

Questions for the Record
House Committee on Veterans' Affairs
"U.S. Department of Veterans Affairs Budget Request for Fiscal Year 2019"

February 15, 2018

Questions for the Record from Chairman Roe:

Question 1: Current appropriations into the Choice Program fund are projected to last through the end of fiscal year 2018. How much additional funding is needed to sustain the program through the enactment and implementation of community care consolidation legislation, and is all such funding provided in the Bipartisan Budget Act of 2018, P.L. 115-123 and its resulting allocations?

- a. Please answer the above questions assuming a March 2019 implementation.
- b. Please answer the above questions assuming any other implementation date that VA believes is appropriate or may become appropriate.

VA Response: The Bipartisan Budget Act of 2018 provided the necessary funds to support the Veterans Choice Program with mandatory resources through May of 2019. VA strongly supports the MISSION Act and thanks Congress for its enactment of this top Administration priority. The fiscal year (FY) 2019 Budget fully funded Community Care, but assumed enactment by February 2018 of community care consolidation legislation (CARE, as proposed by VA). Due to the delay in enactment, VA will require an additional \$1.6 billion in FY 2019 for VA's traditional community care program. In addition, the final MISSION Act included expanded eligibility and new programs that were not included in the VA's FY 2019 or FY 2020 Advanced Budget Request.

Question 2: Assuming enactment and implementation of community care consolidation legislation, considering VA's budget request for fiscal year 2019 appropriations, fiscal year 2020 advance appropriations, and additional funding provided in the Bipartisan Budget Act and its resulting allocations, would community care programs be fully funded in fiscal years 2019 and 2020?

VA Response: The FY 2019 Budget fully funded Community Care, but assumed enactment by February 2018 of CARE legislation. Due to the delay in enactment, VA will require an additional \$1.6 billion in FY 2019 for VA's traditional community care program. This does not include the additional funding due to new unfunded MISSION Act programs and expanded eligibility.

Question 3: Many of the figures in the Department's budget proposal assume VA legislative proposals have already been enacted.

- a. If all legislative proposals are not enacted by the beginning of fiscal year 2019, assuming the proposed funding levels were enacted, would those funding levels be sufficient and those budget projections remain accurate?

VA Response: There are a few proposals that, with delayed enactment, will increase costs. One that is particularly impactful and therefore concerning is a provision enacting Medicare rates for the new Community CARE program. Delay could increase VA's costs by approximately \$1.6 billion in FY 2019.

- b. If the community care consolidation proposal is not enacted by the beginning of fiscal year 2019, assuming the proposed funding levels were enacted, would those funding levels be sufficient and those budget projections remain accurate?

VA Response: The MISSION Act provided the necessary funds to support the Veterans Choice Program with mandatory resources through May of 2019. VA strongly supports the MISSION Act and thanks Congress for its enactment of this top Administration priority. The FY 2019 Budget fully funded Community Care, but assumed enactment by February 2018 of CARE legislation. Due to the delay in enactment, VA will require an additional \$1.6 billion in FY 2019 for VA's traditional community care program. In addition, the final MISSION Act included expanded eligibility and new programs that were not included in the VA's FY 2019 or FY 2020 Advanced Budget Request.

- c. If the legislative proposals regarding construction and leasing thresholds and joint facilities authorities are not enacted by the beginning of fiscal year 2019, assuming the proposed funding levels were enacted, would those funding levels be sufficient and those budget projections remain accurate?

VA Response: Yes, even if the legislative proposals are not enacted by FY 2019, the funding levels would be sufficient to cover cost for these programs.

Question 4: VA's budget request represents a historic increase for the Department, larger in percentage terms than for any other agency. The budget narrative mentions "modernization reforms and other efficiencies." What are the top 10 proposed reforms or efficiencies that will produce savings, ranked in order of dollar value? Such savings should not be offsets for other spending increases but rather efficiencies, programmatic, administrative, or otherwise, that will produce tangible savings measured against current expenditures.

- a. How will veterans experience the proposed reforms, efficiencies, and savings, and how will VA services be impacted?
- b. How will the reforms, efficiencies, and savings impact access to care?

VA Response: VA is modernizing to improve performance and to better serve Veterans, their families, caregivers, and survivors while being good stewards of tax

payer dollars. Guided by both the Secretary's priorities and the President's Executive Order (EO), "Comprehensive Plan for Reforming the Federal Government and Reducing the Federal Civilian Workforce," VA is focused on reducing bureaucracy; simplifying core functions; increasing accountability; encouraging bold and decisive leadership; streamlining services and programs by eliminating redundancies; and empowering employees to do the right things for Veterans.

In developing this plan, VA reviewed numerous studies and assessments that project potential cost savings or avoidance as a result of these modernization efforts. While we are still evaluating the tangible and intangible benefits associated with each initiative, we believe there are specific cost reduction opportunities in several areas, including our contact centers and supply chain as detailed below.

Modernization is not a one-time effort to make updates: these are significant changes that will advance internal and external operations. The following provides insight into how the Department is modernizing to improve efficiency and delivery of care and services for Veterans.

1. Telehealth: VA will continue to leverage Telehealth technologies to enhance accessibility, capacity, and quality of VA healthcare. By expanding Telehealth capabilities, VA seeks to increase access to services for Veterans living in rural and remote locations, increase availability of specialty services, and reduce the volume of onsite patient care.
2. Community Care: VA has submitted, and Congress has passed a plan for consolidating several programs that provide community care through non-VA providers into a new, single VA Community Care program in FY 2018. This will expand access to care by allowing Veterans to obtain health care services outside the Veterans Health Administration (VHA) if those services are not available or readily accessible within VHA. Consolidating programs under a single executive will improve accountability and provide VA with the ability to direct funding for non-VA care to emerging high-priority needs as appropriate.
3. Change in Timing of Obligations: The FY 2019 Budget includes a savings of \$1.8 billion from changing the time of community care obligation. The proposed accounting change will mean that obligations will be recorded at the time claims are processed and approved, thereby eliminating the uncertainty regarding the actual total obligations against the program. The Department believes that this change in obligation procedure will improve program management and the ability to forecast and justify budget requirements.
4. Appeals Modernization: Working collaboratively with stakeholders to implement legislative change by February 2019, Veterans Benefits Administration (VBA) and the Board of Veteran Appeals (Board) will address the current pending inventory of legacy appeals and implement a streamlined process. This effort will shorten the time to process appeals; increase transparency of the appeal

process; and reduce the amount of time and resources required to process appeals.

