K, Other Services for reimbursements is estimated to increase by \$6.45 million in 2016. The increase in reimbursements is mainly due to Defense Finance and Accounting Service (DFAS) servicing more VA personnel and from rate increases for pay and payroll processing. The DFAS reimbursable agreement will increase by \$6.34 million to \$39.34 million in 2016. The remaining \$104K increase for reimbursements are inflationary costs associated with contracts and agreements. The increase in Other Services for the Office of Human Resources and Administration (HR&A) is attributed to a reduction in the FY 2015 Current Estimate budget due to a delay in deployment of HR•Smart. HR•Smart is a state-of-the-art human resource solution to VA's personnel management and pay challenges. The new HR•Smart will replace VA's 51-year-old-legacy system and will provide the following HR functions:

- 1) Personnel action processing, to include an entry-on-duty solution;
- 2) Benefits management; and
- 3) Compensation management, to include an interface to the Defense Finance and Accounting Service (DFAS) for payroll services. The new system will also interface with other internal and external systems, such as VA's electronic official personnel Folder (eOPF), VA's Time and Attendance System, and the Office of Personnel Management's USA Staffing System

WHISTLEBLOWERS

Question 15. Of the estimated \$127 million being requested for "developing leaders and improve workforce skills" under the Office of Human Resources and Administration, how much would go towards teaching managers and lower level employees on how to report and appropriately handle whistle blower complaints?

Response: The FY 2016 Budget Request includes a funding in the total amount of \$482.5K to provide mandatory training that addresses Prohibited Personnel Practices, consisting of:

- \$250,000 for EEO, Reasonable Accommodation, Diversity, Inclusion, Alternate Dispute Resolution and Conflict Management for Managers and Supervisors: Addresses reprisal and retaliation, as required by EEO Laws. Training is mandatory for all Executives, Managers, and Supervisors.
- \$232,500 for Prevention of Workplace Harassment/No FEAR Act: Addresses requirements of No FEAR Act of 2002 and will be enhanced to address Whistleblower Rights and Protections (WPA of 1989, as amended) and Prohibited Personnel Practices. Training is mandatory for all VA employees

PERSONAL SECURITY

Question 16. One of the largest issues brought up to Committee staff recently by AFGE members was the need to improve safety for VA employees and veterans alike at VA facilities across the country. Please tell us how your budget will support the need for this increased security?

Response:

Insider Threat

The National Insider Threat Policy and recent high profile Insider Threat incidents at federal agencies have demonstrated the need for a robust Insider Threat Program at VA. The Office of Operations, Security, and Preparedness (OSP) recognized this requirement and allocated funding for two FTE to establish an Insider Threat Program that examines the foreign intelligence entity threats to the U.S. Government (within VA) and those domestic threats that are organic within the VA work force. In order to expand the purview of the Insider Threat program to include threats from individuals (insiders) who wish to harm VA employees, operations, an/or Department interest, OSP requested funding. This request will support and create a safer work place by addressing threats from within the Department.

Identity, Credential, and Access Management (ICAM)

The VA Identity, Credential, and Access Management (ICAM) Program Management Office (PMO) was founded in October of 2014 and has been making continual progress in advancing the VA's ICAM vision, which is based upon the Federal ICAM model. The ICAM PMO is establishing an end-to-end enterprise-wide Onboarding, Monitoring, and Off-boarding Program and remediating Continuous Readiness in Information Security Program (CRISP) recommendations that will improve security for VA employees and Veterans at VA facilities across the country. ICAM represents the intersection of digital identities, credentials, and access control into one comprehensive approach that is

focused on delivering greater convenience and appropriate security and privacy protection, more efficiently. The VA ICAM program will establish a reliable process for assigning data attributes to a digital identity and connecting that identity to an individual. This includes the procedures for maintaining and protecting the identity data of an individual over its life cycle within an organization. In regards to credential management ICAM supports the life cycle of the credentials, tokens and their associated secrets, by coordinating activities related to credential management across the VA. Access management refers to the policies, procedures and technologies that control how entities and individuals are granted or denied access to resources. The purpose of access management is to ensure that the proper identity verification is made when an individual attempts to access physical resources, computer systems or data. Access management is composed of two (2) areas of operations: logical access (access to IT networks, systems, and / or applications) and physical access (access to physical locations such as buildings, parking lots, offices, etc.). The VA ICAM program will coordinate activities related to access manage across VA to include the processes for establishing and maintaining data for a resources that require access control, the processes for establishing and maintaining the entitlement or privilege attributes that comprise and individuals access profile, and the processes for establishing and maintaining policies that incorporate business rules and logic, usually based upon attributes or roles.

Homeland Security Presidential Directive 12 Program Management office (HSPD-12)

Homeland Security Presidential Directive 12 (HSPD 12), dated August 27, 2004, entitled "Policy for a Common Identification Standard for Federal Employees and Contractors," directed the promulgation of a Federal standard for secure and reliable forms of identification for Federal employees and contractors. The HSPD-12 Program Management Office is responsible for carrying out the requirements of HSPD-12 at VA and for managing the issuance of federal identification cards to all VA employees, contractors, and affiliates. HSPD-12 requires a Government-wide, common identification standard for all Federal employees and contractors requiring physical and/or logical access. It is critical that this program be funded to ensure secure and reliable identification of employees providing services to Veterans. Security and safety is ensured by implementing the following steps:

- a. Is issued based on sound criteria for verifying an individual employee's identity.
- b. Is strongly resistant to identity fraud, tampering, counterfeiting, and terrorist exploitation.

- c. Can be rapidly authenticated electronically and provides very high confidence in users asserted identity, attestation and verification.
- d. Is issued only by providers whose reliability has been established by an official accreditation process.
- e. Ensure controlled substances and pharmaceuticals are issued in a secure manner by medical professionals.

Personnel Security and Suitability Program (PSS)

By developing formal VA personnel security and suitability training, oversight and compliance programs as well as a robust communications road map will ensure compliance with regulatory requirements and the proper vetting through background investigations processes for VA employees, contractors, and affiliates. Standardized vetting and prompt background investigation submission and processing provide for decreased onboarding timeliness for employees, contractors, and affiliates enabling more Veterans to receive care and benefits. Ensuring program equipment lifecycle replacement is a must to maintain compliancy with required data collection.

OCLA STAFFING

Question 17. What is the justification of moving 13 FTE from the Office of Public and Intergovernmental Affairs to the Office of Congressional and Legislative Affairs?

Response: The Intergovernmental Affairs section of the Office of Public and Intergovernmental Affairs (OPIA) was moved from OPIA to the Office of Congressional and Legislative Affairs (OCLA) in order to align all VA government relations functions under one office. This was done to create synergy between the Department's state and local government, congressional, and Tribal Government Relations government affairs programs. Moving Intergovernmental Affairs to OCLA will result in a transfer of 13 FTE from OPIA to OCLA.

Question 18. The budget reflects an increase of over 20 OCLA employees. I know you have said on numerous occasions that you are committed to more transparency and communication between OCLA and Congress, but up until this point we still have many outstanding deliverables and requests. Do you believe

adding more employees is the answer to this problem, or do you believe there is a deeper issue within the Department to getting the information to Congress?

Response: The OCLA budget reflects an increase of over 20 FTE. However, 13 FTE are from the move of the Office of Intergovernmental Affairs from the Office of Public and Intergovernmental Affairs (OPIA) to OCLA. OCLA will have budgetary responsibility for these 13 FTE beginning in FY2016.

The increase of 7 FTE is to align OCLA's personnel resources with its forecasted work requirements. This is an overall increase of only 4 FTE over the office's FY2014 personnel structure of 49 FTE. The additional personnel will support greater transparency and communications between VA and Congress. Specifically, the additional personnel will enable OCLA to support over 70 hearings, 800 briefings, responses to over 4,330 requests for information, 185 GAO activities, technical assistance to over 325 pieces of draft legislation, and respond to over 25,500 constituent casework inquiries.

OCLA would use the additional personnel to improve its outreach and communications with all Members of Congress, not just those Members on the Department's committees of jurisdiction.

The increase in personnel would also mitigate an increasing turnover rate that will exceed 25% in FY2015, primarily as a result of work-life imbalances. OCLA's personnel are the office's most important asset and we must provide a work environment that promotes sustained performance, supports professional development, and ensures a work-life balance, thereby minimizing personnel turnover.

NATIONAL ADVERTISING

Question 19. How much of the FY 2016 budget is going to be spent on national advertising and how much of this is related to recruiting vs. benefits outreach?

Response: The attached excel spread sheet includes the input of the four VA Administrations and the VACO Special Staff and reflects the projected funding for their respective advertising programs. The projected total VA advertising spends for FY 16 is \$13,486,224 million. Only the Veterans Health Administration (VHA), Veterans Benefit Administration (VBA), Human Resources & Administration (HR&A) and Office of Public Affairs (OPA) plan to advertise in FY 16.

VHA projects approximately \$9.8 million for clinician recruiting efforts in specified national and regional markets. The remaining VHA advertising budget is for healthcare

VBA FTE

Question 20: In March 2013, before the Senate Veterans' Affairs Committee, General Hickey received a question about staffing levels and this inquiry happened to have occurred at the height of the disability claims Backlog. In response, General Hickey stated, "...I am reluctant to say let us throw more people at a problem where I have the capability to potentially make the work go faster by the nature of the change in the process we are doing and the changes in technology." However, in the current budget proposal, VA is requesting an additional \$85 million in FY 2016 for 770 new FTE for VBA."

What has changed to create the request for the additional FTE and what is the expected level of staffing for claims processing five years from now?

Response: In 2013, VBA was focused on implementing the largest transformation in the organization's history in order to eliminate the claims backlog. VBA's transformation plan includes actions targeted to reorganize and retrain our people, streamline our processes, and deploy technology solutions, such as our Web-based electronic claims processing system, the Veterans Benefits Management System (VBMS). VBA deployed VBMS to all 56 regional offices six months ahead of schedule in June 2013. Through these transformation initiatives, VBA has reduced the disability claims backlog by 70 percent, from the peak of 611,000 in March 2013 to approximately 182,000 claims as of April 15, 2015. The average age of the pending claims in the inventory is now 131 days, down 151 days from the peak of 282 days in February 2013. We have increased our claim-based accuracy from 86 percent in 2011 to 91 percent. When we measure accuracy at the issue level within each claim, our accuracy level is 96 percent.

Our progress in reducing the rating claims backlog has impacted other workload areas. As VBA continues to receive and complete more rating claims, the volumes of appeals, non-rating claims, and fiduciary exams correspondingly increase. We are grateful for funding in 2015 to hire 250 FTE, and we are asking for funding in 2016 to hire another 770 to right-size our workforce. This request is necessary to meet Veterans' expectations for more timely actions on non-rating claims and appeals and ensure strong fiduciary oversight.

In accordance with the Office of Management and Budget's Circular A-11, VBA's FY 2016 budget only projects staffing requirements through FY 2016. Therefore, staffing projections for FY 2020 are unavailable at this time. VBA will continue to assess workload projections and efficiencies in the claims process to ensure the annual budget

request to Congress includes appropriate staffing levels based on the most recent information available.

Question 21: VA's budget submission has identified an expected increase in claims receipts for FY 2015 at 1.302 million and FY 2016 at 1.411 million. These figures represent an increase of 17% and 27%, respectively, over the 1.114 million claims received in 2014. Please explain in detail what factors and information you considered in your projections to arrive at these specific figures for anticipated volume of claims receipt for these two years.

Response: VBA anticipates a growth in the number of claims received in all categories of compensation claims in FY 2015 and FY 2016. The categories with the most significant growth are supplemental claims (reopened claims and claims for increased benefits) and routine future examinations (disability examinations to verify continued severity of a disability). This growth in these categories is driven by the increase in the number of Veterans, particularly Gulf War Era Veterans, already receiving compensation benefits. The number of claims received during the first six months of FY 2015 aligns with the projections included in the FY 2016 budget request.

VBMS

Question 22: To date, Congress has provided VA with approximately half a billion dollars in funding for the Veterans Benefits Management System (VBMS). VBA is now asking for an additional \$253 million in funding for various technology improvements and processes, and for sustainment of the existing components of VBMS.

a. How does the Department distinguish between what is considered "development" of VBMS, as compared to "sustainment"?

Response: Funding for VBMS is provided by VBA as well as the Office of Information Technology (OIT). Funding from OIT is divided into development and sustainment costs. Development costs are associated with building new functionality. Sustainment costs are associated with maintaining current functionality.

b. What features of VBMS have been developed thus far, and which of those features are now considered to be in sustainment?

Response: Current features in VBMS enable VA to receive claims electronically, establish internal controls, develop and evaluate for evidence, and provide decisions electronically. Some of the major features already used in VBMS include:

- The electronic folder (eFolder) used to electronically store claim-related documents and evidence,
- A guided development plan,
- Automatic correspondence generation,

- Workload management tools, and
- Evaluation builder calculators to assist with rating decisions.

Sustainment funding is used to maintain all of the above features as well as the infrastructure supporting VBMS. Development to date has enabled VA to achieve the following recent successes and milestones:

- Nearly 95 percent of VBA's current claims inventory can be processed electronically, a 63 percentage point increase from June 2013.
- More than 2.8 million rating decisions have been completed in VBMS.
- More than 1.4 million claims have been completed in VBMS.
- Over 1.32 billion images are housed in electronic folders (eFolders) in VBMS.
- Over 1.5 million Disability Benefits Questionnaires (DBQs) have been processed in VBMS.
- More than 28,000 unique end-user accounts are supported in VBMS.

The VBMS software releases in FY 2015 include advanced automation features that deliver the following benefits:

- Improve visibility of workload, the status of claims, and access to information needed to make decisions and process claims;
- Help employees complete their work more efficiently and effectively;
- Reduce errors and organize tasks for employees; and
- Empower employees to successfully manage their work.

c. What percentage of total VBMS development has been completed?

Response: Rating claims can be completely processed electronically in VBMS. The purposes of ongoing development activities are to enhance existing functionality and application performance, deploy new features that will increase claims processing efficiency, add capabilities for additional work types, and help VA's workforce meet its strategic goals. Development plans are prioritized and tailored as new business requirements are identified by leadership.

d. If VBMS is fully funded according to the FY 2016 request, what will be the total budget authority provided for VBMS since its inception?

Response: Since inception in FY 2009, VA has invested \$783.5 million to create new functionality and \$507.2 million to maintain VBMS.

Question 23: What specifically does VBA intend to accomplish with the additional quarter of a billion dollars requested for VBMS, and will that complete development of VBMS?

Response: Releases scheduled for FY 2016 will focus on integration with systems, both internal and external to VA, and reducing reliance on legacy systems to improve access to information and make claims processing more efficient. Specific functionality

for FY 2016 includes:

- Automation to support pension claims processing,
- Integration to support and streamline Integrated Disability Evaluation System claims processing, and
- Functionality to support appeals modernization

This functionality will improve VA operations to deliver seamless and integrated support to help process all compensation and pension claims in a timely and accurate manner.

Question 24: Please describe in detail the functionality VBMS currently contains to process paperless appeals.

Response: Some appeals-specific functionality has been delivered for VBA and the Board of Veterans' Appeals (the Board). This functionality provides the Board's end-users with a distinct eFolder view, the ability to bookmark, and restricted viewing of the Board's annotations and notes. These features support paperless appeals processing with reduced reliance on legacy systems to retrieve information and documents. VBMS has collaborated with the Board's subject matter experts to create more appeals-specific requirements for future development.

Performance Standards

Question 25: VBA's process initiatives center around concepts such as the "national work queue" and "centralized mail" operations. But, these nationalized models will not address underlying issues in poorly performing Regional Offices.

As the Department looks to expand its workforce by several hundred employees, how will it set performance standards for your claims processing employees going forward?

Response: VBA recognizes that periodic review of the performance standards is necessary to ensure employees are accountable to the right measures based on new processes such as the national work queue and centralized mail. VBA's Office of Field Operations recently created workgroups to assess performance standards for claims processing employees. The workgroups are gathering data, evaluating how new technology and processes impact the work of claims processors, and then recommending changes to the current performance standards. Revised standards will be used to hold all claims processing employees accountable for performance.

NATIONAL CEMETERIES

Question 26. The National Cemetery Administration requests \$45,000,000 to fund grants for veterans cemeteries in 2016. The budget submission indicates that

these grant recipients, including state, territory, and tribal cemeteries, fulfilled 20% of total veteran interments in 2014.

What level of oversight does NCA have on these state, territory and tribal cemeteries; specifically, does the Department have a formalized inspection and enforcement authority, to ensure that grant recipients properly allocate the funds and properly maintain the cemeteries?

Response: NCA is committed to ensuring that all VA grant-funded cemeteries are maintained as national shrines dedicated to preserving our nation's history, nurturing patriotism, and honoring the service and sacrifice Veterans have made. NCA develops and maintains operational standards for State and Tribal Veteran cemeteries aimed at achieving this mission. 38 C.F.R. Part 39 provides guidance and procedures for the proper use of grant funding. To ensure State and Tribal Veterans cemeteries are being operated in accordance with the standards established by NCA and are providing the best possible customer experience, NCA established the Veterans Cemetery Grants Compliance Review Program. The Compliance Review Program also serves as a means to afford state and tribal Veterans cemeteries the opportunity to receive recognition as National Shrines.

As part of the Compliance Review Program, NCA performs on-site reviews of each state and tribal Veteran cemetery approximately once every five years. The reviews are conducted by NCA staff, or individuals appointed by NCA, in accordance with the requirements set forth in the National Cemetery Administration's *Operational Standards and Measures (States, Territories and Tribal Organizations)*. The reviews assess five key areas of cemetery operations: Interment Operations; Grounds Maintenance Operations; Headstone, Marker and Niche Cover Operations; Equipment Maintenance; and Other Operations. Upon completion of the review, NCA provides cemetery staff with a report detailing the cemetery's performance against NCA standards, National Shrine Status determination, strengths, and opportunities for improvement.

Any cemetery found to be non-compliant with NCA standards is required to develop a Memorandum of Agreement (MOA) which outlines a strategy and timeline for addressing any issues identified through the review process and achieving compliance with NCA standards. The MOA is agreed upon and signed by the Veterans Cemetery Grants Service (VCGS) Director as well as officials from the respective state or tribal program responsible for overseeing the cemetery. NCA coordinates with cemetery staff to track progress against the action plan outlined in the MOA to ensure the cemetery is working toward achieving compliance with NCA standards.

The results of any recent compliance review serves as an important factor to be considered when assessing grant applications submitted through the Veterans Cemetery Grants Program administered by VCGS. A history of non-compliance with NCA operational standards may adversely impact grant award decisions for a state or tribal organization seeking funds to establish, expand, or improve a Veterans cemetery.

Additionally, grant funding may be prioritized for cemeteries which require assistance to address major issues identified through the Compliance Review Program.

The VCGS Compliance Review Program provides NCA with quantitative information on compliance and improvements aligned with NCA operational standards, which ultimately leads to an improved overall customer experience.

Question 27. As regards the National Cemetery Gift Fund, the budget submission notes that Public Law 93-43, as amended, provides authority to accept gifts and bequests for the purpose of beautifying or benefitting national cemeteries. I am aware of a partnership in Florida, whereby the Sarasota National Cemetery partnered with The Patterson Foundation for the creation of "Patriot Plaza" - a ceremonial amphitheater that was funded by the Patterson Foundation. Does NCA have additional sites at this time where an individual or entity has engaged in a large scale gift or dedication?

Response: NCA is offered both monetary and physical gifts and donations for the purpose of beautifying or benefitting national cemeteries but there are no additional sites at this time where an individual or entity has engaged in a donation of the magnitude of "Patriot Plaza."

Question 28. Years ago, VA embarked on a plan called the National Shrine Initiative to eliminate the backlog of one-time repairs at VA's National Cemeteries and please detail the status of that effort. What is the number and cost of a one-time repairs needed today?

Response: In FY 2011, in order to maintain an up-to-date comprehensive assessment of repairs needed at the national cemeteries, NCA initiated an independent Facility Condition Assessment (FCA) process in which each cemetery facility is evaluated by a qualified independent team of contractors to identify needed repairs. An FCA is performed every three years on a staggered schedule for each cemetery facility by Memorial Service Network. An FCA contract is awarded to an Architectural/Engineering (A/E) firm to provide an independent assessment of the site, utilities, buildings, and building service systems and subsystems. Systems are evaluated, described, and graded from "A" to "F." Estimated correction costs are included for deficiencies graded "D" or "F." NCA completed the first series of assessments at the end of FY 2014.

NCA maintains the information and uses it to plan, justify, and fund projects to correct identified deficiencies. Corrective action is taken through Major and Minor Construction projects, Non-Recurring Maintenance (NRM) projects, and Maintenance and Repair projects.

Although the status of required repairs changes constantly, based on the results of the most recent assessments performed, the estimated number and cost of one-time repairs (for deficiencies graded "D" or "F") for each MSN is as follows:

MSN	Number of Repairs	Estimated Cost of Repairs in Millions	Assessment Completed
1	2,779	\$33.6	July 2013
2	1,289	\$13.3	August 2013
3	641	\$7.8	May 2014
4	428	\$23.6	June 2014
5	553	\$14.6	September 2014
Total	5,690	\$92.9	

The FY 2016 Budget requested \$2 million for NCA NRM projects, as well as \$69 million for minor construction projects, many of which will address repairs identified in the table above.

Question 29. If an entity or individual wishes to provide a gift to NCA on behalf of our veterans, does the current law enable VA to accept those gifts?

Response: According to Title 38 U.S. Code, Section 2407, "Subject to such restrictions as the Secretary may prescribe, the Secretary may accept gifts, devises, or bequests from legitimate societies and organizations or reputable individuals, made in any manner, which are made for the purpose of beautifying national cemeteries, or are determined to be beneficial to such cemetery." Additionally, NCA (Under Secretary for Memorial Affairs) has authority, as stated in regulation at Title 38, Code of Federal Regulations, Section 2.6(f)(3), "[t]o accept donations, except offers of land, made in any manner, for the beautification or benefit of national cemeteries."

Question 30. VA's budget submission notes that Land Acquisition funds in the Major Construction account provide NCA the flexibility to acquire land when an opportunity arises and not be encumbered by the timing of the budget process, and highlights many of the uncertainties that surround the process, of locating new cemeteries.

The 2016 request does not include land acquisition funding in "Major Construction" because it notes that current funds are sufficient to acquire land needed for all identified major expansions through 2016. However, it appears that the budget submission does contain two million dollars in the "Minor Construction" request.

To clarify, that funding is for potential expansion or site work at existing locations, or is can that also be used to purchase land for new National Cemeteries?

Response: The minor construction land acquisition funds are intended for the acquisition of small parcels of land that may become available for purchase in order to expand existing cemeteries that often have no land for additional development. These funds may not be used to purchase land for new national cemeteries or for a major construction expansion.

CHOICE PROGRAM

Question 31. Regarding the statement that the Administration will submit legislation to reallocate a portion of Choice program funding to support essential investments in VA system priorities in a fiscally responsible, budget neutral manner. If the Department admits that "more resources in certain areas" are needed, why are those resources not requested in this budget submission and when can we expect to receive this legislative proposal?

Response: H.R. 3236 Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 was passed and signed by the President on July 31, 2015. This law provides essential budget flexibility and authority to support Care in the Community through September 30, 2015. The Department appreciates this legislation as it also makes a series of amendments to the Veterans Access, Choice, and Accountability Act of 2014 and instituted additional requirements to improve access to care and VA's budgeting process.

Question 32. What amount of Choice funding will the proposal reallocate and in support of what other programs and given that VA's budget materials repeatedly references the high degree of uncertainty that exists regarding the Choice program-what data was used to support the allegation that the program is being "underutilized?"

Response: H.R. 3236 Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 was passed and signed by the President on July 31, 2015. The Choice Improvement Act provides a total of \$3,348,500,000 to be used for VA Community Care, of which up to \$500,000,000 can be used for Hepatitis C pharmaceutical expenses.

As of April 11, 2015, there were 43,971 authorizations for the Choice Program and 37,648 appointments scheduled. The Department of Veterans Affairs recognizes that early utilization of the Choice Program has not been as robust as expected. Based on input from all of our stakeholders: Veterans, Veterans Service Organizations, our employees, and Congress, the Department knows that many Veterans are frustrated with the Choice Program. The frustration and confusion is leading to the lower utilization of the Choice Program. The Department, however has been eagerly seeking feedback on the Program from these stakeholders and is working diligently to address any challenges that may be contributing to the low utilization.

Question 33. VA's budget submission assumes a \$452 million cost-shift in FY 2016 as a result of veterans seeking care through the Choice program who would otherwise seek care through VA facilities.

However, VA's budget materials also reference spending \$3.25 billion dollars on fee care through the Choice program in FY 2016.

This seeming disconnect continues in VA's assumptions for FY 2017, when VA anticipates a cost-shift of \$733 million while expecting the Choice program to fund \$2.83 billion in non-VA care.

Response: The Veterans Choice Program (VCP) may provide a measure of short-term relief from the pressure of escalating health care requirements as some current patients in the VA system elect to receive their care through the program. The 2016 and 2017 requests for Medical Services appropriations assume that some Veterans who would otherwise receive care in the VA health care system will now receive that care through VCP instead thereby reducing spending of the discretionary appropriations by the same amount. The assumed cost shift is \$452 million in 2016 and \$733 million in 2017.

Key assumptions in the cost-shift model:

- Consistent with the Regulatory Impact Analysis (RIA) for the Veterans Choice Program Interim Final Rule, we split the population into the two cohorts – (1) veterans living more than 40 miles from a VA facility (or meeting the other geographic criteria); and (2) Veterans waiting more than 30 days for their scheduled appointment.
- In general, we used the same assumptions that were published in the RIA, wherever possible.
- One of the most sensitive factors involves the assumption about how many eligible Veterans will participate in VCP. It's difficult to predict Veterans' behavior in response to this new choice, so we used a range of rates, from low to high.

40-mile group:

There are approximately 320,000 Veterans who are eligible for VCP based on this eligibility criterion. However, only about 58% of these Veterans use VA system for care, in any given FY. Therefore, we reduced the eligible population by 42%, resulting in about 185,000 Veterans for whom a cost shift could apply.

Next, we estimated the total annual cost of care that would have been provided in the discretionary program in FY 2015. Using projections from the Enrollee Health Care Projection Model, we estimated the annual cost of care per veteran in each of the eight priority levels. We excluded from the cost of care those services that would be unlikely to shift to VCP (e.g., recreational therapy), or are ineligible to shift (e.g., institutional long-term care).

Once we had these expenditures, the next step was to apply the assumptions on participation rates – what percent of these veterans would elect to receive care through the VCP instead of through the regular discretionary program? For the 40-mile group, we assume 20%, 40%, and 60% as the participation rate scenarios, which are based on the rates in the RIA.

The total estimated costs were discounted by the level of estimated veteran cost-sharing. Over the three-year period FY 2015-2017, this results in an estimated total cost-shift of \$600 million to \$1.8 billion, depending on the assumed participation rate. The Budget assumes \$219 million in FY 2016 and \$455 million in FY 2017 in cost-shift, for this cohort.

30-day cohort:

To determine the population, we modeled the total annual number of appointments that would meet the long-wait criteria (more than 30 days from either the date that is determined clinically appropriate, or absent this determination, the Veteran's preferred date).

Using VA's wait-time access data, there were 605,669 pending appointments over 30 days. We assumed each appointment stays on the wait list for 2 months, which implies that the annual number of appointments that qualify under the wait-time standard is 6 times the number of appointments on the list at any given point in time. We assumed a small portion of the waiting appointments may never have resulted in VA treatment. This yields an annual number of eligible wait-list appointments of about 3.27 million.

We next estimated the annual cost of care associated with these appointments. We used an average cost per appointment of \$295. Once we had these expenditures, the next step was to apply the assumptions on participation rates. For this group, we assume 35%, 60%, and 85% as the participation rate scenarios. The total estimated costs were then discounted by the level of estimated veteran cost-sharing. The estimate also assumes that as VA increases its capacity to deliver care in-house, the number of veterans waiting too long for care decreases each fiscal year.

Over the three-year period FY 2015-2017, this results in a total estimated cost-shift of \$620 million to \$1.5 billion, depending on the assumed participation rate. The Budget assumes \$233 million in FY 2016 and \$278 million in FY 2017 in cost-shift, for this cohort.

These estimates are highly dependent on the number of Veterans who choose to participate in VCP; to the extent that participation is higher or lower than anticipated, VA will realize more or less of a cost shift.

Question 34. What formula was used to determine the amount of cost-shift that would occur as a result of the Choice program?

Response: The Veterans Choice Program (VCP) may provide a measure of short-term relief from the pressure of escalating health care requirements as some current patients in the VA system elect to receive their care through the program. The 2016 and 2017 requests for the Medical Care appropriations assume that some Veterans who would otherwise receive care in the VA health care system will now receive that care through VCP instead, thereby reducing the discretionary appropriations request by the same amount. The assumed cost-shift is \$452 million in 2016 and \$733 million in 2017. These estimates are highly dependent on the number of Veterans who choose to participate in VCP; to the extent that participation is higher or lower than anticipated, VA will realize more or less of a cost-shift.

Key assumptions in the cost-shift model:

- Consistent with the Regulatory Impact Analysis (RIA) for the VCP Interim Final Rule, we split the population into the two cohorts – (1) Veterans living more than 40 miles from a VA facility (or meeting the other geographic criteria); and (2) Veterans waiting more than 30 days for their scheduled appointment.
- In general, we used the same assumptions that were published in the RIA, wherever possible.
- One of the most sensitive factors involves the assumption about how many eligible Veterans will participate in the VCP. It's difficult to predict Veterans' behavior in response to this new choice, so we used a range of rates, from low to high.
- 40-mile group:
 - i. There are approximately 320,000 Veterans who are eligible for VCP under this eligibility criterion.
 - ii. However, only about 58% of these Veterans use the VA system for care, in any given FY. Therefore, we reduced the eligible population by 42%, resulting in about 185,000 Veterans for whom a cost shift could apply.

- iii. Next, we estimated the total annual cost of care that would have been provided in the discretionary program in FY15. Using projections from the Enrollee Health Care Projection Model, we estimated the annual cost of care per veteran in each of the eight priority levels. We excluded from the cost of care those services that would be unlikely to shift to VCP (e.g., recreational therapy), or are ineligible to shift (e.g., institutional long-term care).
- iv. Once we had these expenditures, the next step was to apply the assumptions on participation rates – what percent of these Veterans would elect to receive care through VCP instead of through the regular discretionary program?
- v. For the 40-mile group, we assume 20%, 40%, and 60% as the participation rate scenarios, which are based on the rates in the RIA.
- vi. The total estimated costs were discounted by the level of estimated Veteran cost-sharing.
- vii. Over the three-year period FY15-17, this results in an estimated total cost-shift of \$600 million to \$1.8 billion, depending on the assumed participation rate.
- viii. The Budget assumes \$219 million in FY16 and \$455 million in FY17 in cost-shift, for this cohort.
 - 30-day cohort:
 - i. To determine the population, we modeled the total annual number of appointments that would meet the long-wait criteria (more than 30 days from either the date that is determined clinically appropriate, or absent this determination, the Veteran's preferred date).
 1. Using VA's wait-time access data, there were 605,669 pending appointments over 30 days. We assumed each appointment stays on the wait list for 2 months, which implies that the annual number of appointments that qualify under the wait-time standard is 6 times the number of appointments on the list at any given point in time. We assumed a small portion of the waiting appointments may never have resulted in VA treatment. This yields an annual number of eligible wait-list appointments of about 3.27 million.
 - ii. We next estimated the annual cost of care associated with these appointments. We used an average cost per appointment of \$295.
 - iii. Once we had these expenditures, the next step was to apply the assumptions on participation rates.

- iv. For this group, we assume 35%, 60%, and 85% as the participation rate scenarios.
- v. The total estimated costs were then discounted by the level of estimated veteran cost-sharing.
- vi. The estimate also assumes that as VA increases its capacity to deliver care in-house, the number of Veterans waiting too long for care decreases each fiscal year.
- vii. Over the three-year period FY15-17, this results in a total estimated cost-shift of \$620 million to \$1.5 billion, depending on the assumed participation rate.
- viii. The Budget assumes \$233 million in FY16 and \$278 million in FY17 in cost-shift, for this cohort.

Question 35. Why is there such a discrepancy between the relatively modest cost-shift that VA is anticipating in FYs 2016 and 2017 and the large amount of fee care that the Choice program is expected to fund?

Response: The assumed cost shift from Non-VA Care to the Veterans Choice program is \$452 million in 2016 and \$733 million in 2017. These estimates are highly dependent on the number of Veterans who choose to participate in the Veterans Choice Program; to the extent that participation is higher or lower than anticipated, VA will realize more or less of a cost shift. VA's estimates of Veterans Choice Program obligation assumptions are detailed in the Regulatory Impact Analysis provided to Congress. VA anticipates that its experience with the Veterans Choice Program in 2015 will be used to inform the 2017 budget process and the final 2017 funding requirements

GLOBAL

Question 36. The \$59.961 billion budget request for medical care represents an increase of \$1.299 billion above the FY 2016 advance appropriations level and a 7.4% increase over the FY 2015 enacted level. Of note, this increase is requested on top of the \$17 billion that the Department received just six months ago in Public Law 113-146. However, VA's patient population and workload are expected to increase only modestly.

Can you explain the seeming disconnect between the large increase VA is requesting to support the VA health care system and the nominal increases in patient population and workload that VA is projecting?

Response: VA's estimates are based on projections provided by the VA Enrollee Health Care Projection Model, as described in detail below.

VA Enrollee Health Care Projection Model

The VA Enrollee Health Care Projection Model supports more than 90 percent of the VA health care budget. The Model, which was first developed in 1998, is a sophisticated health care demand projection model and uses actuarial methods and approaches to project Veteran demand for VA health care. These approaches are consistent with the actuarial methods employed by the Nation's insurers and public providers, such as Medicare and Medicaid.

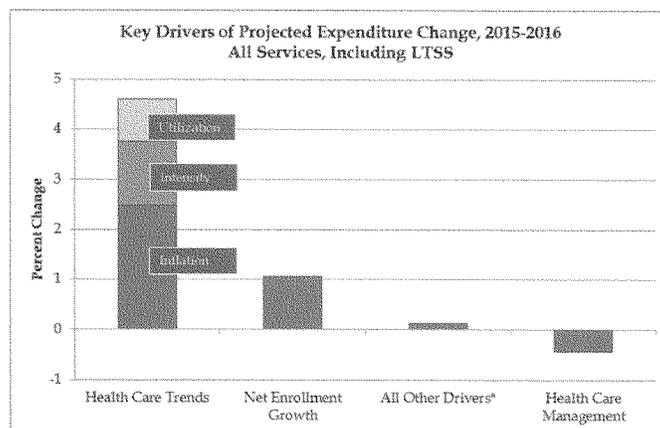
The Model projects enrollment, utilization, and expenditures for the enrolled Veteran population for 83 categories of health care services 20 years into the future. The Model consists of three main components. First, VA uses the Model to project how many Veterans will be enrolled in VA health care each year and their age, gender, priority level, and geographic location. Next, VA uses the Model to project the total health care services needed by those enrollees and then estimates the portion of that care that those enrollees will demand from VA (known as "reliance"). Finally, total health care expenditures are developed by multiplying the expected VA utilization by the anticipated cost per service.

Key Drivers of Growth in Projected Resource Requirements

In projecting future Veteran demand for VA health care, the Model accounts for the unique characteristics of the Veteran population and the VA health care system and environmental factors that impact Veteran enrollment and use of VA health care services.

The current growth in the Model is 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. Health care trends increase VA's cost of care independent of any growth in enrollment or demographic mix changes. Enrollment dynamics contribute to a portion of the expenditure growth; however, their impact varies significantly by the type of health care service. An assumption that VA's level of management in providing health care will improve over time is expected to reduce the cost of providing care to enrollees. Figure A quantifies the key drivers of the projected increase in expenditure requirements for FY 2016 for all modeled services.

Figure A



*Modeled initiatives, economic conditions, and reliance changes.

These drivers and their impact on the resources required to provide health care to enrolled Veterans are discussed in detail in the following sections.

Health Care Trends

Health care trends represent a significant driver of growth in the cost of health care in the United States and in the VA health care system. Health care trends (inflation, utilization, and intensity) represent anticipated changes in health care utilization and cost due to advances in technology, including new diagnostics, drugs, and treatments, as well as price inflation. Health care trends affect VA's projected expenditure requirements independent of any enrollment growth or demographic mix changes. The health care trends incorporated into the Model are informed by Federal policy and anticipated trends in Medicare, together with VA-specific trends for pharmacy and prosthetics, and private sector trends for services that VA routinely purchases (for example, maternity services).

Inflation is comprised of personnel and non-personnel components. Inflation on VA's personnel costs is determined by Federal wage policy, including wage increases. VA's projected inflation for pharmacy and prosthetics products reflects VA's well-managed purchasing programs for these products. VA's expected inflation on supplies, utilities, etc., is based on projected Consumer Price Index - Urban (CPI-U) and Producer Price Index (PPI) inflation trends for these items.

Utilization and intensity (cost) trends increase health care costs due to changes in health care practice and new technology. VA's costs are driven by these trends similar to other health care insurers and providers, because Veterans expect access to these advances in the VA health care system. The newly approved drug therapy to treat individuals infected with Hepatitis C is an example of how new technology increases VA's costs to

care for the enrolled Veteran population. These expensive drugs significantly increased VA's expected intensity trend for pharmacy in the 2014 Model.

VA's utilization and intensity trends for Medicare-covered medical services are informed by anticipated Medicare utilization and intensity trends, as projected by the Center for Medicare and Medicaid Services' Office of the Actuary. They have been adjusted downward for efficiencies in the VA health care system as compared to Medicare's primarily fee-for-service environment. VA's pharmacy and prosthetics trends are set by VA workgroups to reflect VA's unique practice patterns for these services.

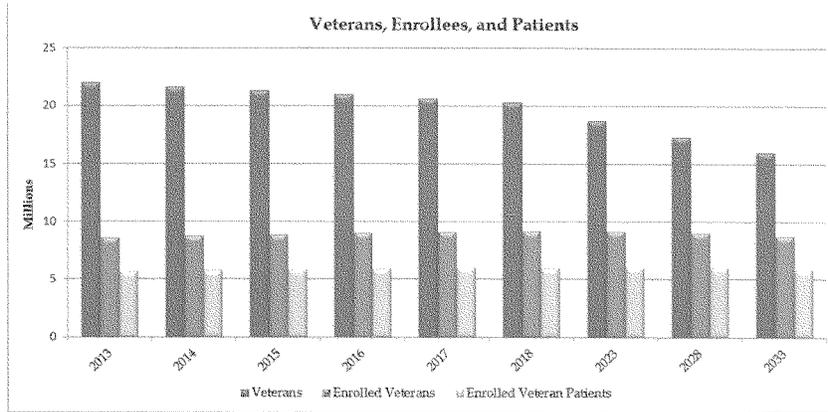
Net Enrollment Growth and Demographic Mix Changes

Veteran demand for VA health care is influenced by the following demographic characteristics of the Veteran population and environmental factors. Many of these factors are dynamic and are expected to change over time. Some can be anticipated (e.g. changing demographics) and some cannot (e.g. future economic downturns).