5. 5. Suicide Prevention: Reducing suicide among Veterans is VA's top clinical priority and VA is implementing a comprehensive strategy (e.g., leveraging Federal, state, local, private, services and benefits) to reduce suicide from its current rate of approximately 20 Veterans per day.
6. 6. IT Modernization: This initiative will replace legacy IT systems and infrastructure with modern technologies and applications in order to overcome security and business requirement deficiencies. VA currently has more than 130 legacy systems that place the Department at considerable risk of being unable to deliver care and benefit services. This effort will increase responsiveness, agility and flexibility while reducing recurring costs necessary to sustain outdated, legacy systems.
7. 7. Electronic Health Record Modernization (EHRM): On May 17, 2018, VA signed a contract with Cerner to modernize its Electronic Health Record (EHR) by replacing the legacy VISTA system and adopting/deploying a common system being deployed by the Department of Defense (DoD). It is one of the largest IT contracts in the federal government, with a ceiling of \$10 billion over 10 years. When complete, this will increase interoperability, accuracy of information, responsiveness and access to care, reliability, transparency and accountability while reducing improper payments.
8. 8. Financial Management Business Transformation: VA's Financial Management Business Transformation (FMBT) will replace VA's legacy Financial Management System by providing a modern, integrated financial management and acquisition solution. FMBT will increase the transparency, accuracy, timeliness, and reliability of financial and acquisition information across VA, resulting in improved fiscal accountability to American tax payers and an increased standard of excellence for Veterans and those who serve them.
9. 9. Navigator - Contact Center Modernization: VA is transitioning its contact centers away from antiquated, defragmented, legacy systems to an agile, innovative cloud solution to optimize responses to the 140 million calls flooding VA's 1,000+ toll-free and direct dial numbers annually. Specifically, best practices for enterprise contact centers include use of a tiered structure to drive calls to the least expensive tier capable of responding to the callers' needs. By implementing such a structure VA expects to realize enterprise operating cost avoidance for labor standardization and first call resolution that exceeds \$400 million annually. Additionally, a centralized source of data and interaction history will enable VA to make data-driven, Veteran-focused improvements.
10. 10. Improving Foundational Business Functions: VA is restructuring its central office functions to become more agile and responsive. This includes consolidating

redundant functions, delaying and pushing decision rights to the lowest appropriate level, improving processes and technology, and redirecting resources from headquarters to the field to support delivery of services to Veterans. The following three examples illustrate progress on this initiative:

- a. Supply Chain Modernization: Modernizing VA supply chain to a streamlined, responsive enterprise supply chain will significantly enhance the delivery of care and service in a timely fashion. Applying the insights from the Commission on Care (e.g., recommendation #8, "Transform the management of the supply chain", which described the organizational structure as "chaotic" and noted that "processes are not aligned to business functions."), and several independent analyses, VA achieved cost avoidance in excess of \$150 million in each of last 2 FYs. This effort will drive accountability and consistency across VA, gaining efficiencies that better serve Veterans, taxpayers, and VA clinicians while contributing to improvements in patient safety, quality of care, access to care, and allocation of clinical resources.
- b. Human Resources (HR) Modernization: VA is seeking to gain efficiencies by consolidating HR transactional service capabilities; business functions and upgrading HR information technology systems. This will improve performance of HR functions and result in efficiencies through process consolidation and reform.
- c. Construction and Facilities Management: VA is assessing options to establish a unified, fully integrated enterprise construction and facilities management function through the realignment of operational components currently dispersed among 7 offices and 19 sub-offices. This initiative is in accordance with findings and recommendations from the Commission on Care Independent Assessment Section K, United States Army Corps of Engineers and Defense Health Agency reviews. The positive impacts include reduction of needless bureaucratic hurdles and resultant wasted staff time and effort. In addition, the referenced studies indicate that (depending upon the ultimate realignment) considerable savings are possible via: appropriate capital facilities inventory; elimination of redundant staff; streamlined procedures; reduced facility maintenance costs; discretionary redirection of facility management savings, and more. These effects will allow for improvements in delivery speed in providing modern efficacious facilities for Veterans' point of health-care delivery. Though it will require time, a direct benefit to Veterans is that VA will be more enabled to strategically address the \$19 billion Facility Condition Assessment backlog of deficient findings. The long-term result will be more reliable, better designed facilities allowing for better patient access, scheduling and throughput.

While each initiative is intended to ultimately benefit Veterans, the following table summarizes which initiatives will have a direct impact to Veterans and access to care.

Modernization Initiatives	Direct Impact to Veterans	Direct Access to Care
Telehealth	X	X
Community Care	X	X
Change in Timing of Obligation		
Appeals Modernization	X	
Suicide Prevention	X	X
IT Modernization	X	X
Electronic Health Record	X	X
Financial Management Business Transformation		
Navigator	X	X
Delaying VA Central Office	X	X
- HR Modernization		
- Supply Chain Modernization		X
- Construction and Facilities Management		X

Question 5: Written testimony indicated VA has taken steps to achieve mandatory savings of \$30 billion over the next 10 years. Is that a \$30 billion savings or a slowing of the rate of spending growth of \$30 billion over the next 10 years?

VA Response: The reduction in mandatory spending will be achieved through administrative reforms that will slow the rate of growth over ten years starting in FY 2021.

Question 6: Please detail how the growth rate of VA's mandatory expenditures will be reduced.

VA Response: Due to advancements in treatment and medical technologies, there has been a decrease in the impacts of certain disabilities on the lives of many Veterans. VA will realize savings by promoting the well-being and enhanced functioning of Veterans and conducting administrative reviews of the disability compensation criteria.

Question 7: Under the proposed Electronic Health Records Modernization (EHRM) program and its contract which has now been essentially completely negotiated, please describe the end states of interoperability with the Defense Department and with VA community providers which will be achieved at the end of two, five, and ten years.

VA Response: VA will leverage a business and technical solution that will help to ensure the health and safety of Veterans through a new EHR interoperable with DoD and community providers. VA will continue to work closely with DoD to implement their lessons learned and optimize VA's prospective schedule. At the end of implementation, VA will achieve interoperability across the Department, between DoD, and amongst VA community care providers. VA is cautiously balancing the timeline of implementation of the EHR with risk to cost, schedule, and performance objectives.

Question 8: When does VA project to reach a "break-even point" after completing EHRM, comparing the costs of carrying out the program and sustaining its future-state systems against the known costs of sustaining current systems, including VistA, CPRS, and all others which are slated for replacement?