- Growth of the Operation Enduring Freedom/Operation Iraqi Freedom/ Operation New Dawn (OEF/OIF/OND) and female Veteran populations.
- Enrollee age, gender, mortality, income, travel distance to VA facilities, and geographic migration patterns.
- Increases in prevalence of service-connected conditions and changes in enrollee income levels. These are associated with transitions between enrollment priorities.
- Unique health care utilization patterns of OEF/OIF/OND, female, and new enrollees, and other enrollee cohorts with unique utilization patterns for particular services.
- Economic conditions, including changes in local unemployment rates and home values (as a proxy for asset values) and the long-term downward trend in labor force participation.
- New policies, regulations, and legislation, as introduced, such as the five-year OEF/OIF/OND combat enrollment eligibility period.

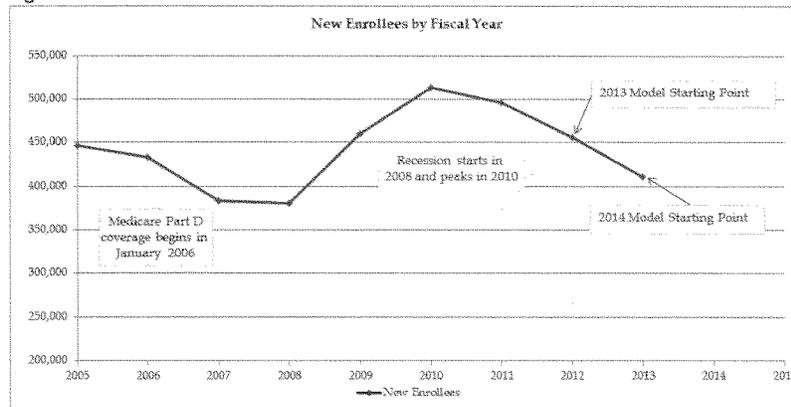
In the 2014 Model, using current assumptions, Veteran enrollment in VA is projected to grow by 6.6 percent from FY 2013 to FY 2021 even though the Veteran population is declining (see Figure B). This growth is largely due to the high enrollment rates for Gulf War and OEF/OIF/OND Veterans. After FY 2021, enrollment is projected to decline slightly as the impact of mortality in the enrollee population begins to outweigh new enrollment. As described below, costs for VA health care are dependent not just on the number of enrollees but on the demographics of the enrolled Veteran population.

Figure B



Veteran enrollment in VA is dynamic and responds to all of the demographic factors discussed above. Changes in the broader environment also impact Veterans' decisions to enroll. The decrease in new enrollment in FY 2006 and FY 2007 seen in Figure C was partially driven by the availability of the new Medicare drug benefit (Part D). The chart also shows the growth in new enrollment as a result of the economic recession and the decline in new enrollment as the economy has recovered. Of note, it is sometimes difficult to ascertain causal impacts due to the multiple factors changing over any given time period.

Figure C

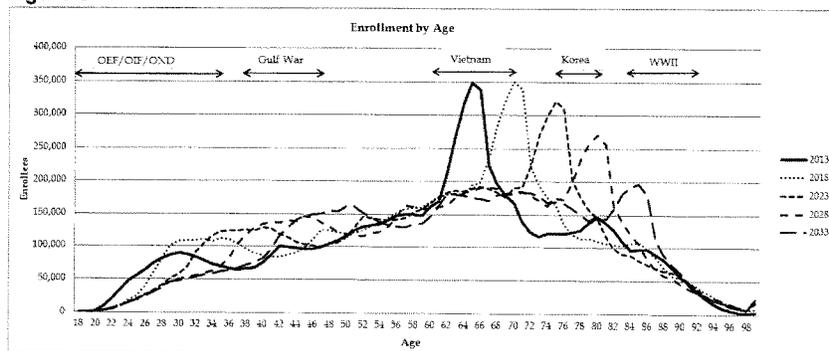


While the enrolled Veteran population is expected to continue to grow, net enrollment growth (new enrollment minus deaths) is not a significant driver of increases in annual expenditure requirements for VA health care. This is because the enrollees who are dying are generally sicker and more reliant on VA health care than new enrollees. However, the cost of caring for enrollees can change due to other demographic factors (e.g., aging) and changes in the broader environment (e.g., the economic recession).

Within the enrollee population, two dynamic demographic trends are impacting the projected future cost of VA health care: the aging of the Vietnam Era enrollee population and the increasing number of enrollees being adjudicated for service-connected disabilities, which increases the number of enrollees in Priorities 1, 2, and 3. These demographic trends combine in the Vietnam Era enrollee population with particular implications for demand for Long Term Services and Supports (LTSS).

Figure D shows actual enrollment in FY 2013 and projected enrollment by age and highlights the relative size of the Vietnam Era enrollee cohort compared to other period-of-service cohorts.

Figure D*



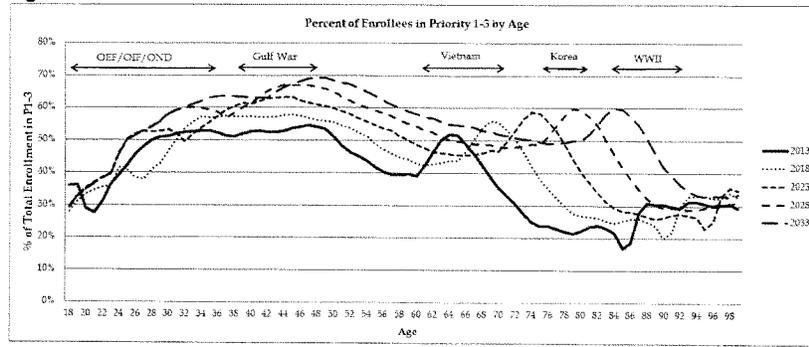
* The period of service cohorts in this and other charts are defined by enrollee age in 2013 because enrollee level data on period of service is not available for all enrollees. Note, an enrollee may be in the age range for the cohort and not have served in the conflict, and the cohorts are not mutually exclusive.

An enrollee's enrollment priority is dynamic. In recent experience, approximately 40 percent of new enrollees transitioned to a new priority level within three years of enrolling. Enrollees transition between Priorities 5, 7, and 8 due to changes in income. Enrollees also transition into Priorities 1, 2, and 3 as a result of adjudication for service-connected disabilities by the Veteran Benefits Administration.

The number and percentage of enrollees being adjudicated for service-connected disabilities has increased in recent years. As of FY 2013, about 7 percent of enrollees had transitioned from a non-service-connected priority into Priority 1, 2, or 3 within the previous three years, about double the rate as of FY 2007. Based on historical experience, these enrollees are also expected to increase their reliance on VA health care, resulting in an increase in the cost of care.

Figure E shows the significant projected growth in service connected status for OEF/OIF/OND, Gulf War, and Vietnam enrollee populations over the next 20 years. As a result of the increasing numbers of enrollees moving into Priorities 1-3, projected enrollment in Priorities 5, 7, and 8 is declining slightly.

Figure E



Further, as of FY 2013, 4.5 percent of enrollees had transitioned into Priority 1a (70 percent or higher service-connected disability) over the previous three years, compared with 2 percent as of FY 2007. As a result, the Priority 1a population is projected to grow by 25 percent between FY 2013 and FY 2016 and 72 percent between FY 2013 and FY 2023.

Aging and the changes in the Priority 1a population are significant drivers of projected expenditure increases for LTSS. VA is mandated by law to provide continuing care nursing home services to Priority 1a enrollees. Additionally, World War II enrollees are in the age bands (greater than age 75) that are the highest users of LTSS and are driving the recent and near-term annual growth in LTSS expenditure requirements, and Vietnam Era Veterans will be an increasing driver of LTSS expenditures, with most having aged beyond age 75 by 2026.

Enrollee Morbidity

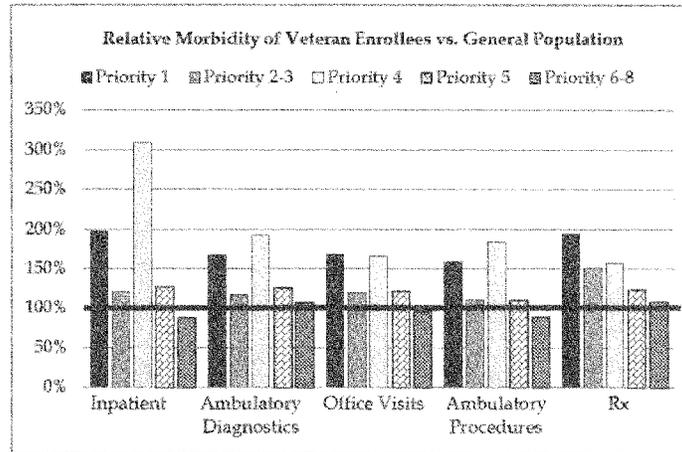
The VA enrollee population consists largely of older males, which is typically the segment of the population with the highest healthcare costs. Even after accounting for the age and gender mix of the enrollee population, the VA enrollee population is significantly more

morbid (sicker) than the general population in the United States, and this higher morbidity further increases VA's cost of providing care.

In the 2013 VHA Survey of Enrollees, 31 percent of enrollees rated their health as "fair" or "poor" compared to other people their age. Only 12 percent of the U.S. population responded similarly in Centers for Disease Control's (CDC) National Center for Health Statistics' 2012 National Health Interview Survey. Similarly, only 37 percent of enrollees rated their health as "excellent" or "very good" compared to 61 percent of the U.S. population in the CDC survey. Using a diagnosis-based methodology, the average morbidity of the VA enrollee population is estimated to be approximately 40 percent higher than that of the general U.S. population.

Morbidity varies significantly by priority level and health care service. For example, the morbidity of Priority 4 (catastrophically disabled) enrollees results in inpatient care costs that are five times that of the general U.S. population, even after accounting for the demographic differences in the populations. Figure F shows the relative morbidity of enrollees compared to the morbidity of the general population by priority for several large categories of health care services. In the figure, 100 percent reflects the cost of health care based on the morbidity of the general U.S. population.

Figure F



Enrollee Reliance on VA Health Care

An important aspect of the enrolled Veteran population is that many enrollees have multiple options for health care coverage in addition to VA: Medicare, Medicaid, TRICARE, and private insurance. According to the 2013 VHA Survey of Enrollees, approximately 81 percent of enrollees have some type of public or private health care coverage in addition to VA: 56 percent have one other source, 23 percent have two other

sources, and three percent have coverage through three or more sources in addition to VA. As a result, enrollees on average rely on VA for approximately one-third of their health care needs.

Figure G presents the impact of insurance coverage on reliance on VA health care. There is no clear information on why enrollees with no other form of insurance coverage are not 100-percent reliant on VA care. It may be due to a combination of factors, including personal choice, ease of access to VA health care, access of community health centers, availability of charity care, and/or survey response issues.

Figure G

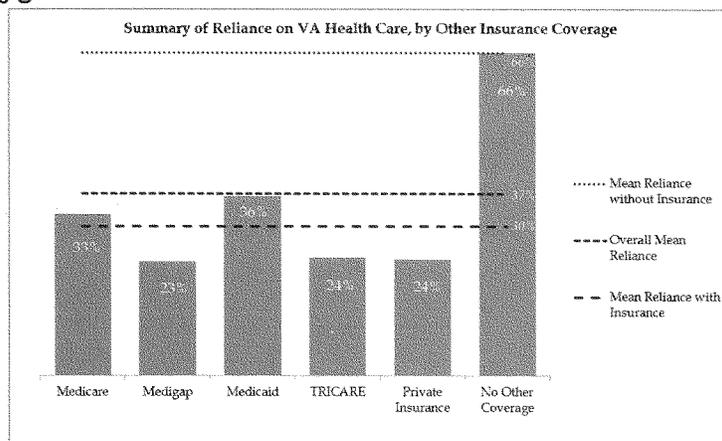
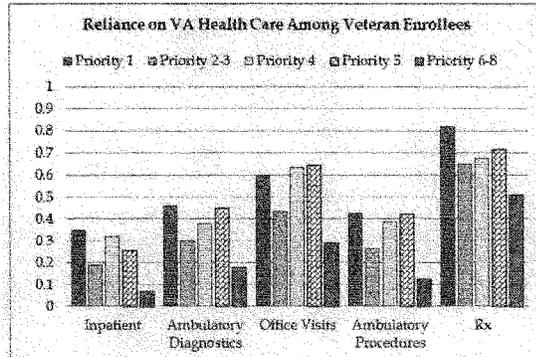


Figure H shows reliance by priority for several large categories of health care services. For example, Priority 4 enrollees get approximately 35 percent of the inpatient care they need in VA.

Figure H



Like Veteran enrollment and demographics, enrollee reliance on VA health care is dynamic. Changes in enrollee reliance occur as a result of many factors: enrollee movement into service-connected priorities; changing economic conditions; VA's efforts to provide Veterans access to the services they need (e.g., mental health and homeless initiatives); VA's efforts to enhance its practice of health care (e.g., Patient Aligned Care Teams (PACT)); the opening of new or expanded facilities; the cost sharing associated with services (e.g., dialysis) in the private sector compared to VA.

For example, enrollees' reliance on VA for dialysis services has increased from 18 percent in FY 2006 to 31 percent in FY 2013 and is expected to continue to increase through FY 2017. This increase is due in part to significantly lower cost sharing in VA. Enrollees have either a \$15 co-payment or no co-payment for dialysis treatments in VA. For Medicare enrollees, the co-payment is 20 percent of the cost of the treatment or approximately \$50 per treatment. This represents a potential difference of as much as \$7,500 in out-of-pocket expenses per year.

Enrollee Cohorts

Within the enrollee population, several cohorts of enrollees exhibit unique health care utilization patterns that reflect their morbidity and/or reliance on VA health care. These include OEF/OIF/OND, Vietnam Era, post-Vietnam Era, World War II Era, and female enrollees.

- OEF/OIF/OND enrollees have notably higher utilization rates than non-OEF/OIF/OND enrollees of the same age for many services. For mental health services, this is attributable to higher morbidity levels. However, for other services, the difference is attributable to the higher utilization rates typically experienced by new enrollees, and therefore, is not expected to persist over time. OEF/OIF/OND represents 12 percent of the enrollee population in FY 2013 and is expected to grow to 19 percent in FY 2023.

- Women are one of the fastest growing enrollee cohorts. Women comprise seven percent of the enrollee population in FY 2013 and are expected to grow to 10 percent by FY 2023. Females tend to use more health care than males at younger ages and fewer services than males at older ages. Women enrollees also use a different mix of services than the historically male-dominated enrollees. For example, females are more likely to use physical therapy and preventive services, but less likely to use cardiovascular services.
- Enrollees who used VA prior to the Eligibility Reform Act of 1996 (“Pre” enrollees) differ from those who enrolled after (“Post” enrollees). Pre enrollees are both sicker and more reliant on VA for health care and therefore, have higher utilization rates. These higher utilization rates are observed even after accounting for the higher average age of the Pre enrollees. Pre enrollees represented only 21 percent of enrollees in FY 2013, but accounted for 39 percent of modeled expenditures. Since there are no new Pre enrollees, this group is declining over time due to mortality; Pre enrollees are projected to decline to 12 percent of the population by FY 2023, but still account for 25 percent of expenditures.
- Vietnam Era enrollees (those born between 1947 and 1952) exhibit higher-than-average levels of utilization for some services, notably mental health and homeless services. Currently, this cohort is aging into Medicare eligibility with a corresponding drop in reliance on VA health care. As they age and transition into Priority 1a, Vietnam Era enrollees are expected to be significant users of LTSS. Vietnam Era enrollees represent 19 percent of the enrollee population in FY 2013.
- Enrollees who served immediately after Vietnam (those born between 1953 and 1963) have the highest healthcare utilization relative to other enrollees of the same age. These enrollees exhibit higher than expected needs for almost all mental health and substance abuse services and for a number of non-mental health services as well (e.g. emergency room visits). This cohort represents about 18 percent of the enrollee population FY 2013.
- World War II Era enrollees are high utilizers of Long Term Services and Supports, since those services are typically provided to older enrollees. This cohort represents less than 8 percent of overall enrollment in FY 2013.

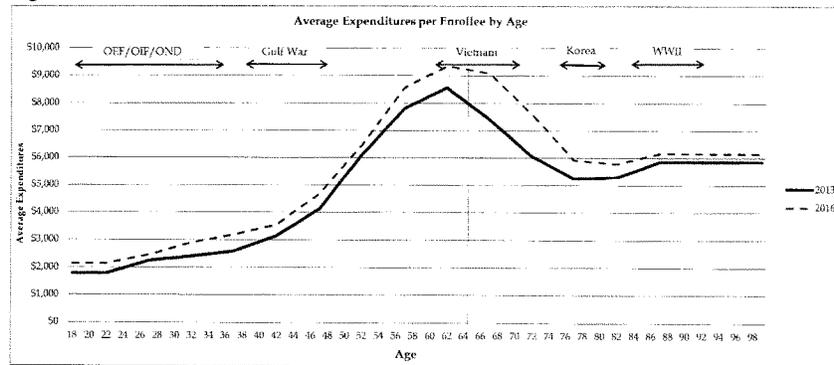
Expenditure Requirements by Enrollee Age

As discussed, many demographic and environmental factors influence Veteran demand for VA health care and the resources required to provide that care. Some of these factors increase VA’s resource requirements and some decrease VA’s resource requirements. Figure I shows the net impact of all the factors on expenditures.

In Figure I, the actual FY 2013 expenditures by age highlight the impact of key factors influencing the cost per enrollee. For the under age 65 enrollee population, the figure shows the impact of the increase in the need for health care services as enrollees age. It also highlights how the impact of aging is mitigated by a steep decline in reliance on VA

health care beginning at age 65 when enrollees typically become eligible for Medicare. Figure I also displays the projected increase in expenditure requirements to provide care to enrolled Veterans in FY 2016.

Figure I



Net Increase of \$1.299 Billion

In summary, the total net increase of \$1.299 billion is due to the following factors:

- Ongoing health care services estimate increased by \$599.9 million, driven largely by estimates of the cost of new Hepatitis C treatments and updated actuarial trends based on the latest actual data.
- A reduction in projected base appropriations health care costs due to enactment of the Veterans Choice Act; VA estimates that \$452 million in requirements will shift from the regular program as Veterans who would otherwise receive care in the VA health care system instead choose to participate in the new Veterans Choice Program, as established in the Veterans Choice Act and funded by section 802 of the Act.
- Long-Term Services and Supports estimate has increased by \$51.1 million, reflecting trends in the most recent actuals and the continued investment into non-institutional settings.
- Ongoing health service programs not projected by the Enrollee Health Care Projection Model (EHCPM) increased by \$221.6 million. The Caregivers program cost estimate increased by \$249.4 million, driven largely by an increase in the projected number of Caregivers receiving stipend payments. The combined sum of the estimates for CHAMPVA, reimbursement to the Indian Health Service and tribal health programs, caring for eligible Camp Lejeune Veterans and families, and

readjustment counseling decreased by \$27.8 million based on updated actuals and revised assumptions in workload for Camp Lejeune and Indian Health Service.

- VA programs to end Veterans' homelessness increased by \$128 million, for a total of \$1.393 billion. The increased estimate allows VA to fully support projected utilization in its homeless programs, including the Supportive Services for Veterans Families (SSVF) program and the Department of Housing and Urban Development-VA Supportive Housing program (HUD-VASH).
- Healthcare Infrastructure Enhancements increased by \$666.9 million. Facility activation costs have increased by \$468.2 million over the initial advance appropriation estimate of \$130 million to \$598.2 million; the initial estimate was based on construction delays that have caused under-execution of activations in recent years. However, VA has made progress in resolving these issues, and as a result has increased confidence that the additional funding will be required in FY 2016. The cost estimate of supporting the Veterans Integrated System Technology Architecture (VISTA) evolution project has been revised downward from \$208.3 million to \$159.6 million. Estimated non-recurring maintenance obligations grew from \$460.6 million to \$708.0 million, to address high-priority emerging capital needs as identified through the Strategic Capital Investment Planning (SCIP) process; this increase excludes funding provided by the Veterans Choice Act. See Volume 4, Chapter 7 for additional information on the SCIP process and the NRM program.
- The cost of VHA proposed legislation remains nearly unchanged with an estimated cost decrease of \$0.5 million. The 2016 budget includes estimates for Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) healthcare benefits for beneficiaries up to age 26.
- Additional budgetary resources decreased by \$84.4 million (collections, reimbursements and transfers). The estimate for the Medical Care Collections Fund decreased by \$26.3 million. Reimbursements decreased by \$51.0 million and transfers to the Joint DoD-VA Medical Facility Demonstration Fund increased by \$7.1 million.

Question 37. What specific outcomes are these increases expected to help achieve?

Response: See table below.

Topic	Dollars in Thousands	Comments
Health Care Services	\$599,920	Additional funds required to treat nearly 6.9 million unique patients, supports continuing improvements in

Topic	Dollars in Thousands	Comments
		the delivery of mental health care, and specialized care for women veterans, and new treatments for Hepatitis C. Hepatitis C estimate reflects additional demand for Hepatitis C Virus (HCV) treatment with the newly available drugs. Total number of treatments is expected to grow to nearly 12,000 in 2015 and beyond.
Veterans Choice Program Cost-Shift	(\$452,000)	Shift in requirements from the regular program as Veterans who would otherwise receive care in the VA health care system instead choose to participate in the new Veterans Choice Program.
Long-Term Services and Supports (LTSS)	\$51,065	Reflects continued investment into non-institutional settings (5.3% increase over the Advance Appropriation). Aging and the changes in the Priority 1a population are significant drivers of the projected expenditures increases for LTSS. World War II enrollees are in the age bands (greater than age 75) that are the highest users of LTSS and are driving the recent and near-term annual growth in LTSS expenditure requirements. Average Daily Census (ADC) levels of nearly 41,000 are anticipated in Institutional long-term care.
CHAMPVA, Spina Bifida, FMP, & CWVV	\$29,012	<u>Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)</u> – Beneficiary must be the spouse or child of a Veteran who has a total and permanent service-connected disability, or the widowed spouse or child of a Veteran who: (a) died as a result of a service-connected disability; or (b) had a total, permanent disability resulting from a service-connected condition at the time of death; or (c) died on active duty and in all cases the family member is not eligible for medical benefits under the Department of Defense (DoD) TRICARE Program. <u>Foreign Medical Program (FMP)</u> – Health care benefits program for United States Veterans with VA-rated service-connected conditions that are residing or traveling abroad, excluding the Philippines. <u>Spina Bifida</u> – VA administers the Spina Bifida Health Care Benefits Program for birth children of Vietnam Veterans diagnosed with spina bifida (excluding spina bifida occulta). <u>Children of Women Vietnam Veterans (CWVV)</u> – VA administers the CWVV program for children with certain birth defects born to women Vietnam Veterans.
Caregivers (Title I)	\$249,380	Increase driven largely by an increase in the projected number of Caregivers receiving stipend payments.

Topic	Dollars in Thousands	Comments
Indian Health Services (PL 111-148)	(\$10,587)	Decrease based on updated actuals and revised assumptions in workload.
Camp Lejeune – Veterans & Family (PL 112-154)	(\$52,186)	Decrease based on updated actuals and revised assumptions in workload.
Readjustment Counseling	\$5,939	Inflationary increase
Ending Veterans Homelessness	\$128,000	Increase allows VA to fully support projected utilization in its homeless programs, including the Supportive Services for Veterans Families (SSVF) program and the Department of Housing and Urban Development – VA Supportive Housing program (HUD-VASH).
VISTA Evolution	(\$48,669)	Revised assumptions
Non-Recurring Maintenance	\$247,400	Addresses high-priority emerging capital needs as identified through the Strategic Capital Investment Planning (SCIP).
Activations	\$468,174	Initial estimate was based on construction delays that have caused under-execution of activations in recent years. However, VA has made progress in resolving these issues, and as a result has increased confidence that the additional funding will be required in 2016.
VA Legislative Proposals	(\$539)	Cost remains nearly unchanged. Includes estimate for CHAMPVA healthcare benefits for beneficiaries up to age 26.
Funding Availability	(\$84,381)	Additional funds required to cover decreases in the Medical Care Collections Fund, reimbursements and an increase in the transfer to the Joint DoD-VA Medical Facility Demonstration Fund.
Annual Appropriation Adjustment	\$1,299,290	

HIGH RISK LIST

Question 38. The Government Accountability Office (GAO) has added veteran health care to their biennial "high risk" list, which highlights government programs most in need of transformation due to financial and management deficiencies and/or vulnerability to fraud, waste, and abuse. The Committee was informed that VA has implemented only 20% of the 170 GAO recommendations made over the last five years relating to VA health care.

What is your action plan and timeline for addressing each of the problem areas GAO referenced?

Response: The Department of Veterans Affairs' (VA) Veterans Health Administration (VHA) was included in this year's Government Accountability Office's (GAO) High-Risk Report. Any GAO recommendation about a VA program or policy is taken very

seriously. During this critical time of organizational change, appropriate oversight is important and VA appreciates the oversight role in order to help the Department as we continue to change and develop this robust system that Veterans have earned and deserve.

This particular report highlights the issues that are important to Veterans and the public. In many ways, VHA is on the cutting-edge of the industry. In others areas, we realize we need to make significant improvements.

VA recently implemented important changes to remedy many of the issues and concerns identified by GAO. In September 2014, VA began the *MyVA* initiative, which will refocus VA's efforts to view customer service from a Veteran's perspective. With that, VHA's future goals are to ensure:

- 1.) That Veterans have a clear understanding of VA and where to go for what they need within any of VHA's facilities;
- 2.) That employees are empowered with the authority, knowledge, and tools they need to solve problems and take action, and;
- 3.) That the products and services that VHA delivers to Veterans are integrated within the organization.

In August 2015, the Under Secretary for Health charged a diverse workgroup including central office and field representatives to develop a plan and implement process changes to improve enterprise policy management in VHA and assisting the field in developing appropriate local policies that align with national policies and clearly state oversight criteria and requirements. The recommendations including implementation and communications plans are scheduled to be completed by Q2 FY2016. This effort will assign responsibilities for the implementation of strategies identified within the plan including implementation accountability and a consistent, sustainable policy monitoring and reporting process for VHA. In addition, the workgroup is working to create a clear training plan that will be integrated with specific policies to ensure that employees' receive the required training to comply with the policy requirements.

VA will continue to identify and rectify issues within our Department. We respect GAO's work, and we share their goal of ensuring Veterans are provided with the high quality health care they have earned and deserve.

Question 39. Why have 80% of GAO's recommendations been ignored by the Veterans Health Administration and when will they be fully implemented?

Response: The Veterans Health Administration (VHA) values GAO's input and recommendations for improvements to Veterans' health care and the fiduciary stewardship of this Federal Agency. VHA promptly initiates action on GAO recommendations with which the Agency concurs. Of the 44 GAO reports containing

open VHA recommendations from fiscal years 2010 to 2015, GAO closed 46 recommendations based on VHA's completed actions; GAO is considering VHA's request for closure on an additional 39 recommendations based on completed actions; and VHA continues to take action on 72 recommendations. Each of the remaining open recommendations have an independent timeline for completion; each timeline depends on the nature of the recommendation and the complexity of actions required to complete it. GAO and VHA meet regularly to discuss open recommendations, actions underway, and documentation that GAO needs to assess VHA's completed actions.

Many of GAO's recommendations require multi-year, complex, project planning and implementation across all 153 VA medical centers. GAO recommendations requiring new information technology (IT) capabilities made to VHA after passage of the year's appropriations bill are often delayed until funding becomes available, and then actions on the recommendation must outweigh other congressional and agency IT priorities before the recommendation can be funded, designed, tested, and implemented. VHA actions also take longer to complete when GAO recommendations require interagency coordination, such as with Indian Health Service, Department of Defense, and Health and Human Services.

Supporting Data: GAO recommendations to VHA from March 30, 2010 to March 30, 2015

Total number of recommendations made by GAO in open reports: 157

Number of recommendations GAO already closed based on completed VHA actions: 46

Number of recommendations GAO is considering for closure based on completed VHA actions: 39

Number of recommendations with ongoing actions: 72

MYVA

Question 40. One of the major reforms of the MyVA initiative, according to testimony, is that it will allow for, "...better integration of the Department by moving from nine separate regional maps to one." Yet, no information has been released to-date regarding how the 21 Veterans Integrated Service Networks (VISNs), a significant organizational component of the VA, will be aligned under this "single regional framework."

Please clarify how the VISNs will be organized under the MyVA initiative?

Response: As with many other MyVA initiatives, the intent of moving to five districts is more effective and efficient internal VA operations that, in turn, will result in better

service to Veterans.¹ The goal is better coordination and an improved Veteran experience. The new district alignment is based upon state boundaries and will align the disparate organizational boundaries of the Department into a single framework, easing internal coordination and collaboration between business lines. This will make the department more seamless to Veterans, who will begin to perceive their interactions with one VA rather than individual organizations. The end goal is that our internal operating boundaries will be transparent and irrelevant to Veterans. Basing the framework upon state boundaries will also enhance collaboration with external stakeholders, e.g. Congress.

To be clear, however, the three Administrations (VHA, VBA, and NCA) remain responsible for the delivery of their respective services and benefits and the district construct does not change those responsibilities or the reporting chains within each administration. The three administrations have been tasked to align their operations within the five district construct. VA will ensure its field structures fit within the new district framework.

In the case of VHA, the Secretary of Veterans Affairs has tasked VHA to examine the how to align its VISN structure within the state-based boundaries of the district framework. VA is currently finalizing its plan to realign the VISNs under the MyVA initiative. This realignment will likely result in some consolidation of the number of VISNs with several VISNs within each district. Although the analysis is not yet complete, we anticipate a decision in the near future. VA stakeholders will be offered a briefing once the plan is finalized.

Question 41. Would this regional framework result in any changes in how VHA approaches the VA Medical Surgical Prime Vendor Program?

Response: The district framework will result in a change to how VA approaches the Medical Surgical Prime Vendor (MSPV) Program.² These geographic areas take into account the new VA district framework and have been coordinated with VA's Office of Small and Disadvantaged Business Utilization. VA is currently conducting an end-to-end examination of a number of our internal support services, including acquisitions, to determine the most efficient and effective means to operate. However, at this time there is no reason to believe that the new district framework will impact the Medical

¹ VA named the five operational areas "districts" rather than "regions" to avoid confusion with the current VBA Regional Offices (ROs).

² VA named the five operational areas "districts" rather than "regions" to avoid confusion with the current VBA Regional Offices (ROs).

Surgical Prime Vendor Program.

Question 42. What exact outcome measures will be used to assess the "success" of the MyVA initiative?

Response: The MyVA Task Force is currently developing outcome performance measures within each of the major workstreams as part of an integrated operating plan. More specifically, performance measures are being developed for "Veterans Experience" and "Employee Experience" that will be used to support VA's FY2016 – FY2017 Agency Priority Goal Measures, per OMB Circular A-11.

SECTION 801 SPENDING PLAN

Question 43. Per the budget submission, "VA plans to obligate \$1.3 billion of the \$5 billion provided in Section 801 of the Veterans Choice Act for non-recurring maintenance (NRM)."

Does this explain the significant drop in your 2016 estimate of \$708 million as compared to the 2014 actual of \$1 billion spent on Non-Recurring Maintenance?

Response: Section 801 of the Choice Act provided \$1,291.8 Million for Non-Recurring Maintenance (NRM). VA developed and submitted a Spend Plan for these funds that provided \$759.185 Million in FY 2015 and \$532.615 Million in FY 2016. The Choice Act NRM funds are in addition and separate from the FY 2016 Budget Request for NRM.

Question 44. The budget submission states that, "VA plans to obligate \$225.2 million of the \$5 billion provided in Section 801 of the Veterans Choice Act for IT infrastructure.... VA cost estimates associated with new activations include \$28 per square foot for lease and new construction, and \$6,600 per new employee."

Question 45. How are these IT costs accounted for currently?

Response: Section 801 of the Veterans Choice Act ("the Act") provided funding to activate new leases and add additional IT staff and equipment. These new leases, additional IT staff, and equipment are to address activations that occur as a result of the Act, which is in addition to activations that are funded by VA's IT Appropriation.

Funding for IT Infrastructure		
(\$ in millions)	FY 2015	FY2016
Lease activations	\$36.4	\$33.6
Constr. Activities	\$13.5	\$5.2
Equip New VHA Staff	\$32.2	\$63.4
Added IT staff & Equip	\$13.6	\$27.3
	\$95.7	\$129.5

The buildout of IT resources for facilities acquired or expanded under "the Act" (lease and construction) includes the wiring and cabling or network drops, local server requirements, network connections, and other ancillary IT requirements to bring new VHA space on-line. The estimate of \$28 per square foot is the same amount use for standard construction appropriation. The \$6,600 per employee will provide desktops, laptops, tablets, phones, printers, software, and other end-user IT equipment and services for over 4,000 new VHA employees.

Question 46. How is IT maintenance paid for?

VA Response: IT maintenance is currently paid for through expenditures from the IT Appropriation for VA; after the expenditure of the activation funds made available through Section 801 of the Act, the new maintenance requirements will be incorporated into the IT budget going forward.

IT INTEROPERABILITY

Question 47. In your budget, you state, "in addition to VISTA improvements, the VHA 2016 investment supports our commitment to achieve interoperability with the Department of Defense's electronic health record and community health care providers, including those who are participating in the new Veterans Choice Program"

With a 136% increase in EHR and VISTA funding from FY 2015 to FY2016, and given your stated emphasis on making the seamless transition between systems, can we now expect to see the Third Party Administrators and non-VA providers provided with operational access to VISTA and what is your timeline for achieving interoperability with DOD?

Response: As a point of clarification, the Office of Information & Technology budget for the VistA Evolution Program, made up of the VistA Evolution, EHR Interoperability, and VLER Health categories, did not increase by 136% between FY 15 and FY 16. There was a 32% decrease in funding between the FY 15 enacted level of \$343.6M to the FY 16 requested level of \$232.6M. Additional detail is below.

Appropriation Fiscal Year OI&T (Dollars in Thousands)		
FY 2015		
	DME	OM
VistA Evolution	\$179,922	\$89,484
EHR Interoperability/VLER Health	\$49,208	25,000
Total DME and OM	\$229,130	\$114,484
Total		\$343,614

Funding by Fiscal Year OI&T (Dollars in Thousands)		
FY 2016 (President's Budget Submission)		
	Development, Modernization, Enhancements (DME)	Operations and Maintenance (OM)
VistA Evolution	\$81,900	\$100,700
Interoperability	\$15,000	\$15,000
Virtual Lifetime Electronic Record (VLER) Health	\$10,000	\$10,000
Total DME and OM	\$106,900	\$125,700
Total		\$232,600

In accordance with the FY14 NDAA, Section 713, "by December 31, 2016 VA will ensure that its EHR system is interoperable with DoD's EHR system, provide an integrated display of data, and comply with national standards and architectural requirements, as identified by the IPO." However, the Department of Veterans Affairs' (VA) has health data interoperability now. Clinicians at VA and DoD facilities already have real-time access to both Servicemember and Veteran patient health information. Today, a Servicemember can receive care at a DoD medical facility, where information about the visit is recorded into DoD's EHR. The Servicemember can visit a VA medical facility and the information from the DoD visit is automatically available in VA's EHR, allowing the VA clinician to properly care for the Servicemember. Additionally, VA is a world leader in safe and secure health information sharing. VA invented VA Blue Button, a program that lets any VA health system patient download a portable copy of his/her health record from their computer. VA also established a groundbreaking program that allows Veterans to receive select immunizations at local pharmacies, such

as Walgreens, and the immunization information updates into the Veteran's VA electronic health record.

The VA's Electronic Health Record (EHR), VistA, is continuing to evolve to meet a number of clinical and technical objectives, including achieving new levels of interoperability, while DoD is pursuing the acquisition of a new system to provide these abilities. VA's work is being done under the VistA Evolution Program. Achieving meaningful interoperability with a wide range of healthcare systems is critical to both agency missions because nearly 50 percent of DoD care and over 30 percent of VA care today is handled by third-party providers. VA will continue mapping data from the way it is currently stored in VistA to suitable national standards. (This mapping is a near term strategy to provide near-term clinical benefits.) Further, VA will also begin moving to using national standards natively in VistA in order to move away from the manually intensive mapping and remapping. These national standards will also be updated yearly. VA will also move to enhance its VistA standardization program by upgrading the VistA file structure, known as FileMan, which will allow VA to have a more effective way to access data sources for interoperability within VA, with DoD and with private providers.

Additionally, the VA's Virtual Lifetime Electronic Record (VLER) Health Project is being developed to provide a secure, nationwide, interoperable health information infrastructure that will connect with approved Healthcare providers, consumers, and others involved in supporting Veteran's healthcare through a secure network known as eHealth Exchange. Currently, tens of thousands of records are sent between VA and Third Party Providers who are registered Exchange partners. VA currently has 55 exchange partners. A list along with details to sign up new exchange partners can be found here: <http://www.va.gov/VLER/vler-health-your-area.asp>.

Under our "Get the Data Back" initiative, VA is currently developing methods that will allow us to more efficiently share data with private sector providers on an as-needed basis that minimizes risks to patient privacy and costs to the taxpayer. Under this initiative, providers treating VA patients would be given limited access to information on that patient in VistA and the private sector provider's clinical notes on the Veteran would be captured in a way that was more easily reviewed by VA clinicians.

CAREGIVER

Question 48. Cost estimates for the caregiver program increased by \$249.4 million due to an increase in the project number of caregivers receiving stipend payments.

The Government Accountability Office (GAO) issued a report last fall which found that: staffing was insufficient to meet higher-than-expected caregiver demand at

some VA medical centers; staffing shortages impeded the timeliness of key functions and negatively affected services to caregivers; and, oversight of the Family Caregiver program was impeded by IT system limitations.

What actions has VA taken to address these issues?

Response: The Government Accountability Office (GAO) issued a report last fall which found that: staffing was insufficient to meet higher-than-expected caregiver demand at some VA medical centers; staffing shortages impeded the timeliness of key functions and negatively affected services to caregivers; and, oversight of the Family Caregiver program was impeded by IT system limitations.