VA Response: The EHRM Program Executive Office (PEO) is planning efforts to generate the data needed to conduct a "break-even point" analysis. These types of analyses are complex. These efforts include gathering the data needed to estimate EHRM's total life-cycle costs to help the program understand the costs that will have an impact and when these costs will occur. In addition, PEO is working through plans to understand the regional aspects of nationally deployed systems that can be depreciated and estimating the cost savings as a result. Finally, PEO will collaborate with counterparts in the Office of Information & Technology to understand and validate current development, maintenance and sustainment costs.

Question 9: In what year does VA expect completely to phase out VistA and CPRS, assuming the EHRM program's scheduled progress is achieved through its completion?

VA Response: We expect VistA to operate in parallel with the Cerner Millennium solution for a period of time that has yet to be determined. Our Initial Operating Capability (IOC) site implementation in the Pacific Northwest over the first 18 months of EHR implementation following contract award will solidify our "pivot plan" for when we will be able to transition from VistA-delivered functionality at a site to the new EHR solution without compromising our Veteran care objectives. These findings at IOC will be used to support full enterprise deployment timelines and corresponding site transitions from VistA to the state-of-the-market EHR.

Question 10: The budget proposal includes funding within the Electronic Health Record Modernization Infrastructure Support line item for continued VistA Standardization. How will VA ensure the ongoing VistA standardization effort will not impede progress to implement the Cerner EHR?

VA Response: It is expected that the current VistA Standardization work will be completed at the beginning of FY 2019. Furthermore, VA anticipates additional work on a limited scope for data dictionary normalization as a part of the VistA Standardization work. The funding would also address some potential portions of VistA and CPRS that will need to be standardized with the new commercial EHR. This would provide best practices in certain workflows from the new EHR to VistA and CPRS.

Question 11: As presented in VA's annual agency financial report, the Department's total budgetary resources in fiscal year 2017 were approximately \$229 billion. Assuming the Department's total FY 2019 request of \$198.6 billion is granted, how much are the total budgetary resources expected to be?

VA Response: The \$229 billion in total budgetary resources identified in the annual Agency Financial Report (AFR) represents the Department's total spending authority in FY 2017. In addition to appropriations, this figure includes collections from revolving funds (Medical Care Collections Fund [MCCF], Canteen, Supply, Franchise, others), unobligated balances, including VA' mandatory programs, and borrowing authority.

VA's 2019 President's Budget request complies with scoring practices established by the Office of Management and Budget (OMB). The AFR includes off-budget authority and unobligated balances, which are identified in the budget. Therefore, the President's Budget is the most accurate representation of VA's request for new appropriations in FY 2019.

Question 12: VA previously proposed recording community care obligations at the time of payment, rather than estimating them in advance and then reconciling actual expenditures. VA has determined it has the authority, without legislation, to start doing so at the beginning of fiscal year 2019. The proposed community care budget assumes a favorable, one-time change in the timing of obligations worth \$1.8 billion. Please explain in detail how this number was developed.

VA Response: VA used the historical FY 2015 and FY 2016 inpatient and outpatient payment data to determine the FY 2019 \$1.8 billion one-time timing of obligations savings. VA ascertained that on average it takes up to 3 months before VA receives the claim from the community providers, the claim is adjudicated, and the payment is made to the community providers. VA also determined that 92 percent of the accrued obligations (those not executed in the current fiscal year) resulted in a payment within 2 years. VA anticipates minimal obligations during the first 3 months of FY 2019, the first year of the transition to recording the obligation at the time of adjudication. VA will continue to process payments (expenditures) for care obligated prior to FY 2019 using the previous methodology (obligate at time of authorization) to reconcile actual expenditures.

Question 13: The proposed community care budget relies on \$1.38 billion of "transfers, unobligated balances, and recoveries" in fiscal year 2019. Please explain

what this number contains and how each element of the overall total was developed.

VA Response: Please see the chart below.

Dollars in Thousands (\$000)	2019 Revised Request
Description	
Transfers (+/-)	
Medical Community Care Transfer to Medical Facilities (0162).....	(\$39,334)
Medical Community Care Transfer to FHCC (0169).....	(\$26,504)
Transfer from Medical Services (0160) to Medical Community Care (0140).....	\$446,000
Subtotal.....	<u>\$380,162</u>
Unobligated Balances	
Unobligated Balance (SOY).....	\$1,000,000
Unobligated Balance (EOY).....	\$0
Subtotal.....	<u>\$1,000,000</u>
Prior Year Recoveries.....	\$0
Total.....	<u>\$1,380,162</u>

Transfer

- Proposed transfer of \$39.334 million to Medical Facilities will support estimated obligations of \$6.145 billion, which includes anticipated Non-Recurring Maintenance obligations of \$1.446 billion.
- Proposed transfer of \$26.504 million to the Joint-DoD VA Medical Facility Demonstration Fund will support estimated obligations of \$449 million.
- Transfer of \$446 million from Medical Services to Medical Community Care will support estimated obligations of \$10.515 billion. In FY 2019 the budget submission proposes to merge the Medical Community Care appropriation with the Medical Services appropriation. For purposes of responding to this question, Medical Community Care is shown separately.

Unobligated Balances

- Funds remaining (carryover from FY 2018 into FY 2019) from Medical Community Care. Medical Community Care obligations estimate in FY 2018 is \$9.363 billion. Funds will be utilized in FY 2019 to support Medical Community Care obligations of \$10.515 billion.

Prior Year Recoveries

- Prior Year Recoveries estimate is \$0.

Question 14: The budget includes a legislative proposal to grant VA general transfer authority between discretionary accounts up to 2 percent of the Department's total discretionary appropriations. This year, VA's discretionary request is a little over \$83 billion, excluding medical care collections; 2 percent of that total equates to approximately \$1.7 billion. Please provide examples when it has been necessary to transfer this much funding and complying with the existing congressional notification process hampered the Department's operations.

VA Response: The Department's request for General Transfer Authority of 2 percent would provide the needed flexibility to manage unanticipated needs during the FY. One recent example where this authority would have provided the Department the flexibility to address unplanned requirements was the proposed transfer of funding for the EHR initiative.

Question 15: The budget proposal contains a narrative contending the separate Community Care account has restricted VA medical center directors from managing their budgets effectively. Please provide specific examples of this.

VA Response: The current multiple medical care appropriations structure presents an administrative burden to the Medical Center Directors. While not insurmountable, it does not permit the Medical Center leadership to easily leverage all the tools available for providing Veterans with the care they need. Having both Medical Services and Medical Community Care (MCC) aligned under one appropriations account would allow Medical Center Directors the flexibility needed to expediently address care-related issues in ways that are beneficial to our Veterans.