VA concurs with the three recommendations in the GAO report and is currently addressing all 3 recommendations. VA continues to increase the number of Caregiver Support Coordinators (CSCs) located in facilities across the country. At the end of FY14, VA was centrally funding 267 positions, an increase of 34 positions since the publication of the GAO report. In addition, VA is making changes to the current IT system, allowing other VA staff to assist CSCs with administrative tasks, allowing CSCs to focus on the application process for the Program of Comprehensive Assistance of Family Caregivers. In addition, the Caregiver Support Program Office is evaluating the current policy and procedures for monitoring the well-being of Veteran participants. Currently, VA uses home visits to provide this oversight. Under new guidance, local medical centers will have more flexibility to determine the appropriate level of oversight based on the clinical needs of the Veteran. This new guidance was rolled out nationally in May 2015.

The National Caregiver Support Program Office has engaged leadership at medical centers through publishing a memo with specific guidance regarding the Program of Comprehensive Assistance for Family Caregivers and through briefings of leadership in various programs including mental health.

VA's Office of Information and Technology (OI&T) is currently involved in a two phased project in support of the Caregiver Support Program. The first phase is to provide added support and increased data integrity to the existing Caregiver Application Tracker (CAT). As a short-term solution. This initial phase of the project is referred to as CAT Rescue. The contract for CAT Rescue was awarded in July 2015 and a deployment is planned for June 2016. The second phase of the project involves the design and implementation of a new replacement IT solution referred to as CareT. A CareT contract award is anticipated for the end of September 2015; however a deployment of the new system is not anticipated until September 2017.

Question 49. How much, if any, of the projected increase in caregiver funding will be devoted to increasing caregiver staffing and/or resolving caregiver IT system issues?

Response: The Caregiver Support Program Office has requested an increase of \$4 million in FY 2016 to increase staffing of field-based Caregiver Support Coordinators. None of the increase in caregiver funding will be devoted to resolving caregiver IT systems. The IT projects described above are funded through OI&T.

PAIN MEDICATION MANAGEMENT

Question 50. The management of patients experiencing acute or chronic pain and the amount of prescription medications - particularly high-risk opioid medications -that these patients receive remains a concern

I understand that VA is, "...soliciting studies to examine the implementation of new informed consent processes for patients being prescribed long-term opiate medications for pain." Please elaborate on that?

Response: VA's Health Services Research and Development Service put out a Request for Applications (RFA) in December 2014, Targeted Solicitation for Service-Directed Research Award: Research on VHA Policy Directive on Informed Consent for Long-Term Opioid Therapy for Pain: Application to Patients with Cancer. (See attached) There has been one submission which is currently under review and nothing has yet been funded.



Opioids SDR
RFA.PDF

Question 51. What actions do you have planned for FY 2016 regarding pain and medication management, particularly in response to the troubling reports regarding alleged inappropriate prescribing and abuse of authority at the Tomah VA medical center? What is the cost for the Opiate Pain Management tool and is it fully integrated into VA health IT systems?

Response: VA is deeply concerned with and is actively addressing the overuse and dependence on opioid medications by Veterans. After many years of promoting the aggressive treatment of pain with powerful opioid analgesics, the United States is in the midst of an epidemic of misuse and abuse of opioid analgesics. The extent and complexity of our nation's Veterans multiple chronic pain conditions, including many severe battlefield injuries associated with blasts and co-morbid traumatic brain injury and/or psychological conditions such as depression and post-traumatic stress disorder, often make effective pain management clinically challenging and increase the risks for complications due to both over- and under-treatment with opioids and other therapies.

In the months following the clinical review findings for Phase 1 of the VA investigation at

Tomah VAMC, the medical center has been vigorously pursuing implementation of the Opioid Safety Initiative (OSI) similar to other VA facilities to ensure optimal pain management and to safeguard Veterans from harm inherent in high-risk medications such as opioids and benzodiazepines. The objective of OSI is to make the totality of opioid use visible at all levels in the organization with a particular emphasis on identifying and remediating prescribing practices that place Veterans at increased risk for adverse outcomes. To assist Veterans, providers and clinical teams in achieving OSI goals for safer opioid prescribing practices, an interdisciplinary VHA Task Force assembled a 15 module, peer-reviewed OSI Toolkit that is continually updated as new information becomes available, including new evidence-based practices. The OSI Toolkit is accessible to all VHA clinicians and disseminated widely and repeatedly through multiple communication channels and educational formats to facilitate safe opioid prescribing practices.

The Opioid Therapy Risk Report (OTRR) is a patient-focused, actionable and provider-specific report that is available to Primary Care Providers (PCP), Primary Care Managers, PAC Teams, Clinical Pharmacists and others who need to identify patients receiving long-term Opioid Therapy (OT). The cost to build the OTRR report is approximately \$125K. The majority of costs are in salary and benefits. The efforts of 4 staff total about 75% of a GS13 FTE estimated to be \$150K. Additional costs include travel to Florida for a VA eHealth University presentation for 2 travelers and production costs. Support costs in FY16 will likely be much lower.

The OTRR report is accessible to all PACT staff through the CPRS tool menu and through the VSSC website through the Almanac. Additionally, other staff such as other prescribers, specialty providers and facility managers can access the information through a new stand-alone OTRR report: [Opioid Therapy Risk - Individual Patient](#). Lastly, a BHIP OTRR report has been developed for BHIP teams to manage their paneled patients on long term opioid treatment: [Opioid Therapy Risk for BHIP Teams](#). It is fully integrated into VA health IT systems, pulling data directly from the CDW data warehouse and updating frequently.

To date, every VISN has used the OTRR report though one means or another. Specifically in FY15, 6,948 individuals have accessed the OTRR reports with 48,905 web hits. To make the reports easier to use and faster to update, VSSC continue to make reporting and processing improvements.

Part I - Overview Information**Department of Veterans Affairs****Participating Organizations**

Veterans Health Administration, Office of Research and Development (VA-ORD).

Components of Participating Organizations

Health Services Research and Development (HSR&D) Service, VA-ORD.

Title: Targeted Solicitation for Service-Directed Research Award: Research on VHA Policy Directive on Informed Consent for Long-Term Opioid Therapy for Pain: Application to Patients with Cancer

Announcement Type

New.

NOTICE: Applications submitted in response to this Request for Applications (RFA) must be submitted electronically through Grants.gov (<http://www.grants.gov>) using the Adobe-compatible version of the SF424 Research and Related (R&R) forms. Only Adobe-based application packages may be submitted.

This RFA must be read in conjunction with the VA version of the SF424 (R&R) Application Guide available on the VA-ORD **Intranet** site at <http://vaww.research.va.gov/funding/electronic-submission.cfm>. Several registration processes must be completed before an electronic application can be submitted (See [Section IV](#)). Applicants must provide their completed application to the appropriate VA institutional signing official for submission to Grants.gov. Applicants are highly encouraged to start the submission process well in advance of the submission deadline to ensure it passes the validations performed at Grants.gov and the National Institutes of Health (NIH).

Request for Applications (RFA) Number/Funding Opportunity Announcement (FOA) Number: HX-15-014

For Assistance downloading this or any Grants.gov application package, please contact Grants.gov Customer Support at <http://grants.gov/CustomerSupport>.

Catalog of Federal Domestic Assistance Number(s) (CoFDA)

Not Applicable.

Key Dates

Release/Posted Date: December 15th, 2014

Opening (earliest submission to Grants.gov) Date: December 15th, 2014

Only investigators with a previously approved Concept Paper may submit an application in response to this RFA. All applications received from investigators without an approved concept paper will not be accepted or reviewed.

Application Submission/Receipt Date(s): Standard dates apply. (See [Table 4](#), in Part II, Section IV).

Application Submission/Receipt Date(s):

All applications must meet **two (2) separate deadlines:**

- 1) Submission and acceptance in Grants.gov on or before 6:00 pm (local time) of the Last Possible Submission Date (submission deadline) in [Table 4](#).

AND

- 2) Verification by eRA Commons on or before the Verification Deadline in [Table 4](#).

All proposals should be proofread carefully prior to submission.

Applications that miss either deadline will not be accepted for review.

Note: Applications accepted by eRA Commons with no errors (with or without warnings) are provided a two (2)-business day examination window to check for errors.

The application is automatically verified on the third (3rd) business day if it is not explicitly rejected (withdrawn) by the signing official (SO) during the 2-day examination window.

Once verified, an application is considered final and no other version will be accepted for review. It is the responsibility of the PD/PI and AOR/SO to check for errors during the 2-day examination window.

Applications which fail to follow formatting and content requirements or are incomplete will be administratively withdrawn and not reviewed. It is strongly recommended that submissions to Grants.gov be completed prior to the Down to the Wire Deadline in [Table 4](#) to ensure sufficient time to correct any errors that may be identified by either Grants.gov or eRA Commons.

Applications submitted to Grants.gov and accepted after the "Last Possible Submission Date" in [Table 4](#) will miss the verification deadline; **late applications will not be accepted for review.**

Peer Review Date(s): Standard dates apply. (See [Table 4](#) Part II, Section IV.)

Earliest Anticipated Start Date(s): Standard dates apply. (See [Table 4](#) in Part II, Section IV.)

Additional Information: Not Applicable.

Expiration Date: December 31, 2016

Additional Overview Content**Executive Summary**

This Funding Opportunity Announcement (FOA) will use the non-U.S. Department of Health & Human Services (HHS) Research Project (1o1) award mechanism.

Purpose

Purpose. The Veterans Health Administration (VHA) Office of Research and Development (ORD), Health Services Research and Development Service (VA HSR&D), and the National Center for Ethics in Health Care announce the opportunity for Department of Veterans Affairs (VA) medical facilities to submit applications in response to this initiative. The primary purpose of this initiative is to facilitate innovative research focused on the effects of possible application of the VHA Directive 1005 (May 6, 2014) on informed consent for long-term opioid therapy for pain in patients with cancer.

Note: SDR proposals electronically submitted to HSR&D through Grants.gov will be peer-reviewed by a special ad-hoc review group to provide the Director of HSR&D with evaluations of the quality of the research proposed and to make recommendations on scientific merit, budgets, and funding durations.

- **Mechanism of Support.** This Request for Applications will use the Service Directed Research Award (1o1) mechanism for VA research.
- **Funds Available and Anticipated Number of Awards.** Availability of funds is dependent on Congressional appropriation.
- **Eligible Institutions/Organizations.** Only VA medical centers with an active research program and with Principal Investigators with previously approved concept papers are eligible. Each VA medical center must be registered as an applicant organization in Grants.gov and eRA Commons before any proposals can be submitted.
- **Eligible Project Directors/Principal Investigators (PDs/PIs).** The Service Directed Research Award Program is an intramural program and only funds research conducted by VA-ORD investigators at VA medical centers or VA-approved sites. See [Section III](#) for eligibility information.

Number of Applications and Funded Awards. HSR&D will fund one proposal from this solicitation. An application that is submitted to HSR&D may not be submitted concurrently to any other component of VA-ORD (i.e., Biomedical Laboratory Research and Development (BLR&D) Service, Clinical Science Research and Development (CSR&D) Service, or Rehabilitation Research and Development (RR&D) Service). HSR&D will not accept or review an application from an applicant who has an overdue Final Report.

See the VA SF424 Application Guide for instructions on submitting a Changed/Corrected Resubmission application. Failure to follow these instructions may result in the application being removed from review.

Renewals. Not applicable for HSR&D Merit Review or SDR Awards.

Application Materials. See [Section IV](#) for application materials.

General Information. For general information on SF424 (R&R) Application and Electronic Submission to VA-ORD, see <http://vawww.research.va.gov/funding/electronic-submission.cfm>.

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Part II - Full Text of Announcement

Section I. Funding Opportunity Description

Background

VHA practitioners are required to obtain signature consent for all diagnostic and therapeutic treatments or procedures that have a significant risk of complication or morbidity. VHA Handbook 1004.01 establishes procedures for obtaining and documenting informed consent for all clinical treatments and procedures; practitioners are required to obtain the patient's signature consent for all treatments and procedures that "can be reasonably considered to have a significant risk of complication or morbidity." Current VHA policy regarding pain management specifies that the safe and effective use of opioid analgesics for the management of pain, particularly complex chronic pain conditions, requires special attention to personal and public health risks. These risks include: side effects of opioids; opioid dependence, tolerance, and addiction; intentional or unintentional fatal overdose; and risks to the public through diversion of prescribed medications. Long-term exposure to opioids increases the risk for developing opioid hyperalgesia, and hypogonadism with concomitant loss of libido.

In recent years, a number of VA practitioners and clinics have used locally created opioid pain care agreements (OPCAs) to document discussions with patients regarding long-term opioid therapy. A number of benefits have been proposed for OPCAs, including their potential to improve adherence, reduce misuse and diversion, and clarify treatment goals, expectations, and responsibilities. However, other experts have raised concerns about OPCAs, including their use of threatening language and their potential to undermine trust. Poorly crafted OPCAs may potentially harm the patient-provider relationship, lead to practices that are inconsistent with VHA policy, or lead to adverse outcomes. To address this concern, and to meet VA's responsibilities under the 2011 Prescription Drug Abuse Prevention Plan from the Office of National Drug Control Policy, the National Pain Management Program and the National Center for Ethics in Health Care have jointly developed, with input from other national program offices and VHA medical facility staff, a patient information guide along with a consent form titled "Consent for Long-Term Opioid Therapy for Pain." When used together as part of a discussion with the patient or surrogate decision maker, the patient information guide and consent form satisfy VA's legal and policy requirements pertaining to informed consent, while at the same time serving the educational and risk management purposes of an OPCA. The goal of the new policy is to improve decision making and risk communication about long-term opioid use, to ensure that treatments are directed safely to those patients who will truly benefit from them, to reduce potential overuse and the attendant risk, and to make sure each patient is fully informed about these risks should they and their clinician choose long-term opioid treatment.

At the time of the proposed change in consent policies, the Oncology Service raised concerns about the potential impact of new policies on the use of opioids for treatment of cancer pain. These concerns were based on the perception that overuse of opioids was less of a concern in patients with cancer pain and that the balance of risks and benefits of opioid treatment was qualitatively different among patients with advanced cancer than in patients with causes of chronic pain that were not life-threatening. Oncology leadership also expressed concern that requiring treating oncologists and patients to complete the formal consent documents might unintentionally deter clinicians from using opioids, thus leading to under-treatment of pain. As a result of these concerns, the current consent requirements exclude patients being treated for cancer pain.

Unfortunately, current data is relatively limited to address the concerns described above and to prove that the exclusion of cancer patients from these new policies is justified. Among the uncertainties is whether current practice is appropriately selecting patients for treatment of cancer pain with opioids, what the incidence of adverse effects of opioid treatment in cancer patients and their consequences are, and whether new consent processes would have adverse impacts on treatment decisions. This solicitation is intended to address these

questions in order to provide the needed evidence to affirm or change current consent policies for long-term opioid use in patients with cancer.

Goals of Solicitation

The overall objectives of this Service Directed Research (SDR) announcement, supported by Health Services Research and Development Service (HSR&D) and VHA's Office of Policy and Planning (OPP), are to assess the:

- Demographic and clinical characteristics of Veterans receiving long-term opiates for treatment of cancer pain,
- Treatment patterns for using opiates to treat Veterans with cancer pain – dosing, duration, preparation – and comparisons with treatment patterns in patients being treated for other painful conditions,
- Long-term outcomes and possible risks (including serious side effects, hospitalization and overdose) associated with the use of long-term opioid therapy for cancer pain, and comparisons to risks of long-term opioid therapy for other types of pain,
- Potential impact of a requirement for signature informed consent for long-term opioids for cancer pain on outcomes for patients and families – including communication and provision of information, patient knowledge, clinician – patient relationships, pain outcomes, side effects, and the Veteran / family experience,
- Potential impact of a requirement for signature informed consent on outcomes for providers, including prescribing practices for cancer patients and burden on the healthcare team,
- Effect of the informed consent policy on desired and undesired outcomes of opioid use among patients with cancer.

Research Objectives

For the purposes of this solicitation “research” will be interpreted broadly to include organizations, research communities, other groups, individuals, and human subjects engaged in research. This solicitation invites a two-part investigation focused on the effects of possible application of this informed consent policy directive to VA cancer patients with pain. The two studies would include:

- An observational study employing existing data, to describe patterns of treatment and outcomes of VA cancer patients receiving long-term opioid therapy for pain and contrast them to patients being treated for non-cancer pain;
- A prospective pilot study to examine the impacts of an expanded consent process on patients treated for cancer pain.

Eligibility

This solicitation is open only to VA researchers and collaborators with a previously approved concept paper. All other VA researchers are not eligible to submit an application in response to this RFA.

To be eligible to submit a Merit Review or SDR proposal to HSR&D, the PD/PI must have at least a 5/8ths time VA appointment **at the time the Merit Review or SDR Award is funded** (refer to [VHA Handbook 1200.15](#)).

Collaborations

Program office collaborations are neither required nor mandatory. Collaborations are welcomed with clinical programs who are delivering some of the services being examined. Research proposals, however, will have to ensure that the objectivity of the investigators and analysis is not compromised by the collaboration or participation of programs and services that are the subject of the research.

Funding

Funding decisions for the Service Directed Research (SDR) proposals will be made by the Director of VA HSR&D, on the basis of reviews of the SDR applications.

In planning project budgets, applicants are reminded to adhere to Office of Research and Development (ORD) guidelines regarding allowable use of funds for specific categories of expenses. SDR applicants should follow budget guidelines for Investigator-Initiated Research projects funded by HSR&D. Budgets for this SDR are capped at **\$250,000.00 per year** for a **maximum of two years (no more than \$500,000.00 total)**. Budgets exceeding the maximum budget limits will not be approved or reviewed.

Review Criteria

- i. The first level of review will be performed by HSR&D's Scientific Merit Review Board (SMRB), often called a "study section" or "review committee." The SMRB is a Federal Advisory Committee Act board charged to evaluate the scientific and technical merit of applications. The SMRB does not make funding decisions. Information about SMRB membership may be obtained from the HSR&D web site at <http://www.hsr.d.research.va.gov/>
- ii. The second level of review will be performed by HSR&D, based not only on considerations of scientific merit, as judged by the SMRB, but also on the relevance and responsiveness of the proposed study to the mission, programs, and priorities of HSR&D. Final funding decisions are made at the discretion, and approval, of the Director of HSR&D.
- iii. **Evaluation Criteria.** Applications will be evaluated on the basis of the following major criteria:
 - a) **Administrative Review Criteria.** Applicants are expected to meet the following minimum administrative review criteria to be considered for scientific merit review:
 - Facility eligibility requirements.
 - Application is endorsed by the local R&D Office of each relevant VA medical facility.
 - b) **Selection Criteria.** The ad hoc review group will evaluate applications on merit, innovation, and completeness using the following criteria:
 - **Focus and Goals:** Relevance and potential importance to VA of the proposed mission, goals and focus of improving the culture of research within VA and to contribute to improving factors that protect human subjects without impeding successful research and compromising research integrity.
 - **Stakeholders:** Engaging important stakeholders within and outside VA.
 - **Plans for Addressing Issues Identified:** Quality, appropriateness and feasibility of the ideas and plans presented to meet the identified goals, including the quality and appropriateness of any proposed projects.
 - **Research Team Capacity and Qualifications:** (a) Documented experience and expertise; (b) health services research and implementation research qualifications; (c) and capability of the team (e.g. coordinators and academic/clinical partners) to accomplish stated goals and to contribute to improving factors that protect human subjects without impeding successful research and compromising research integrity.
 - **Facilities and Other Resources:** Actual and potential VHA and other non-VHA resources and collaborators (including any specific recruitment plans).

SDR Proposal Review

HSR&D will appoint Scientific and Technical Expert Reviewers to evaluate proposals and make recommendations about scientific merit of each project to the Director of HSR&D. See [Section V](#) for review information.

Additional evaluative criteria for reviewing proposals include:

- Relevance and importance to VHA of the questions framed by the study team
- Depth and breadth of proposal's collective contribution to the body of knowledge

- Rigor of study design and analytic plan ensure valid and useful results
 - Mix of quantitative and qualitative methods appropriate to the study question
 - Innovation in observational and experimental methods
- Sample is sufficiently large and diverse to permit generalization of results
- Likelihood that study design will yield early “lessons learned” to facilitate eventual adoption or implementation
- Collaboration among relevant VHA entities in the design of the proposal
-
- Balance of required expertise on the study team and ability to collaborate
- Management plan for the partnership among collaborators, including specification of a coordinating plan.
- Budget and resources sufficient to support successful study completion.
- Timeline for completion has high degree of utility for the emerging needs of VHA

The aim of the review process is to judge the scientific merit of research projects which will make substantial and timely contributions to knowledge.

Under the SDR mechanism, if an application is judged to be within a fundable range, the applicants will have the opportunity to revise the proposal in response to reviewer comments and suggestions without requiring a formal resubmission and re-review as is done with Investigator Initiated Research. The summary statement from the review will be distributed to applicants and, if the project is potentially fundable, a follow-up call between HSRD leadership and the applicants will be held to discuss any major areas of revision that are recommended based on the review. A revised proposal will be reviewed in an expedited fashion and, once the responses are deemed satisfactory, a formal funding letter will be provided.

References

Section II. Award Information

1. Mechanism of Support

This Request for Applications (RFA) will use the Service Directed Award (101) mechanism for VA research. Applicants may receive funding for more than one HSR&D project.

The “contact” PD/PI identified in Box 14 of the SF424 (R&R) Cover Component, will be responsible for planning, directing, and executing the proposed project. If the project has multiple PD/Pis, each PD/PI is accountable to the VA for the proper conduct of the project.

This RFA uses “Just-in-Time” information concepts.

2. Funds Available

Budget of Individual Project Awards: Merit Review budgets are capped. The budget may not exceed a total of \$500,000.00 for the project. Projects can be for a maximum of two (2) years with a maximum total project budget of \$250,000.00 per year.

Salary increases (cost of living adjustments - maximum of 3% per year) are permitted for all current VA salaried personnel (including the contact PD/PI), and may be budgeted in out year. Cost of living adjustments are not permitted for any other budget category; including IPAs. Cost of living adjustments may not be used to exceed the annual budget cap. Salaries are to include actual fringe benefits for all current VA salaried personnel and no more than 30% fringe benefits for all “to be determined” positions.

Exceptions to the Duration and/or Budget Caps: Exceptions to the duration and/or budget caps will not be granted.

Duration of Awards: Total project funding is limited to two (2) years. All funding is contingent on available funds and adjustments to budgets may be imposed after an award is initiated.

Section III. Eligibility Information

1. Eligible Applicants

1.A. Eligible Institutions

Applications may be submitted from any VA medical center with an active research program.

Documentation of support for the application from the local Medical Center Director must be included as a separate attachment in all applications. Proposals submitted without such documentation will be administratively withdrawn. See Item "8. Director's Letter" in Table 2 for details on meeting this requirement. A separate approval letter from the R&D Committee is no longer required to be submitted with the proposal application.

1.B. Eligible Individuals

Determinations regarding eligibility are made by individual services within VA-ORD. The general policy for eligibility to receive research support from VA-ORD is described in [VHA Handbook 1200.15](#) (http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2948).

The Service Directed Research Award Program is an intramural program to fund research conducted by VA-salaried investigators at VA medical centers or VA-approved sites. Each proposal must have at least one PD/PI who is eligible to submit a Service Directed proposal (see below for multiple PD/PI proposals). A PD/PI shall hold a MD, PhD, or equivalent doctoral degree in a field relevant to the research proposed. An investigator profile (Page 18) including the Commons ID, must be completed in ePromise for all personnel assigned to the PD/PI role.

To be eligible to submit a Service Directed Research proposal to HSR&D, the Principal Proponent and the PD/PI of each individual project must have at least a 5/8ths time VA appointment **at the time the Award is funded** (Refer to [VHA Handbook 1200.15](#)).

2. Cost Sharing or Matching

Not Applicable.

3. Other—Special Criteria

3.A. Location of Research Space

It is expected that the PD/PI and VA co-investigators will perform all of the funded research in VA space or VA leased space. If any portion of the proposed work will be carried out in laboratory space assigned to (i.e., controlled by) a PD/PI or VA co-investigator/collaborator at any other location(s), a waiver to perform the research offsite must be obtained for that investigator **prior to submitting the proposal** (Refer to [VHA Handbook 1200.16](#)). The use of an off-site core facility or an off-site non-VA collaborator's laboratory does **not** require an off-site waiver, except when the VA investigator is the director of the core facility.

Guidelines for submitting an application for an off-site waiver are described in the [VHA Handbook 1200.16](#), VA Off-site Research Handbook. **Requests for off-site waivers must be submitted at least 60 days prior to the due date for receipt of proposals.**

A copy of the approval letter for the off-site waiver must be included in Item "[8a. Letters of Support](#)" in Table 2 below.

Although the use of VA leased space does not require an off-site waiver, VA-ORD must approve a plan for local VA oversight of the research activities performed in the leased space (refer to [VHA Handbook 1200.16](#)).

3.B. Duplicate Submissions

A proposal submitted to HSR&D may not be concurrently submitted to any other VA-ORD Service (RR&D, BLR&D, or CSR&D).

Section IV. Application and Submission Information

For a completed SF424 (R&R) application package to be submitted, a one-time institutional registration is required for each VA medical center at both:

- Grants.gov (<http://www.grants.gov/GetStarted>) and
- eRA Commons (<http://era.nih.gov/ElectronicReceipt/preparing.htm>)

In addition, the PD/PI named in Box 14 on the SF424 (R&R) Cover Component must be individually registered in the NIH eRA Commons.

- A PD/PI who is also an Authorized Organization Representative/Signing Official (AOR/SO) must have separate eRA Commons accounts for each role.
- If the applicant has a PD/PI role and an Internet Assisted Review (IAR) role, both roles should exist under one eRA Commons account.
- All PDs/Pis at the applicant VA medical center must be affiliated with that organization. PDs/Pis located at another VA medical center need not be affiliated with the applicant organization, but must be affiliated with their own organization to be able to access the eRA Commons.
- The registration/affiliation of PD/Pis must be done by the AOR/SO or their designee who is already registered in eRA Commons.

Both the PD/PI(s) and AOR/SO need separate accounts in the NIH eRA Commons since both are authorized to view the application image.

Note that if a PD/PI is also an NIH peer-reviewer with an Individual DUNS and CCR (Grants.gov) registration, that particular DUNS number and CCR registration are for the individual reviewer only. **That individual DUNS number should not be used on any SF424 (R&R) application submitted in response to this RFA.**

1. Request Application Information

Applicants must download the specific SF424 (R&R) application forms for this RFA through [Grants.gov/Apply](#). Click on the link to "Download a Grant Application Package" and then enter the RFA number from page 1 of this announcement in the middle box labeled "Funding Opportunity Number." **VA-ORD RFA Numbers cannot be found by using the Grants.gov search engine.**

Note: Only the forms package directly attached to a specific RFA can be used to respond to that RFA. You will not be able to use any other SF424 (R&R) forms (e.g., sample forms, forms from another RFA), although some of the "Attachment" files may be useable for more than one RFA.

Adobe Reader 8.1.1 or higher is required to open and work on the SF424 (R&R) application forms for this RFA; version 9.0 or higher is strongly recommended. The full version of Adobe Acrobat is not required (See VA SF424 Application Guide for further information on use of Adobe Reader and Acrobat).

For further assistance downloading the package, contact Grants.gov Customer Support at <http://grants.gov/CustomerSupport>.

2. Content and Form of Application Submission

Prepare all applications using the SF424 (R & R) application forms for this RFA in accordance with the VA Application Guide SF424 (R&R) found at <http://vaww.research.va.gov/funding/electronic-submission.cfm>. The SF424 (R&R) application has several components. Some components are required, others are optional. The forms package associated with this RFA in Grants.gov/Apply includes all applicable components, required and optional. A completed application in response to this RFA includes the data in the following components:

Table 1. Components of a VA-ORD Application

Document	Required	Optional	Instructions*
SF424 (R&R) Cover Component (Applicant Information, Project Title, etc)	✓		Section 4.2
SF424 (R&R) Other Project Information (Abstract, Relevance, Introduction to Revised Application, Specific Aims, Research Plan, VA Career Plan, Mentoring Plan, Progress Report Publications, Human Subjects, Vertebrate Animals, Biohazards, Director's Letter, Letters of Support, Checklist, Appendices)	✓		Section 4.3
SF424 (R&R) Project/Performance Site Locations	✓		Section 4.4
SF424 (R&R) Senior / Key Person Profile(s) (Biosketches and Current & Pending Support)	✓		Section 4.5
SF424 (R&R) Budget [†]	✓		Section 4.6
SF424 (R&R) Subaward Budget Attachment Form [‡]		✓	Section 4.7

*Sections refer to the VA Application Guide SF424 (R&R) found at <http://vaww.research.va.gov/funding/electronic-submission.cfm>

[†] Application packages for VA-ORD funding opportunities include only the SF424 (R&R) Budget; modular budgets are not accepted. A budget component must always be submitted.

[‡] Subaward Budgets are required for multi-site projects if funds will be sent to separate sites.

Guidance Specific for this RFA:

The instructions in this RFA may differ from, and supersede, the general instructions contained in the VA-SF424 Application Guide.

Unless otherwise noted, all instructions contained in the VA-SF424 Application Guide must be followed. Failure to follow instructions may cause delays in submission or withdrawal of proposals from review.

SF424 Other Project Information Component

Table 2 below describes the required content of separate files that must be attached to Item 12 "Other Attachments" of the SF424 Other Project Information Component (Section 4.3 of the VA-SF424 Application Guide).

For creation of attachments and format specifications, see SF424 Application Guide, Part I, Section 2.3.2 Creating PDFs for Text Attachments and Section 2.6 Format Specifications for Text (PDF) Attachments.

Note: The file names indicated in boldface, italic type in the table below are mandatory and may not be changed (unless specifically indicated in Table 2). Altered file names will cause warnings to be generated and may result in parts of your proposal being excluded from the final electronic image that the reviewers receive or for the sections to appear in the wrong order. Required file names do not contain any spaces. Inclusion of spaces in file names may result in an eRA error message that a required attachment is missing. Incorrect file names may concurrently generate a warning that a file name may not be correct.

To ensure that your application package will be successfully submitted, please adhere to the following guidelines for attachment filenames: avoid using special characters (example: &, -, %, /, #) including periods (.); avoid attaching documents with same filename; and limit filename to 50 characters or less.

Table 2: Other Project Information Component Attachments for Item 12

Attachment and Required File Name	Instructions	Page Limit
<p>1. Introduction to Application (for Resubmission only) <i>01_VA_Intro.pdf</i></p> <p>1. Introduction to Application (continued)</p>	Not applicable for this RFA	N/A
<p>2. Specific Aims <i>02_VA_Specific_Aims.pdf</i></p>	<p>Concisely state goals of the proposed research and summarize the expected outcomes) including the impact that the results of the proposed research will exert on the research field(s) involved.</p> <p>Succinctly list the specific objectives of the research proposed, e.g., to test a stated hypothesis, create a novel design, solve a specific problem, challenge an existing paradigm or clinical practice, address a critical barrier to progress in the field, or develop new technology.</p> <p>This attachment is limited to 1 page.</p>	1
<p>2a. Research Plan <i>02a_VAResearch_Plan.pdf</i></p>	<p>The Research Plan must include sufficient information needed for evaluation of the project, independent of any other document (e.g., previous application). Be specific and informative.</p> <p>The Research Plan is limited to 14 pages for all 101 applications in all R&D Services. An 101 application with a Plan that exceeds the 14-page limit will not be accepted by eRA Commons. A system validation error will occur. Do not use appendices to circumvent the stated page limit for the Research Plan. An application that utilizes appendices to circumvent the stated 14-page limit of the Plan will be administratively withdrawn and not reviewed.</p> <p>The content of the Research Plan has not changed; the organization of the plan within the 14-page limit is at the discretion of the PI. Although a specific number of page(s) in each area of the plan are no</p>	<p>14 Total</p>

Attachment and Required File Name	Instructions	Page Limit
	<p>question(s) and population? What are the advantages and disadvantages of this approach? Describe new methodologies to be used and why they are preferred over existing methods. Discuss potential problems and limitations to the proposed methods and/or procedures and possible alternative approaches to achieve specific aims.</p> <ol style="list-style-type: none"> 2. If the study uses "usual care" as either the baseline or as a comparison group, usual care must be defined. 3. Where will the study take place? Why is this setting or geographic location appropriate? Will the results be applicable to other places or populations? 4. What are the characteristics of the study population? How will the sample be selected and what steps will be taken to secure and retain the needed number of subjects (and controls, if applicable)? What steps will be taken to ensure adequate representation of women and minorities? What is the estimated sample size and how was it derived? What assumptions were made regarding the magnitude of the expected treatment effect? At what level of power can inferences be drawn? 5. Identify and define the dependent and independent variables and explain their selection. How will the major variables be measured and how will they be linked in the analysis? Comment on the reliability, validity, and appropriateness of the proposed measures for the study. NOTE: If new or unpublished measures are to be used, the data collection instruments must be submitted as part of the appendix. 6. What is the data collection strategy and timeline? What are the potential problems in collecting data and controlling data quality? How will these problems (e.g., missing data, respondent drop-out, interviewer bias) be addressed? 7. What is the strategy for data analysis? Outline the planned analyses, indicating which variables will be used in which analyses and the order in which analyses will be done (do not merely name proposed statistical tests). What are the strengths and limitations of this analytic strategy? Include power calculations as appropriate. Power calculations should be described in terms of clinical significance, if appropriate, as well as statistical significance. <p>Dissemination and/or Implementation Plan A conceptual plan must be included that indicates how and when research findings will be disseminated and, if appropriate, implemented. Discuss conditions or barriers to implementing the eventual findings or products, and identify any plans and promising mechanisms (beyond professional publications) to facilitate dissemination and implementation.</p>	
2b. VA Career Plan <i>02b_VA_Career_Plan.pdf</i>	Do not use. Does not apply.	None

Attachment and Required File Name	Instructions	Page Limit
<p>7. Consortium/Contractual Agreements <i>07_Agreements.pdf</i></p>	<p>This attachment should only be used to describe existing consortium or contractual agreements that are relevant to the proposed research; new agreements to perform a portion of the proposed research will not be considered binding to VA.</p> <p>Do not include IPAs here.</p> <p>It should not be used to describe or to justify the required sub-award budgets for multi-site projects.</p> <p>Explain the programmatic, fiscal and administrative arrangements that exist between the applicant VA Medical Center and any consortium or contractual organization(s).</p> <p>New consortium or contractual agreements will not be considered binding to VA contractually.</p>	None
<p>8. Director's Letter <i>08_VA_Director_Letter.pdf</i></p> <p>The required file name for this attachment may generate a warning message from eRA Commons.</p>	<p>A signed copy of the letter of support from the medical center Director must be submitted as a separate attachment and must include the following:</p> <ul style="list-style-type: none"> • A statement that the Director understands the impact of the proposed research on the facility's organization and that he/she endorses the project. • Where the research will be conducted, if any off-site waivers are included with the application, and that the VA space described in the application and necessary support of the VA facility will be available. <p>If a clinician PD/PI's appointment is to start at the time of funding, the VA medical center Director's memorandum must contain a statement indicating that the PD/PI will be given a VA-paid clinical appointment of at least 5/8ths time.</p> <p>Proposals submitted without this attachment will not be accepted for review.</p>	
<p>8a. Letters of Support <i>08a_VA_Letters.pdf</i></p> <p>The required file name for this attachment may generate a warning message from eRA Commons.</p>	<p>All memoranda/letters should be scanned and submitted as a single document.</p> <p>If applicable, include copies of approval letters for eligibility, budget, off-site waivers, and/or exceeding budget caps/duration. All memoranda and budget limit letters should be addressed to the Director, HSR&D, and must include the Corresponding PI's name, project title, VA facility, signature and date.</p> <p>Letters of endorsement are required from: Participating institutions and persons. Each participating or affected organizational element, institution, collaborator, and consultant must provide a letter of support. The letter must indicate concurrence of the affected person or institution with their specific role or contribution as described in the application, their willingness to fulfill the duties described in the application, and their rate/charge for consulting services, if applicable.</p> <p>Note: Biosketches must be included in the Senior/Key Person Section Profile(s) Component, not in Letters of Support.</p>	

Attachment and Required File Name	Instructions	Page Limit
<p>9. Checklist 09_VA_Checklist.pdf</p> <p><i>The required file name for this attachment may generate a warning message from eRA Commons concerning the attachment name.</i></p>	<p>Attach a completed copy of the Electronic Submission Checklist. Check only the applicable boxes. Use the checklist to verify that all content and formatting requirements have been met and that the final application is complete. Do not check a box until you are sure that the item has been carefully examined and is correct. Proposals with incorrectly checked boxes may not be accepted for review.</p> <p>Proposals submitted without this attachment will not be accepted for review.</p>	
<p>10, 11, 12... Appendices 10_VA_Appendix_1.pdf 11_VA_Appendix_2.pdf 12_VA_Appendix_3.pdf (additional attachments as needed: same file name format)</p> <p>For Appendix names only: If descriptive text is included in an attachment name before the ".PDF" as described in the examples in bold, you will receive a warning message from eRA Commons concerning the attachment name. This warning can be safely ignored.</p>	<p>Do not use appendices to circumvent the 14-page limit of the Research Plan. An application that utilizes appendices to circumvent the stated 14-page limit of the Research Plan will be administratively withdrawn and not reviewed.</p> <p>A summary sheet listing all of the items included in the appendix may be included in the first appendix attachment; this is encouraged but not required.</p> <p>Do not include Informed Consent forms as an appendix, even if already approved by the IRB.</p> <p>Files should be named using the following convention in the following order:</p> <ul style="list-style-type: none"> • Attachment number, starting with 10, then 11, 12, etc. • Underscore • The phrase "VA_Appendix" • Underscore • Appendix number starting with 1, then 2, 3, etc. • Underscore • Brief description of the contents (e.g., Data Collection Instrument, Interview Guide, Clinical Protocol) • ".pdf" <p>The first appendix and should be named, for example, "10_VA_Appendix_1_DataCollectionInstrument.pdf"</p> <p>New and resubmission applications may include the following materials in the Appendices: Similar appendix material should be combined within an attachment. For example, please place all accepted, but not yet published, manuscripts in one attachment.</p> <p>Publications</p> <ul style="list-style-type: none"> • Up to 3 of the following types of publications: <ul style="list-style-type: none"> ○ Manuscripts and/or abstracts accepted for publication <u>but not yet published</u>. ○ Manuscripts and/or abstracts published, but a free, online, <u>publicly available journal link is not available</u>. ○ Patents <u>directly relevant to the project</u>. 	