1. Prior to the implementation of the MCC account, VA medical centers locally allocated funds between VA Medical Center (VAMC) salaries and care in the community, ensuring Veterans had timely access to care. This flexibility was lost with the creation of the MCC account. This proposal allows the previous flexibility while ensuring timely access to care and to strategically and efficiently use the funds. Below are specific examples.
 - a. A VAMC has a physician vacancy that has been unfilled for some time, but is able to finally hire someone for that position. Because the workload associated with this new hire would have been reflected in community care in the recent past, the VAMC would like to move the funds back in house and provide the care at lower cost than purchasing it from the community. Under the current appropriation structure, this requires a time consuming transfer process, and until such a transfer could be accomplished, the VAMC must identify in-house funding offsets, possibility limiting clinical care in another area.

- b. A rural VAMC is providing 1,200 sleep studies each month through care in the community at the cost of \$864,000 a year. Total estimated staffing and supply costs to bring those services in-house is estimated to be \$450,000 a year, but the process of transferring funds between appropriations accounts is time consuming and administratively burdensome.
 - c. A VAMC has sufficient operating room capacity, outpatient clinical space, and equipment to provide clinical services, but lacks the flexibility to convert community care funds to medical services funds in a timely manner.
2. The current multiple medical care appropriations structure negatively impacts existing sharing agreements with adjacent university hospitals. VA sharing agreements are funded with the Medical Services appropriation. When medical centers exceed the annual allotted budget for the sharing agreement(s), the medical center is required to send Veterans for care in the community for the remainder of the FY. For specialty care, such as orthopedic surgeries, the cost is frequently much more costly than through the sharing agreement.
 3. Strategic investment in capital equipment and staffing is limited without the flexibility to transfer funds expeditiously between appropriations. With the combined appropriation, medical center directors would have more flexibility to reallocate the MCC funds to purchase necessary equipment as well as to fund necessary salaries. As one specific example, a VAMC currently sends out all low-dose Computerized Tomography scans to the community. The VAMC would like to realign the community care funds to provide this service in-house at lower cost.

Question 16: If the Medical Services and Community Care accounts are merged as requested, how would VA ensure that each Veterans Integrated Service Networks (VISN) and VAMC allocates sufficient funding to community care, and does not deny veterans access to community providers in order to maintain their internal budgets, as happened not infrequently before the accounts were separated?

VA Response: VA uses an actuarial model, the Enrollee Health Care Projection Model (EHCPM), to develop health care requirements for Veterans. The EHCPM develops estimates for both community care and care provided in VAMCs. If VA's proposed change were made, VA would continue to include separate estimates for community care funded within the Medical Services appropriation in the President's Budget request. VA would also continue to discretely account for community care obligations using the same underlying accounting structure currently in place for the separate Medical Community Care appropriation. Concurrent with the request to combine the Medical Services and Medical Community Care appropriations accounts, VA is submitting a legislative proposal to allow VA to use a model similar to that used for the Consolidated Mail Outpatient Pharmacy program, where the funds will initially reside with each VAMC, but will be provided by the VAMC to the Deputy Under Secretary for

Community Care to manage during the year. Based on the demand for community care and the ability of the VAMC to provide more care in house at lower cost, the amount provided can be rapidly adjusted to meet changes in each VAMC's ability to provide care in-house.

Question 17: What is the VISN's role in making sure facilities within its boundaries have enough funds to cover contingencies in either the Medical Service or Community Care accounts?

VA Response: The VISN is responsible for establishing emergency reserve funds in the Medical Service account. The reserve fund allows the VISN to address contingencies. VISN leadership routinely identifies needs/excess and realigns funds between facilities as needed.

Question 18: How does this budget proposal contemplate absorbing additional demand or utilization that may result from community care consolidation?

VA Response: The FY 2019 Budget request fully funded VA's Community Care needs consistent with the assumptions identified below.

- The FY 2019 Budget includes \$14.2 billion in total programmatic resources after adjusting for the impact of the change in timing of obligations.
- The Budget increases VA's ability to manage limited resources by funding all community care entirely with discretionary funds and by merging the Medical Community Care appropriation account with the Medical Services account. These flexibilities, combined with the efficiencies included in the CARE legislation, will empower VA to focus and manage resources without requiring subsequent bailouts.
- VA will continue to work with Congress and stakeholders to improve Veterans health care and maximize the quality, efficiency, and fiscal sustainability of VA's community health program.

The MISSION Act provided the necessary funds to support the Veterans Choice Program with mandatory resources through May of 2019. The delay in enacting the new community care program could require an additional \$1.6 billion in FY 2019 for VA's traditional community care program. In addition, the FY 2019 Budget did not include funding to support some of the unfunded programs included in Mission or the expanded eligibility.

Question 19: The budget proposal states VISN and medical center leaders are being asked to assess community care options to give veterans greater convenience. Please provide a copy of the policy creating this directive and explain how it was disseminated.

VA Response: Currently, there is no policy. However, VA facility and VISN leaders continue to assess options for health services that could be more conveniently delivered by community providers. VA leaders are also considering accessibility of VA facilities and convenience factors (like weekend hours), as they develop recommendations for community access to non-VA providers for Veterans in their service areas. Defining VA-delivered foundational services and a process for determining which services VA should deliver in its own facilities and which services VA should purchase from community providers and Federal partners will enable VA to provide access to high-quality care for Veterans by balancing care provided by VA and the community/partners while addressing the increasing demand for care. Increased operational efficiency promotes VHA's continuing commitment to its four missions:

- Education of health professionals;
- Research to advance the care of Veterans;
- Supporting our Nation's emergency preparedness and; above all else
- Providing the best possible care for Veterans.

Question 20: In this budget proposal, VA has created a ranking process specifically for non-recurring maintenance projects, whereas previously they were considered together with the minor construction projects. The stated goal is to give VISN directors more input. What is the intended outcome of this change, and how will doing so enable non-recurring maintenance projects to be selected more accurately or accomplished more quickly?

VA Response: In previous years, the budget development of the Strategic Capital Investment Plan (SCIP) decision criteria model was the same for Non-Recurring Maintenance (NRM), Minor Construction, Leasing, and Major Construction. The SCIP decision criteria model included seven primary criteria and over twenty-two sub-elements. Not all elements of the decision criteria model were applicable to the NRM program; as many of the elements were strategic in nature and could not be accomplished through the NRM program. Through this budget proposal a focused and streamlined decision criteria model was developed specific to the NRM program that included the following three primary criteria: VISN Priority, Facility Condition and Planning priorities.

This newly developed decision criteria model provides a more focused request for NRM projects in 2019 and a prioritized list of NRM initiatives that reflect the top priority of the VISN while also focusing the limited NRM funding on the NRM program goals of addressing VHA's most pressing infrastructure needs. This change removes NRM project prioritization from a compiled list of all strategic initiatives in the Minor Construction, Major Construction, and Leasing programs, which approvals are based upon multiple elements not relevant to NRM projects. Additionally, this change allows for the focused criteria specific to the NRM program.

Question 21: The budget includes two legislative proposals allowing expanded funding transfer authority for joint construction and facilities projects, with the Defense Department and other agencies. A version of this language also appears in VA's proposed CARE legislation. If enacted, how will VA ensure such funds would be spent effectively after they become comingled and the management and execution responsibility, formerly residing in VA, is divided between two agencies?

VA Response: If the VA/DoD proposal is enacted, both Departments will utilize lessons learned from previous experiences, including the operation of the Captain James A. Lovell Federal Health Care Center in North Chicago, to ensure proper management and execution of joint capital projects. Prior to the implementation of the effort, VA will ensure appropriate financial controls are put in place to avoid comingling or inefficient use of funds before any funds are transferred between Departments.

Question 22: The budget request includes \$150 million for state extended care matching grants, which is expected to fund 10 grants. How many beds will that produce?

- a. The budget request also includes \$190 million to build one, 120-bed community living center in Canandaigua, New York, as well as to renovate three buildings there. Has the Department conducted any formal analysis or cost-benefit study comparing the efficiency of producing community living and extended care beds through state grants compared to VA construction?

VA Response: Canandaigua VA Medical Center does not have a methodology to determine how many State Veterans Home beds would be created by \$150 million in extended care matching grants or the locations in which the State Veterans Home beds would be created. Population demographics may suggest greater need for this type of bed expansion in other areas of the country. The budget request is not for the construction of a new community living center (CLC), but is for the replacement of the current facilities. The Canandaigua VAMC current has 116 operating nursing home beds on their campus, with an Average Daily Census for the 1st quarter of FY 2018 of 93.7. Currently, there is no capacity in their community to absorb CLC Veteran Residents at this time, either in the State Veterans Homes or Community Nursing Homes. At this time, the Canandaigua VAMC has contracts with 4 community nursing homes (3 in Rochester, NY, and 1 in Lyons, NY). As with many VA CLCs, there are Veterans with medical and mental health co-morbidities for whom there are limited to no community options. The Canandaigua VAMC plans to develop this CLC as a niche with the small house model to assist other facilities across the New York region that have Veterans who are difficult to place in the community settings and who are residing in acute care settings. VA is currently rolling out a new initiative, Care of Patients with Complex Problems to assist VAMCs nationwide in establishing systems to optimize care for this difficult population.

The State of New York currently has 5 State Veterans Homes; however, only one is located within a reasonable geographic proximity (Batavia) and, it is the smallest of the 5 state homes. VA stands ready to assist the State of New York if they should wish to pursue the idea of constructing a new State Veterans Home.

<u>Location</u>	<u>Number of Beds</u>	<u>Distance from Canandaigua (miles)</u>
Jamaica, NY	250	335
Batavia, NY	126	57
Oxford, NY	242	148
Montrose, NY	252	292
Stoney Brook, NY	350	371

Construction plans and designs for the creation of the replacement CLC environments at Canandaigua are being reviewed through value management efforts conducted by the United States Army Corps of Engineers to determine that the construction is the most cost effective and efficient possible and would be consistent with industry construction standards. The budget request replaces out of date and inefficient existing facilities at Canandaigua to house the Veteran population currently served as well as developing specialized placement options for Veterans with medical and mental health co-morbidities for whom there are limited to no community options. New small house construction will provide state-of-the-art care environments for Veterans. The nearest State Veterans Home to Canandaigua is 57 miles away (Batavia) and would not necessarily facilitate the needs of Veterans that would be placed a great distance from their home and family in the Finger Lakes Market.

It is important to note that the census indicated in the narrative below (first quarter FY 2018) is temporarily restricted to facilitate minor renovations to the existing CLC floors. The admission cap will be removed following the completion of renovations.

Question 23: Please explain the aspects of the President’s Infrastructure Initiative that pertain to VA and what impact the Department expects it will have.

VA Response: The President’s Infrastructure Initiative includes new and pilot authorities that will provide additional tools for the Department to modernize and obtain upgrades to VA’s real property portfolio to support delivery of quality care and services to Veterans. If legislation is enacted, the authorities will provide flexibilities for VA to leverage existing assets to continue its efforts to reduce the number of vacant buildings in its inventory and will make lease threshold modifications to change the lease project amount required to obtain congressional authorization for VA medical leases. This change would streamline VA’s leasing process to quickly and efficiently deliver needed facilities to provide care and services to Veterans.

- a. Is this budget request sufficient to fulfill the goals of the initiative?

VA Response: Yes, the budget request is sufficient to fulfill the goals on the initiative. The new tools, if legislation is enacted, will allow VA to leverage existing facilities and land to obtain new facilities and space with little upfront investment cost for VA.

- b. Does VA believe the initiative provides the authorities needed to “right size” and align capital assets and infrastructure, without additional legislation? If not, which authorities would still be needed in legislation?

VA Response: VA is encouraged by the Infrastructure Initiative and believes that legislation authorizing sales and retention of proceeds, exchanges for construction value, and increasing the leasing and construction thresholds will expand the options VA has available to manage its real property portfolio more effectively. In addition to the authorities proposed in the President’s infrastructure initiative, the Department needs the proposed authorities included in the FY 2019 Budget submission to be enacted in order to increase VA’s flexibility to meet its capital asset needs, realign facilities, and reduce energy costs. This includes the following proposals:

- Amend the medical facility definition to allow VA to plan, design, construct, or lease joint VA/DoD shared medical facilities; and to transfer and receive funds for those purposes.
- Increase to the threshold between major and minor construction – from \$10 million to \$20 million.
- Authority to expand VA enhanced-use lease authority beyond supportive housing for other mission needs.
- Authority to contract for long-term provision of renewable electric energy and alternative energy.
- Authority to sell environmental assets created through energy projects and retain the proceeds.

Question 24: The budget request includes a status list of leases that were authorized in previous years. Among other information, the list indicates which of these leases have still not been awarded; they are summarized below by year of authorization. When is VA’s goal to award each such lease, and how will this be accomplished?