Attachment and Required File Name	Instructions	Page Limit
10, 11, 12... Appendices (continued)	<ul style="list-style-type: none"> ○ Chapters from review or text books. • Note: Do not include unpublished theses or abstracts/manuscripts that have been submitted but not yet accepted for publication. • Note: Published manuscripts and/or abstracts that have a free, publicly available online journal should not be included in the appendix. The URL or PMC submission identification numbers should be included, along with the full reference, in the Bibliography and References cited section, List section, and/or the Biographical Sketch section. Other • Surveys, questionnaires, data collection instruments and clinical protocols may be submitted as PDF attachments. • Photographs or color images of gels, micrographs, etc., are no longer accepted as Appendix material. These images must be included in the Research Plan PDF and will count toward the 14-page limit. Images embedded in publications are still allowed. 	

R&R Budget Component

Budget Guidance

Be sure to include all requested funding periods in the Budget Component.

Cost-of-living adjustments (maximum of 3% per year) may be budgeted in out years (year 2, year 3, year 4) of a project for all current VA salaried personnel (this does not include IPAs) to address cost of living increases and personnel actions, and all differences in the operating expenses between years need to be fully justified. While the dollar fields allow cents to be entered, all dollar fields should be rounded to the nearest whole number. The table below summarizes specific guidance for budget categories.

Table 3. Budget Category Guidance (authorized and unauthorized expenditures)

Personnel	
• Physicians	Salary support is not authorized for any physician (VA or other salaried).
• Nurses or Licensed Medical Professionals	Salary support is not authorized for any Title 38 nurse or licensed medical professional with clinical responsibilities in VA unless a waiver has been granted by the CRADO. If waived, salary support is allowed only for services beyond usual care.
• Increases in salary over years to account for cost of living or salary increases (HR actions)	Maximum 3% increase/year may be budgeted for all current VA salaried personnel.
• Clerical support	Clerical support may not be included as study personnel unless the support provided can be justified as necessary to the conduct of the research.
• Summer students	Not authorized
• Graduate students/Tuition stipends	Not authorized
• IPAs	Costs for IPAs must NOT be listed under B. Other Personnel in Section A or B

	of the R&R Budget Component. These contractual costs are not salaries and should be identified on lines 8-10 (Other) of Section F. Other Direct Costs. IPAs are not authorized for physicians. Cost-of-living adjustments are not allowed for IPAs.
• Consultants	Limit of \$500 per consultation and \$2,500 per annum. Physicians may not be paid as consultants. Expenses other than professional fee (e.g., travel) should be listed under "All Other".
Equipment	
• Computers	Computers (and IT expenditures) should not be listed in the "Equipment" section.
• Furniture	Must be justified as necessary for the conduct of this research. Justification must account for disposition of previously purchased furniture for projects that have terminated.
• Medical Equipment	Must be required for the conduct of the research project and not be used as part of routine and customary patient care.
Supplies	
• Postage	Not authorized, unless special circumstances require other than ordinary mail.
• Phone costs	Special 800 lines may be approved with justification.
• Copying	Not authorized
• Construction	Contact ORD for guidance on construction requests.
• Books, journals, or reprints	Not authorized. However, payment for reasonable page/publication costs for research resulting from HSR&D studies may be included up to \$3,000.
• Professional memberships	Not authorized
All Other Expenses	
• General Administrative costs	Not authorized
• Access to Austin or PBM database	Not authorized
• Contract for Services	Service contracts are used to obtain a deliverable/product from a company or an institution, e.g. service contract with the University of California for statistical analysis of data. You may not contract for clinical services or identify the individual (s) who will provide the service. A non-VA physician may only perform non-clinical work. A detailed description of the services being contracted for, along with the name and credentials of the person(s) who may be providing the services, should be included in the budget justification.
• IPAs	IPAs provide for salary and fringe benefit reimbursements; they do not allow for "overhead" costs. IPAs may not be used for physicians. IPAs may not be used for any individual assigned the PD/PI role.
• Monetary incentives to physicians	Monetary incentives to physicians are not authorized.
• Patient Incentives	Small amounts of money can be offered as a reimbursement for time and/or travel to participate in a study. The incentive must not, in and of itself, constitute an incentive and must be consistent with IRB and ethics policies.

<ul style="list-style-type: none"> • Travel • Travel (continued) 	<p>There are four categories of travel:</p> <p>1) Travel necessary for the conduct of research. Project related travel expenses must be fully explained and a cogent justification provided. Explain why e-mails, conference calls, or teleconferencing are not sufficient to accomplish the goals of the requested travel. Project travel needs to be requested in the budget using the following format:</p> <table border="1" data-bbox="626 590 1143 699"> <caption>Project Travel Table</caption> <thead> <tr> <th>Traveler</th> <th>Status (VA or non VA)</th> <th>Destination</th> <th>Number of Trips</th> <th>Year of Trip</th> <th>Estimated Cost</th> <th>Purpose</th> </tr> </thead> <tbody> <tr> <td> </td> </tr> </tbody> </table> <p>2) Travel to Implement or Disseminate findings. This is not travel to present research findings at national meetings but is the travel necessary to conduct face-to-face meetings or conferences that will facilitate the adoption of the research into practice. An estimated budget should be listed but funds will not be disbursed until study results are available and dissemination/implementation is warranted. Requests for release of funds need to be submitted through the ACOS/R&D to the assigned Scientific Program Manager at least 3 months prior to the project end date. A justification, not to exceed one page, must accompany the request for release of funds. Any changes to the dissemination and/or implementation plan described in the original proposal must be highlighted.</p> <p>3) Travel to present research findings at professional meetings. HSR&D will consider requests to travel to present study findings on a case-by-case basis. Requests for travel funds including an estimate of travel expenses and a justification must be submitted to HSR&D at least two months in advance of the meeting.</p> <p>4) Professional development travel. HSR&D will automatically distribute \$1,200 per year to each funded PD/PI to allow participation of the PD/PI or project staff in scientific meetings/professional development activities. The maximum in professional development travel funds that will be distributed to a PD/PI is \$1,200, irrespective of the number of projects awarded to the PD/PI. The PD/PI for Pilot Projects will not receive professional development travel funds. Professional development funds do not need to be requested in the project budget.</p>	Traveler	Status (VA or non VA)	Destination	Number of Trips	Year of Trip	Estimated Cost	Purpose							
Traveler	Status (VA or non VA)	Destination	Number of Trips	Year of Trip	Estimated Cost	Purpose									
<ul style="list-style-type: none"> • Information Technology 	<p>List all computer requests; unusual requests should be accompanied by a vendor quote and a strong justification. Shared network charges are not authorized. Planned IT expenditures need to be itemized using the following format:</p> <table border="1" data-bbox="643 1356 1138 1461"> <caption>Planned IT Expenditures Table</caption> <thead> <tr> <th rowspan="2">Category</th> <th rowspan="2">Type</th> <th>Amount</th> <th>Amount</th> <th>Amount</th> </tr> <tr> <th>Year 1</th> <th>Year 2</th> <th>Year 3</th> </tr> </thead> <tbody> <tr> <td>Hardware</td> <td>Purchased</td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	Category	Type	Amount	Amount	Amount	Year 1	Year 2	Year 3	Hardware	Purchased				
Category	Type			Amount	Amount	Amount									
		Year 1	Year 2	Year 3											
Hardware	Purchased														

• Information Technology (continued)		Leased			
		Services			
	Software	Purchased			
		Leased			
		Services			
	Telecommunications	Purchased			
		Leased			
		Services			
	IT Supplies and Materials	Purchased			
		Leased			
		Services			
	IT Personnel (personnel on a 2210 Position Description)				
		TOTAL			

Personnel (Sections A and B): Starting with the PD/PI of each individual project, list all personnel involved in the project. In the appropriate columns list their names, role in the research proposed, the calendar months effort each will devote to the project, and whether or not salaries are requested. Salaries are to include actual fringe benefits for all current VA salaried personnel and no more than 30% fringe benefits for all "to be determined positions" to be paid from HSR&D funds. Secretarial salaries are not allowed. Physicians and dentists and, in most cases, nurses may not receive salaries from the medical research appropriation. Physicians and dentists who are not licensed to practice in the United States may request salary, but they must be clearly identified as such in the budget justification section. PDs/Pis cannot be paid through Inter-agency Personnel Act (IPA) agreements.

To request salary support for a VA employee on the Research and Related budget pages you must base your request on the individual's **VA salary (commensurate with their appointment)** and the time that is spent on the project. This is also true when requesting salary support for an individual who has a joint appointment-**only** their VA salary (commensurate with the VA appointment) and time spent on the project factor into the request for salary support. It does not matter how many calendar months they work elsewhere.

HSR&D will pay salary only for the actual time the PI or other VA paid study personnel spend on the project. One of the major differences between how BLR&D and HSR&D operates is that BLR&D will pay "up to the entire" **VA Salary of a PI** on a project, regardless of his/her effort on the project.

- 1) To calculate calendar months for **VA paid employees or employees with a joint appointment** (use only VA hours worked and VA time spent on project):
 - a) First, calculate the number of calendar months which will be spent on the project. Use the Table below to convert hours worked/work week to calendar months. Only calendar months should be used in Section A of a VA budget. This calculation is based on a standard VA 40 hour work week. Overtime and compensatory time are not factored into this calculation – just regular work hours.

Hours per 40 hour work	Calendar Months	Percent Effort (Based on 40 hour
------------------------	-----------------	----------------------------------

week spent on the project	Effort	work week)
1	0.3	2.5
5	1.5	12.5
10	3.0	25.0
15	4.5	37.5
20	6.0	50.0
25	7.5	62.5
30	9.0	75.0
35	10.5	87.5
40	12	100.0

- b) Second, calculate the "requested salary" in section A of the Research and Related budget page. Take "% of hours worked" from the last column in the Table above and multiply by the full VA salary.

NOTE: For individuals with joint appointments, signature by the institutional official on the applications certifies that: 1) the individual is applying as part of a joint appointment specified by a formal Memorandum of Understanding between the University and VA; 2) there is no possibility of dual compensation for the same work; and 3) there is no possibility of an actual or apparent conflict of interest regarding such work.

- 2) The request for calendar months effort for **non-VA individuals** is to quantify the non-VA person's time commitment to the project. No salary should be requested in section A of the Research and Related budget page. For the purpose of the "Other Support" section, an individual with multiple appointments may have more than 12 calendar months total effort. However, for the budget page base the calculation of calendar months on the hours worked at a single (non-VA) institution. To calculate the calendar months:

- a) Determine the number of hours of a regular work week at the institution, e.g. 35 hours or 37.5 hours. Divide the number of hours worked at that institution by the number of hours in the work week and multiply by 12.

For example: an individual works 20 hours a week and the normal University work week is 35 hours, you would divide 20/35 (0.57) and multiply by 12 to determine the calendar hours worked = 6.86 calendar months.

- b) Multiply the per cent effort spent on the project by the calendar months worked by the individual.

Equipment Description (Section C): Only major equipment is included in this section. Major equipment is defined as an individual item of property that has an acquisition cost of \$5,000 or more. Such equipment consists of relatively permanent, fixed assets that are essential to the completion of the proposed research. Expendable items and small (<\$5,000) equipment items are to be requested as Materials and Supplies under Other Direct Costs. When feasible, equipment is to be purchased in the first year of the project. Only under unusual circumstances and if properly justified will HSR&D Service consider equipment requests in years 2-4.

Other Direct Costs (Section F): List service contracts for equipment utilized only for the proposed research. If the equipment is used by multiple research projects, request a proportionate amount of the service contract. List costs for any personnel to be paid through an IPA.

Consultant Services (Section F, Line 3): A consultant may not receive more than \$2,500 per year. MD consultants may not receive salary compensation.

Budget Justification (Section K)

All items in the budget (budget categories, budget years, and performance sites) must be clearly justified in a single narrative and attached to Section K of the Research and Related Budget. This is a required attachment

to the application. When research is to be performed at multiple VA medical centers, the submitting VA is considered to be the primary performance site. A separate budget(s) for the additional VA medical center(s) must be submitted on a separate budget page(s) using the SF424 (R&R) Subaward Budget Attachment form. Justification of all items in the subaward(s) budget(s) must be included in the justification document for the primary performance site. (See example below).

Begin the justification narrative by summarizing all expenditures using the **Summary Budget Table – this is a required attachment to the application (in addition to the budget justification narrative)**.

An example of a properly completed Summary Budget Table can be viewed at <http://www.hsrc.research.va.gov/funding/default.cfm> under "How to Apply".

Following the Summary Budget Table explains all differences in operating expenses between years.

Summary Budget Table

Expense Category										
Primary Site Personnel	Degree	Primary Site	Role	Grade	Step	% Effort	Year 1 Salary+Fringe	Year 2 Salary+Fringe	Year 3 Salary+Fringe	Year 4 Salary+Fringe
Site Subtotal							0	0	0	0
Additional Site Personnel	Degree	Additional Site	Role	Grade	Step	% Effort	Year 1 Salary+Fringe	Year 2 Salary+Fringe	Year 3 Salary+Fringe	Year 4 Salary+Fringe
Site Subtotal							0	0	0	0
Project Total for Personnel							0	0	0	0
Consultant	Site						Year 1	Year 2	Year 3	Year 4
Equipment (total-do not itemize)							Year 1	Year 2	Year 3	Year 4
Supplies (total-do not itemize)							Year 1	Year 2	Year 3	Year 4
Project Travel (total from Travel Table do not itemize)							Year 1	Year 2	Year 3	Year 4
Other (Do not list IT expenses from Planned IT Expenses Table)	Degree for IPA	Site					Year 1	Year 2	Year 3	Year 4
TOTAL							0	0	0	0

Personnel: Fully explain the role and calendar months effort of the PD/PI and all personnel listed under personnel. An investigator profile (Page 18) including the Commons ID, must be completed in ePromise for all personnel assigned the PD/PI role. If the PD/PI is a non-clinician scientist paid by the research appropriation, fully describe the basis for any difference in the calendar months effort for the work proposed and total VA effort (salary support). Submission of the application signifies facility agreement to have the non-clinician PD/PI perform the work described to justify salary. Physicians and dentists who are not licensed to practice in the United States and are requesting salary must be clearly identified as such and justified in this section. If the project has more than one site, identify the personnel by site, for example:

Washington, DC Personnel
Justification narrative

Boston, MA Personnel
Justification narrative

Note: DO NOT LIST IPAs UNDER B. OTHER PERSONNEL IN SECTION A OR B.

Equipment: For each item, justification should include a discussion of why the equipment is needed and why similar existing equipment (if any)—whether at the applicant VAMC or in a nearby research space, common resource equipment, borrowed, or on loan—cannot be used. Include the cost of maintenance. Patient care equipment purchased for use in the research study must be equipment that is not provided in the customary care of patients. If the project has more than one site, identify and justify the equipment needed by site, for example:

Washington, DC Equipment
Justification narrative

Boston, MA Equipment
Justification narrative

Travel: Travel costs for the conduct of research should be clearly justified in the budget justification section using the Project Travel Table format in [Table 3](#) above.

Materials and Supplies: Itemize expendable supplies in separate categories. Explain how the costs for each category of supplies were derived (e.g., based on the PD/PI's expense history in performing similar research). Small (<\$5,000) equipment must be justified. If the project has more than one site, identify the materials and supplies needed by site, for example:

Washington, DC Materials and Supplies
Justification narrative

Boston, MA Materials and Supplies
Justification narrative

Consultant Services: Clearly explain the expertise and involvement of each consultant with regard to the proposed research, the nature of the service to be provided, the number of consultations, and professional status (PhD, RN, etc.). If the project has more than one site, identify the consultants needed by site, for example:

Washington, DC Consultants
Justification narrative

Boston, MA Consultants
Justification narrative

ADP/Computer Services: Do not include IT costs in the SDR Budget. However, a separate table listing all IT items that must be purchased for the proposed research and their cost (per item and total) must be itemized in the Budget Justification (budget summary table) attachment in "Section K, Budget Justification" of the SF424 R&R Budget Component using the Planned IT Expenditures Table format in [Table 3](#).

Other: Justify the costs of any items listed under this budget category. If the project has more than one site, identify the other expenditures by site, for example:

Washington, DC Other
Justification narrative

Boston, MA Other
Justification narrative

SPECIAL INSTRUCTIONS

Applications Involving Multiple Institutions: All items in the budget (budget categories, budget years, and performance sites) must be clearly justified in a single narrative and attached to Section K of the Research and Related Budget. When research is to be performed at multiple VA medical centers, the submitting VA is considered to be the primary performance site. A separate budget(s) for the additional VA medical center(s) must be submitted on a separate budget page(s) for each active budget period with subaward funding using the SF424 (R&R) Subaward Budget Attachment form. Justification of all items in the subaward(s) budget(s) must be included in the summary budget justification document for the primary performance site. As an intramural program, "subcontracts" with non-VA institutions cannot be submitted through this mechanism.

Be sure to include the total cost of all subaward budgets in Section F, Other Direct Costs, line 5 of the R&R Budget Component.

3. Submission Dates and Times

3.A. Deadline, Review, and Award Dates

Deadlines. Avoid delays and misunderstandings by reading and following the instructions carefully. [Table 4](#) contains deadlines for the Merit Review and SDR Award Program applications. Depending on the investigator's particular circumstance, requests for off-site waiver, eligibility determination, or approval to exceed budget limits may be needed. The Office of the ACOS for R&D or HSR&D Scientific Review Administrators can help determine which approvals may be required.

Table 4. Deadline, Review and Award Dates for 2014	
Health Services Research & Development (HSR&D)	
SUBMISSION CYCLES:	WINTER 2015 (2015/05 Council)
First day to submit Merit Review and SDR Award applications to Grants.gov*	December 17th
Down to the Wire Submission deadline to Grants.gov This deadline allows errors identified by Grants.gov, eRA, or the PI/SO during the two business day examination period to be corrected. All changed/revised applications must be submitted by December 10/June 10. NOTE: After this date the 2 business day correction window cannot be used.	February 4th
Last Possible Submission Date to Grants.gov Assumes that no errors (Grants.gov or eRA) will be identified or need to be corrected. WARNING: If you submit an application on June 10/ December 10 to Grants.gov and there are errors identified by Grants.gov or eRA there will not be time to fix the errors, resubmit, and have the application received and verified by eRA. You will miss the submission and verification deadlines. If your proposal is accepted by eRA (with no errors), do not withdraw the application during the two business day examination window as you will miss the verification deadline.	February 6th
Verification Deadline in eRA † Once verified, an application is considered final and no other version will be accepted for review.	February 11th
Review and Award Cycles:	
Scientific Merit Review	February
Administrative Review	February
Earliest Project Start Date Note: VA-ORD R&D Services may not always be able to honor the requested start date of an application; therefore, applicants should make no commitments or obligations until confirmation of the start date by the awarding service.	June

*If the deadline falls on a weekend or Federal holiday, the due date is the next business day.

† Verification occurs two (2) business days after receipt of an application with no errors or only warnings.

3.B. Submitting an Application Electronically

To submit an application in response to this RFA, applicants should access this RFA via http://www.grants.gov/applicants/apply_for_grants.jsp and follow steps 1–4. Note: Applications must be submitted electronically.

3.C. Application Processing

All new or changed/corrected applications must meet 2 separate deadlines:

1. **Submission and acceptance in Grants.gov on or before 6:00 pm (local time) of the Last Possible Submission Date (submission deadline) in [Table 4](#)**

AND

2. **Verification by eRA Commons on or before the Verification Deadline in [Table 4](#)**

All proposals should be proofread carefully prior to submission.