2005: 2

2006: 1

2010: 2

2011: 3

2012: 1

2014: 21

VA Response: The following leases were replaced by subsequent lease authorizations as noted in the FY 2019 budget submission: Norfolk, VA (2005), San Diego, CA (2005), Tyler, TX (2006), Kansas City, KS (2010), and San Diego, CA (2011). Due to lack of availability within the market the Boston, MA (2011) lease has been decreased to a minor level lease of approximately 10,000 sf, with specific services to now be provided through existing infrastructure.

The following leases are moving forward in earnest and currently slated for award in FY 2018 or early FY 2019: Bakersfield, CA (2010), Columbus, GA (2012), Brick, NJ (2014), Cobb County, GA (2014), Charleston, SC (2014), Myrtle Beach, SC (2014), New Port Richey, FL (2014), Ponce, PR (2014), Chattanooga, TN (2014), Houston, TX (2014), Lubbock, TX (2014), San Antonio, TX (2014), Tulsa, OK (2014), Redding, CA (2014), Honolulu, HI (2014), Phoenix, AZ (2014), and San Diego, CA (2014). For these leases, VA is currently evaluating offers and negotiating price to ensure treatment as an operating lease, fair and reasonable pricing, as well as vetting offers to ensure bidders have necessary qualifications and relevant experience to deliver projects of comparable magnitude.

For the following leases, VA was unable to obtain suitable proposals that met OMB scoring criteria, or experienced other procurement challenges that made these projects candidates for a re-start under VA's improved lease process: Lincoln, NE (2014), Cape Girardeau, MO (2014), Johnson County, KS (2014), Worcester, MA (2014), and Tyler, TX (2014).

Question 25: How does this year's budget proposal prioritize foundational services over other services, and what differences will veterans and employees see next year as a result of this prioritization?

VA Response: It is VA's priority to provide world-class mental health care to all Veterans. To this end, there are a number of new and expanding mental health initiatives that will enhance mental health services. EO 13822, Supporting our Veterans During Their Transition from Uniformed Service to Civilian Life (January 9, 2018) focuses on ensuring that Veterans have seamless access to high-quality mental healthcare and suicide prevention resources, with an emphasis on the 1-year period following separation from active duty. VA is committed to hiring a net gain of 1,000 additional providers to continue expanding suicide prevention efforts, same day services, and treatment options available to Veterans. The Measurement Based Care initiative will make immediate use of Veteran self-reported outcome measures to individualize and improve mental health care. Overall, the budget request will enable

the Department to continue established, well-validated mental health programs, as well as offer opportunities for continued expansion of services and access.

- a. Will each clinic, medical center, or VISN develop its own foundational services?

VA Response: Every VA medical center already has Primary Care, Geriatrics and Mental Health foundational services established and each service has its own local leadership, reporting to a facility's executive leadership team.

- b. Is each facility expected to provide all of VA's foundational services, or will the services vary from place to place?

VA Response: Services will vary depending on the complexity of the facility. All facilities however, will be required to offer Primary Care and Mental Health at a minimum. All facilities are required to provide a spectrum of Geriatrics and Extended Care Services as articulated in the Medical Benefits package.

- c. Is inpatient care a "foundational service?"

VA Response: Inpatient care is in the Medical Benefits Package, but it is not a foundational service available at every VA medical facility. VA offers hospice and palliative care in all care settings, including in every VA inpatient facility.

- d. Given that a significant amount of VA's assets are directed to inpatient care, does the budget proposal contemplate realigning the assets toward that goal by, for example, converting low-census inpatient facilities into outpatient clinics and surgery centers?

VA Response: The budget request does not include realignment of assets. However, as VA enhances its portfolio of home and community based services, we anticipate reducing preventable hospitalizations and nursing home stays which may have an impact on future budget allocations.

- e. If inpatient services are reduced, how will this affect VA's educational mission, given that a significant portion of graduate medical education support is for inpatient services?

VA Response: Medical research and graduate medical education (GME) are two of VA's four missions and thus VA will continue to place a high priority on fulfilling those roles. While acknowledging that the focusing of VA resources towards Foundational Services could have effects on medical research and GME activities, those impacts will be mitigated by the national methodology that has to be developed for VISN and VAMC leaders; one of the primary considerations is the potential impact on these programs. In addition, if deemed necessary VA will create partnerships to support its research and education missions to ensure the well-being of Veterans and the Nation as a whole.

- f. Will the proposed focus on foundational services direct more inpatient services into the community? If so, will community care funding need to be increased?

VA Response: Well-resourced and well-staffed foundational services optimizing outpatient care and home and community-based services, particularly among high risk patients, should prevent avoidable hospitalizations/inpatient services and nursing home stays. VA facility and VISN leaders are being asked to assess additional, non-VA options for other health services that are important to Veterans, yet may be as effectively or more conveniently delivered by non-VA providers. Local VA leaders have been advised to consider accessibility of VA facilities and convenience factors (like weekend hours), as they develop recommendations for community access to non-VA providers for Veterans in their service areas.

Question 26: During the budget roll-out briefing held on February 12, 2018, at VA headquarters, a Committee staff member was told the budget proposal does not include costs associated with the recent Executive Order to increase access to mental health care and suicide prevention services for transitioning Servicemembers in the year following their separation from service. However, the news release that accompanied the budget stated the budget does support the Executive Order. Please clarify the conflicting information.

VA Response: Shortly before Budget rollout, Congress adopted a bipartisan agreement to raise the FY 2018 and FY 2019 budgetary caps significantly above the current law. Although not reflected in the Budget, the Administration has communicated its preferences for the allocation of these additional resources in FY 2018. In this communication, the Administration outlined a need for \$3.2 billion for VA in FY 2018 to support infrastructure improvements, continuation of the Veterans Choice Program, and implementation of the EO over a 2-year period.

Question 27: The budget assumes 162,000 additional mental health outpatient visits. Are these a result of the expanded mental health authorities from the Executive Order?

VA Response: VA estimates as much as \$100 million from VA's existing budget will be used to support implementation of EO 13822, by realigning funds to support suicide prevention as one VA's core priorities. Not all of the mental health services provided to transitioning Servicemembers and Veterans as a result of the EO will be high-cost services.

Question 28: How many of the additional 162,000 projected mental health outpatient visits are the result of the recent initiative to expand mental health care to veterans with Other than Honorable discharges?

VA Response: Assuming the 2017 trends with Other Than Honorable (OTH) emergency mental health services continue, this will be a small portion of the total projected workload.

a. Has the utilization of care by veterans with OTH discharges been as expected?

VA Response: The number of OTH former Servicemembers seeking emergency services has been below expectation. Overall, since July 5, 2017, 4,973 OTH former Servicemembers have requested VHA healthcare through the present, with only a limited number specifically seeking mental health emergency services.

b. Has VA noticed any regional trends in health care utilization by these veterans?

VA Response: There have been relatively few OTH former Servicemembers seeking VA health care services to date. VA is developing evaluation databases that will allow us to examine regional, demographic and clinical trends in this population in the coming months.

c. What types of mental health services are these veterans seeking?

VA Response: Emergency inpatient hospitalization, outpatient services and medication refills.

d. How many of these veterans are eventually deemed eligible to enroll—and, in fact, do enroll—in the VA healthcare system?

VA Response: VA, DoD and the Department of Homeland Security submitted a Joint Action Plan to the White House on March 9, 2018, related to implementation of EO 13822. Additionally information will be provided once the plan is publically released.

e. How successful has VA been in transitioning those veterans who are not eligible to enroll in the VA healthcare system to other care settings?

VA Response: There has been no indication or report of facility inability to transition care as appropriate. All licensed providers have an ethical responsibility to ensure follow-up is established prior to provider-patient termination.

f. How, if at all, has mental health care to honorably discharged veterans been impacted by the Other than Honorable discharge initiative?

VA Response: Direct impact on access and mental health services has been negligible. The largest impact is typically during the initial period of the request for care. Crisis management commonly takes dedicated provider effort over what can be considerable time. Cross coverage during these periods is critical, and sites with staffing limitations would experience the greatest impact.

Question 29: How would this budget proposal fund suicide prevention initiatives with community partners, given that 70 percent of veterans who die by suicide are unknown to VA?

VA Response: Ending Veteran suicide will take a national effort that is community based. Partners, at all levels, are key to those efforts and a major focus of our innovative approach to suicide prevention. Initiatives underway or currently planned include expansion of partnerships specifically targeting services to Veterans not enrolled in VA care, the Mayor's Challenge program building community capacity to end Veteran suicide, and the evolution of our suicide prevention coordinator model from a healthcare and crisis concentrated model to one that also includes public health, community centered approaches.

Question 30: To what factors does VA attribute the 86 percent increase in the number of veterans receiving mental health services from 2005 to 2017?

VA Response: There are likely a number of social and organizational factors that have contributed to the significant increase in the number of Veterans receiving mental health services. Organizationally, over this 12-year period, VHA has made significant investments in hiring and program development. VHA has consistently demonstrated that if facilities invest in hiring and program implementation, Veterans will utilize the services. The challenge that VHA has been experiencing is that the utilization then outpaced the ability to continue hiring and expanding program availability. Socially, mental health services are more available and culturally accepted. Importantly, the extensive mental health services were not available for returning Vietnam-era Veterans, and in combination with the current war on terrorism, an increasing number of Veterans continue to utilize VHA mental health services.

- a. Is a similar increase expected over the next decade? If so, how much more mental health capacity will be needed within VA to accommodate that increase?

VA Response: There is a huge gap in treatment for mental health conditions across the U.S. as a whole. This gap is due to: a lack of access to treatment, barriers to receiving care, social stigma that still, in some parts of the country, attaches to the receipt of mental health services, or a lack of perceived need for services. For example, the 2015 National Survey on Drug Use and Health (NSDUH) estimated that 21.7 million Americans had clinical need for substance use disorder treatment, but only 2.3 million of these received specialty treatment; however, 95 percent of those with identified clinical need for treatment who didn't receive treatment did not perceive a need for care (e.g. see report at: https://www.samhsa.gov/data/sites/default/files/report_2716/ShortReport-2716.html). These population statistics on one mental health condition frame the general problem. Large populations of Americans, including Veterans, have mental health conditions that are not being treated. Lack of treatment almost certainly has negative personal and societal costs and consequences, but these populations are not necessarily actively seeking services. Prior analyses have suggested that Veterans have slightly lower unmet need compared to the general population (see Golub A, Vazan P, Bennett AS, Liberty HJ). There is an unmet need for treatment of

substance use disorders and serious psychological distress among Veterans (see the Nationwide analysis using the NSDUH: Mil Med. 2013 Jan; 178(1):107-14.).

VHA added treatment capacity from 2005 to 2017, which allowed some of this population to access needed mental health services. The increase in number of patients treated was driven by budget/mental health service capacity in VHA, not by shift in population need for services. While adding capacity, VHA made changes to its health care delivery design to improve mental health screening and bring mental health services to patients being seen in primary care, helping to address the tendency of persons with mental health conditions to not actively seek care. However, there is still a substantial unmet need. VHA is implementing additional innovations in mental health care delivery, including clinical video telehealth and telephone care management services, which may help to make mental health services more accessible and acceptable to Veterans with clinical need. We expect that increased treatment capacity and availability of standard and innovative mental health care, would continue to increase the proportion of Veterans with mental health conditions who receive treatment. If additional capacity for services is provided, we expect to continue to see an increase in mental health service utilization for some time, as we are not near a steady state in terms of meeting the full need for mental health services.

Question 31: The budget proposal includes five additional Vet Centers by 2020.

a. What data was used to determine that five are needed?

VA Response: The Readjustment Counseling Service (RCS) used workload and productivity data, including growth rate in relationship to capacity to determine resource of the new Vet Centers. Since FY 2016, RCS has seen a 27 percent growth in the number of unique Veterans, active duty Servicemembers, and families served by Vet Centers. During the same period RCS has experienced a 17 percent growth in the volume of readjustment counseling services (individual, group, marriage, family counseling, outreach, etc.) provided. RCS is expected to experience similar growth rates in the next several FYs.

RCS current assets consist of the 300 “brick and mortar” Vet Centers, 80 Mobile Vet Centers, and the Vet Center Call Center. Until recently, new Vet Centers were approved and placed into communities based on county Veteran population and proximity to other Vet Centers. This expansion process was changed in 2016 to a demand model taking into account actual Veteran and active duty Servicemember (ADSM) usage and ensuring that services to communities are in line with the needs of those particular communities. This includes having RCS staff regularly provide services beyond the existing 300 Vet Centers through the use of Vet Center Community Access Points (CAPS) and Vet Center Outstations.

- Vet Center CAPS are locations typically in non-cost space located in sites developed in collaboration with community partners where direct counseling

services are provided at levels that are consistent with the needs of these communities (monthly to several times a week). As the demand for services change or moves to other communities, RCS staff are able to move with that demand with minimal effort and cost.