Applications that miss either deadline will not be accepted for review.

NOTE: Applications accepted by eRA Commons with no errors (with or without warnings) are provided a two-business day examination window to check for errors. The application is automatically verified on the third business day if it is not explicitly rejected (withdrawn) by the signing official (SO) during the 2-day examination window.

Once verified, an application is considered final and no other version will be accepted for review. It is the responsibility of the PD/PI and AOR/SO to check for errors during the 2-day examination window.

Applications which fail to follow formatting and content requirements or are incomplete will be administratively withdrawn and not reviewed.

It is strongly recommended that submissions to Grants.gov be completed by the Down to the Wire Deadline in [Table 4](#) to ensure sufficient time to correct any errors that may be identified by either Grants.gov or eRA Commons.

New or Changed/Corrected applications submitted to Grants.gov and accepted after the “Last Possible Submission Date” in [Table 4](#) will cause the verification deadline to be missed; late applications will not be accepted for review.

Once an application package has been successfully submitted through Grants.gov, any errors have been addressed, and the assembled application has been created in the eRA Commons, the PD/PI and the Authorized Organization Representative/Signiug Official (AOR/SO) have 2 business days to view the application image.

Please remember that some warnings may not be applicable or may only need to be addressed after application submission (i.e., JIT). Reminder: warnings do not stop further application processing. If an application submission results in warnings (but no errors), it will automatically move forward after two business days if not action is taken.

During the 2 business day examination period, the electronic image of submitted proposals (e-application in eRA Commons) must be reviewed to ensure that there are no transmission errors. PIs are responsible for printing out and reviewing the electronic image of the e-application during the 2 business day period in order to check the submission for format, transmission or content errors.

E-applications which do not meet formatting and content requirements or are incomplete will be administratively withdrawn and not reviewed. No exceptions will be made. It is the responsibility of the PI to check that each and every page is correct and that all elements of the proposal have been included. After an application has been submitted, the e-application should be checked for problems with font type, font size, margins, characters per inch and lines per inch. It is advised that PIs print out a page of the Research Plan during the 2 business day examination period and **MANUALLY** check for these types of errors as eRA does not generate an error message for them. However, such errors WILL cause the proposal to be administratively withdrawn.

The previously submitted application must be rejected/withdrawn before a changed/corrected application can be submitted. **Duplicate applications will be administratively withdrawn and will not be reviewed.**

If an application is accepted by eRA with no errors, do not reject/withdraw an application during the 2 business day examination window unless there is sufficient time to resubmit a changed/corrected application by the submission deadline.

If everything is acceptable, no further action is necessary. The application will automatically move forward for processing after 2 business days.

Both the AOR/SO and PD/PI will receive e-mail notifications when the application is rejected or the application automatically moves forward in the process after 2 days.

Once an application becomes verified it is considered final and no changed/corrected application will be accepted for review.

VA-ORD will not penalize the applicant for an eRA Commons or Grants.gov system issue. However, unless there is documentation of a processing error at either Grants.gov or eRA Commons, applications that fail to meet either the submission or verification deadline will not be accepted for review.

Once an application becomes verified, it will be evaluated for completeness by the HSR&D Program Review staff. **Applications which fail to meet content and formatting requirements or are incomplete will be administratively withdrawn by HSR&D Program Review staff and will not be reviewed.**

No additional or replacement information will be accepted after submission of the proposal, unless requested by the Program Review staff. The only exceptions are official letters of acceptance for publication of manuscripts submitted by the PD/PI. These may be sent by e-mail to the Scientific Merit Review Program Manager (yhacoscircv@va.gov) at any time.

All SDR proposals must include a separate attachment containing a signed copy of the letter of support from the Director of the Medical Center documenting that sufficient resources (i.e., space, equipment, time, appointment, etc.) are available to the investigator. Review of applications submitted to VA-ORD without this attachment will not be accepted for review (see **Note**: *The file names indicated in boldface, italic type in the table below are mandatory and may not be changed (unless specifically indicated in Table 2). Altered file names will cause warnings to be generated and may result in parts of your proposal being excluded from the final electronic image that the reviewers receive or for the sections to appear in the wrong order. Required file names do not contain any spaces. Inclusion of spaces in file names may result in an eRA error message that a required attachment is missing. Incorrect file names may concurrently generate a warning that a file name may not be correct.* To ensure that your application package will be successfully submitted, please adhere to the following guidelines for attachment filenames: avoid using special characters (example: &, -, *, %, /, #) including periods (.); avoid attaching documents with same filename; and limit filename to 50 characters or less.

Table 2, Section 8).

There will be an acknowledgement of receipt of applications from Grants.gov and eRA Commons. The submitting AOR receives the Grants.gov acknowledgments. The AOR and the PD/PI receive eRA Commons acknowledgments. Information related to the assignment of an application to a Merit Review Panel is also in eRACommons.

The eRA system will make every effort to send an email to the PD/PI and AOR/SO summarizing the download and validation results.

NOTE: Since email can be unreliable, it is the responsibility of the applicant and AOR/SOs to periodically check on the application status in eRA Commons.

VA-ORD will not accept any application in response to this RFA that is essentially the same as one currently pending initial merit review unless the applicant withdraws the pending application. VA-ORD will not accept any application that is essentially the same as one already reviewed. This does not preclude the submission of an application already reviewed with substantial changes, but such application must include an "Introduction" (3 pages maximum) addressing the previous critique. Note such an application is considered a "resubmission" for the SF424 (R&R).

4. Intergovernmental Review

Not Applicable.

5. Funding Restrictions

Not Applicable.

6. Other Submission Requirements

PD/PI Credential (e.g., Agency Login)

VA-ORD requires the PD/PI(s) to fill in his/her Commons User ID in the "PROFILE – Project Director/Principal Investigator" section, "Credential" log-in field of the "Research & Related Senior/Key Person Profile" component.

In addition, the investigator profile (Page 18) in ePromise must be completed (including the Commons ID) for all PDs/Pis.

Organizational DUNS

The applicant organization must include its DUNS number in its Organization Profile in the eRA Commons. This DUNS number must match the DUNS number provided at CCR registration with Grants.gov.

Appendix Materials

Applicants **must** follow the specific instructions on Appendix materials as described in the VA-ORD Application Guide SF424 (R&R).

Plan for Sharing Research Data

Not Applicable.

Sharing Research Resources

Not Applicable.

Section V. Application Review Information

1. Criteria

Only the review criteria described below will be considered in the review process.

2. Review and Scoring of Individual Proposals (SDR)

Criteria for Review and Scoring of the Proposal

The following criteria are considered during scientific merit review:

Significance. Does this study address an important problem? Reviewers assess the scientific significance and theoretical foundation of the stated goals, objectives, and specific research questions and/or hypotheses. Reviewers consider the proposed research in relation to information and/or pilot data that the investigator provides regarding prior work (by self and others), as well as information from other sources that relates to the scientific significance and likely contribution of the proposed work.

Reviewers will be specifically asked to comment on the following questions:

- Does the proposed research support/advance the health and healthcare of Veterans?
- Address an important and priority scientific question/area?
- Have potential for contribution to scientific literature?
- Address critical barriers to progress in the field?
- When applicable, comment on:
 - Magnitude of scientific innovation to be achieved, likelihood of new knowledge
 - Impact on health, especially outcomes, prevalence of problem to be addressed
 - ROI to system, policy relevance

Approach. Reviewers assess the appropriateness of the research design and specific methods proposed for conducting the research. Reviewers evaluate the adequacy of data for the proposed study. For primary data, reviewers consider the adequacy of the proposed data collection instrument(s) or the plan for developing and testing new instruments, as well as the feasibility and appropriateness of data collection procedures.

Secondary data issues to be considered include: appropriateness, availability, accuracy, and completeness of data. Applicants proposing to use existing databases need to provide evidence of familiarity with these, and an awareness of the availability, idiosyncrasies, and limitations of the data. For all types of data, reliability, validity, and adequacy of quality control procedures are important issues.

The following list contains some of the elements that reviewers consider, as applicable to a particular project, and in accordance with their particular expertise:

- Study design (e.g., retrospective versus prospective, experimental, quasi-experimental, etc.).
- Analytical approach (quantitative, qualitative, mixed methods).
- Theoretical model and conceptualization of key components.
- Population and sample, sampling plan, and/or comparison groups.
- Statistical power. Power calculations should be described in terms of clinical significance, if appropriate.
- Key variables, operational definitions, and their measurement.
- Data analysis plan.
- Data collection issues, including respondent burden.
- Definition and feasibility of any intervention.

Reviewers will be specifically asked to comment on the following questions:

- Is the overall research plan well-reasoned and appropriate to the aims of the study?
- Incorporate current scientific/theoretical bases?
- Use appropriate research design/methods for addressing hypothesis/research question?
- Demonstrate feasibility?

- When applicable, comment on:
 - Adequacy of methods to answer question with enough specificity to advance knowledge
 - Data quality
 - Appropriately constructed or identified control group for intervention studies
 - Accuracy of power calculations based on prevalence/incidence of condition of population

Impact and Innovation. Is the project original and innovative? Will there be a substantial gain in knowledge? Will the finding advance the field? To what degree will this study impact the lives of Veterans? Reviewers will be specifically asked to comment on the following questions:

- Is the potential impact on advancing the health and health care of Veterans substantial?
- Risk worth the reward with early pay-off?
- Challenges or re-directs current research models and/or intervention paradigms?
- Addresses novel concepts, methods, interventions and/or gaps in state-of-the-science?
- When appropriate, comment on:
 - Likelihood of uptake of findings or recommendations
 - Study orientation toward implementation
 - Appropriate involvement of relevant clinical or operational partners in proposal development

Investigators and Environment. Reviewers evaluate the overall organization and management of the project to evaluate whether the initiation, conduct, and completion of the proposed research is feasible. Factors that may be considered are:

- Distribution of roles and responsibilities across project staff;
- Justification of Full-time Employee Equivalent (FTEE) allocations for each project year;
- Plans for coordinating multiple participants, tasks, or sites;
- Reasonableness of the timeline showing important benchmarks and products; and
- General feasibility of the management plan.

Reviewers will be specifically asked to comment on the following questions:

- Is the research team appropriate?
- Have a track record for success?
- Have the knowledge/background and resources (e.g., equipment, staff, mentorship for early stage investigators) to ensure timely and successful project completion?
- Capitalize on unique expertise or opportunity?
- When appropriate, comment on:
 - Implementation expertise of study team
 - Qualifications for mixed methods or qualitative analyses

Investigator Qualifications. Reviewers assess the expertise of each investigator and each major consultant, including professional credentials, institutional position, role in the project, expertise (especially as reflected in publications), and relevant experience. All reviewers assess the combined strength of the team in relation to the objectives of the project and determine whether it encompasses all needed skills and competencies.

Leadership Plan. Reviewers assess the rationale for using a multiple PDs/Pis approach. They consider the structure and governance of the leadership team as well as the knowledge, skills and experience of the individual scientists. They evaluate the role of each PD/PI in the project, particularly their unique expertise and potential contribution to the project.

Study Participants. Reviewers evaluate the risk/benefit ratio of the study, analyzing whether the study places human participants at risk of physical or psychological harm and evaluating the adequacy of provisions to minimize risk, protect participants' privacy and the confidentiality of their records or responses, ensure informed consent, and minimize respondent burden. In considering human study participant issues, reviewers may question the decision of an IRB and may impose a stricter standard (see [VHA Handbook 1200.05](#)).

Inclusion of Women and Minorities. VA mandates that all research proposals reviewed and funded by ORD include women and minorities in their study populations to the extent possible. HSR&D reviewers are responsible for considering the adequacy of representation and to assess whether investigators have made a substantive effort to include women and/or minorities in each research proposal.

Facilities and Resources. Reviewers evaluate the adequacy of facilities and resources to carry out the proposed study. The proposal must include evidence of support from the applicant's VA facility, support from any additional study site(s), and documentation of any agreements with consultants, or commitment of non-VA resources to the study.

Budget. Project budgets need to be appropriate to the proposed work, sufficiently detailed, and well-justified. Reviewers assess the reasonableness of the project timeline and costs allocated to major budget categories. Personnel costs, and whether proposals are staffed appropriately, are key considerations. Prior to any funding decisions, all proposals under consideration will undergo administrative review of budgets by HSR&D staff. Items that appear to be outliers, line items that change markedly from one year to another, identical total annual requests, and large amounts for equipment, travel, or subcontracts are scrutinized. This review ensures that VA research funds are not used for any unauthorized purposes and that the proposed budget is well justified.

Importance of the Problem Addressed. Reviewers assess the importance of the problem or question that the proposed research seeks to address, in terms of its prevalence, severity, urgency, cost, etc., for VA and the general public. The importance of the problem is assessed independently of the investigator's approach.

Contribution to VHA. Reviewers consider the expected contribution of findings of the proposed research to improving the quality, effectiveness, or efficiency of health care in VA, or its potential to improve the health status of veterans. This includes consideration of the adequacy and sustainability of the investigator's plans for translating findings into practice.

Disapproved Proposals

A proposal may be disapproved if it is determined that the proposed study is unethical, is unlikely to yield useful information, or is not relevant to VA's mission.

- Proposals that are disapproved are not given a numerical score and may not be resubmitted.
- Studies disapproved for ethical considerations may not be carried out in VA space, with VA resources, even if the project is funded by another agency.

Appeals

The appeals process is intended to ensure that the scientific review of all proposals is fair and equitable. It is not intended as a means to resolve differences in scientific opinion between the applicant and the reviewers, to adjust funding decisions, or to circumvent the peer review process.

If a Principal Proponent submits a revised application and an appeal of the previous application is subsequently sustained and funded before the revised application is reviewed, the revised application will be administratively withdrawn. If the revised application receives a fundable score and the appeal is sustained and fundable, only one of the two proposals will be funded.

Note: Applicants are encouraged to revise and resubmit their SDR, if allowed, or submit a new Merit Review proposal while an appeal is under review.

2.A. Additional Review Criteria

In addition to the above criteria, the following items will continue to be considered in the determination of scientific merit and the priority score:

Protection of Human Subjects from Research Risk: The involvement of human subjects and protections from research risk relating to their participation in the proposed research will be assessed

according to the following criteria: (1) Risk to subjects; (2) Adequacy of protection against risks; (3) Potential benefits of the proposed research to the subjects and others; (4) Importance of the knowledge to be gained; and (5) Data and safety monitoring for clinical trials. See Part II of the VA-ORD Application Guide SF424 (R&R). Plans for the recruitment and retention of subjects will also be evaluated. Use of non-Veteran subjects must be justified.

Inclusion of Women, Minorities, and Children in Research: When human subjects are involved in the proposed research, the scientific merit review group will also evaluate the adequacy of proposed plans to include subjects from both genders and all racial and ethnic groups (and subgroups), as appropriate for the scientific goals of the research. See Part II of the VA-ORD Application Guide SF424 (R&R).

Research involving children is restricted in VA-approved research and must not be conducted by VA investigators while on official duty, or conducted at VA facilities or approved off-site locations, unless a waiver has been granted by the Chief Research and Development Officer.

NOTE: Congressionally-mandated research programs that involve children are exempt from this policy.

If such a waiver is approved, the involvement of children as subjects in research must be in compliance with all applicable Federal regulations pertaining to children as research subjects (see [VHA Handbook 1200.05](#)).

Care and Use of Vertebrate Animals in Research: If vertebrate animals are to be used in the project, the adequacy of the plans for care and protection of vertebrate animals will be assessed for the following: (1) Detailed description of the proposed use of the animals; (2) justification for the use of animals and for the appropriateness of the species and numbers proposed; (3) adequacy of proposed veterinary care; (4) appropriate procedures for limiting pain and distress to that which is unavoidable; and (5) appropriate methods of euthanasia. See the "Other Project Information" component of the SF424 (R&R).

2.E. Additional Review Considerations

Budget and Period of Support: The appropriateness of the proposed budget and the requested period of support in relation to the proposed research may be assessed by the reviewers. The priority score should not be affected by the evaluation of the budget.

2.C. Sharing Research Data

Not Applicable.

2.D. Sharing Research Resources

Not Applicable.

3. Anticipated Announcement and Award Dates

The earliest possible start date is June 1st for proposals submitted to this RFA.

Section VI. Award Administration Information

1. Award Notices

After the peer review of the application is completed, the PD/PI (only) will be able to access his or her Final Score and Summary Statement (written critique) via the NIH eRA [Commons](#) once this information has been released by HSR&D Staff. A separate notification of the review meeting outcome will be sent to the medical

center director, ACOS/R&D, AO/R&D and if there is a HSR&D Center at the PI's location, to the Center (COE, REAP) Director.

If the application is under consideration for funding, VA-ORD will request "Just-in-Time" information from the applicant. If an application is not selected for funding it will remain in eRA in a "pending council review" status.

The summary statement and preliminary budget can be accessed through eRA Commons.

2. Administrative and National Policy Requirements

Research Integrity. HSR&D is committed to the highest standards for the ethical conduct of research. Maintenance of high ethical standards requires that VA medical centers and investigators applying for, and receiving, Merit Review or SDR Awards have appropriate procedures to preclude the occurrence of unethical research practices. All research data must be retained for 5 years after completion of a research project.

The PD/PI and others associated with the research must subscribe to accepted standards of rational experimental research design, accurate data recording, unbiased reporting of data, respect for the intellectual property of other investigators, adherence to established ethical codes, legal standards for the protection of human and animal subjects, and proper management of research funds.

Deliberate falsification or misrepresentation of research data will result in withdrawal of an application, possible suspension or termination of an award, and potentially, suspension of the investigator's eligibility to submit proposals to HSR&D.

Acknowledging VA Research Support. By accepting a Merit Award, the PD/PI of each individual project agrees to properly acknowledge VA affiliation and support in all public reports and presentations (See [VHA Handbook 1200.19](#)). **Failure to acknowledge VA affiliation and support may result in termination of the award.**

Intellectual Property Rights. By accepting a Merit Review or SDR Award, the PD/PI agrees to comply with VA policies regarding intellectual property disclosure obligations and Federal Government ownership rights resulting from the proposed work (See [VHA Handbook 1200.18](#)).

Section VII. Agency Contacts

We encourage scientific/programmatic inquiries concerning this funding opportunity and welcome the opportunity to answer questions from potential applicants. **Questions concerning electronic submission should be directed to Grants.gov or eRA Commons.**

Reminder: To ensure a timely response, all questions related to the Merit Review or SDR submission should be directed to the Scientific Merit Review Program staff (vhacoscirev@va.gov). All questions concerning electronic submission should be directed to the eRA mailbox in Outlook at rd-era@va.gov. Telephone calls and/or emails sent to individual staff may go unanswered if that staff member is out of the office.

1. Scientific/Research Contact:

Inquiries related to SDR submissions should be directed to Joshua Robinson, MPH, Health Science Specialist, at Joshua.Robinson@va.gov. The PD/PI may also contact Mr. Robinson with questions specifically related to scientific issues raised in the summary statement for a reviewed proposal or the scientific content of a proposal

to be submitted. The Associate Chief of Staff for Research and Development (ACOS/R&D) should make all other contacts with HSR&D staff at VA central office (VACO), including questions relating to budget modifications noted in the summary statement.

2. Financial Management Contact:

Mary Jones at mary.jones@va.gov or (202) 443-5628.

3. Administrative Contact(s):

For HSR&D: Joshua Robinson at Joshua.Robinson@va.gov or (202)443-5664.