- Vet Center Outstations are leased spaces located in communities where the demand for services requires at least one full time counselor (40 hours per week) to be permanently assigned. Supervision and administrative responsibilities are provided through the closest Vet Center. Vet Center Outstations are developed by RCS and approved by the Under Secretary for Health pursuant to a delegation of authority signed by the Secretary on June 1, 2016.

Typically, RCS staff begin the expansion process by working to understand the demand and needs of a particular community through targeted outreach and the piloting of service provision through a Vet Center CAP. As services progress, Vet Center leadership assess and increase or decrease services based on that actual demand.

If service provision increases to a point that requires a counselor(s) to be in that community permanently, RCS Leadership works to receive approval for a Vet Center Outstation. This approval also allows RCS to explore leasing opportunities for a permanent location in that community

As demand for services at Vet Center Outstations increase and require more resources such as additional staff and space, RCS Leadership will work to receive approval to create a full “brick and mortar” Vet Center.

b. When are each of the five scheduled to open?

VA Response: The five new Vet Centers are scheduled to open beginning in FY 2019 through the end of FY 2020. At the current rate of growth (both services provided and associated with unique Veterans, ADSM, and their families) and current Full Time Equivalents (FTE) employee levels, continued growth in services will be significantly limited in approximately 2 years. RCS is working to create additional efficiencies to deal with potential capacity issues through decreasing time to hire through a centralized human resource service, authorized FTEs increases, and increasing the number of CAPS to reach underserved areas. This also includes reviewing the current footprint of Vet Center Outstations to assess and determine if any of these locations need to be converted to a full “brick and mortar” Vet Center.

c. Where will they be located?

VA Response: The locations will be determined utilizing the demand model outlined above.

d. What impact will the five additional Vet Centers have on mental health access?

VA Response: Additional Vet Center locations will positively affect the VA's overall ability to increase access to care for eligible Veterans, active duty Servicemembers, and their families while decrease barriers associate with accessing that care (ex: driving distance). The RCS strategic goals for 2018-2020 include improving access to Readjustment counseling in communities distant from existing Vet Center services by increasing the number of Vet Centers (projected increase of five), Outstations (projected increase of five), and Community Access Points in Rural and Highly Rural Areas. In addition, RCS is increasing non-traditional hours of service provision, coordinated emergency response capability, and expanding community partnerships. All RCS service provision is legislated through 38 U.S.C. Section 1712A. RCS, by design, is a non-medical service provided without the need of a diagnosis or enrollment in VHA healthcare. RCS staff work collaboratively with local VHA staff to engage Veterans, Servicemembers and their families and to facilitate obtaining appropriate medical care, including more intensive mental health services. RCS has historically proven to be a very effective entry point into the larger VA, especially with Veterans, Servicemembers and families that might be reticent to enter into mental health treatment given stigma and all other barriers to care.

Question 32: If enacted, how will this budget proposal improve the timeliness of medical health care services that veterans experience, and how will timeliness be measured?

VA Response: This proposed funding would support staffing requirements needed to optimize access where patient demand exceeds staff supply with a particular focus on primary care, mental health, and medical and surgical specialties. Such staffing would include nursing and administrative clinic staff in addition to providers. The funding would also support optimizing recruitment and retention incentives for specialties and parts of the country where staffing has been challenging to optimize. Furthermore, this proposed funding would support the expected rapid increase in virtual care services such as telehealth. Timeliness would be measured by average wait times to see new and established patients that will be publicly displayed on the www.accesstocare.gov website.

Question 33: How will initiatives funded in this budget proposal reduce the Electronic Wait List?

- a. How many unique veteran patients are on the Electronic Wait List as of the date of VA's response to these questions?

VA Response: Presently, there are over 15,960 Electronic Wait List Veteran entries comprising 15,408 unique Veterans (i.e., some Veterans may be listed on the Electronic Wait List for more than one appointment type).

- b. How many are forecasted to be on the list a year from that date?

VA Response: With the added funding proposed to expand Veteran access to medical care, it is projected that in 2019, the number of Electronic Wait List entries will decline by approximately 33 percent to 10,653.

As mentioned in the response to question 32, the proposed funding would support staffing needs to optimize access where patient demand exceeds staff supply with a particular focus on primary care, mental health, and medical and surgical specialties. This staffing would include nursing and administrative clinic staff in addition to providers. Such funding would also support optimizing recruitment and retention incentives for specialties and parts of the country where staffing has been challenging to optimize. Furthermore, this proposed funding would support the expected rapid increase in virtual care services such as telehealth. All of these efforts would be expected to reduce the Electronic Wait List.

Question 34: What is the current utilization rate for same-day services for primary care and for mental health care?

- a. How many veterans seeking same-day access to primary and mental health care currently receive an in-person or telehealth appointment that same day?

VA Response: In Mental Health, 11.1 percent of all face to face and telehealth appointments combined were completed the same day in FY 2017; 11.3 percent of all face to face and telehealth appointments combined were completed the same day during the first quarter of FY 2018.

In Primary Care, 20.5 percent of all face to face and telehealth appointments combined were completed the same day in FY 2017; 23.7 percent of all face to face and telehealth appointments combined were completed the same day during the first quarter of FY 2018.

In Mental Health during FY 2017, 773,235 appointments were completed the same day via face to face appointment where 23,007 appointments were completed the same day via telehealth during FY 2017.

In Primary Care during FY 2017, 2,453,882 appointments were completed the same day via face to face appointment where 3,860 appointments were completed the same day via telehealth during FY 2017.

VA also may provide same day services via telephone encounters and secure email messages. VA is unable to currently measure how many Veterans receive same day services via these care modalities.

Question 35: The budget indicates VA expects to treat 80 percent of enrolled veterans who need Hepatitis C care with new Hepatitis C treatments by 2020. What barriers to care exist for the remaining 20 percent of enrolled veterans with Hepatitis C?

VA Response: Consistent with Centers for Disease Control and Prevention and United States Preventive Services Task Force recommendations, VA recommends screening of all patients born between 1945-1965 for Hepatitis C virus (HCV) as well as those who have on-going risk factors for HCV infection. As of March 30, 2018, 82.5 percent of all high-risk patients have been tested for HCV. VA continues to do outreach to offer testing to patients at risk for HCV

As of April 30, 2018, over 107,719 Veterans under VA care for their HCV have been started on new, highly effective antiviral treatments, with cure rates of 95 percent. It is estimated that there are approximately 31,644 Veterans under our care for HCV who remain to be treated with these new treatments. We estimate that approximately 9,000 of these remaining patients will receive treatment in FY 2018. VA has made documented efforts to contact most, if not all, of the 31,644 Veterans with HCV who remain to be treated. Many have not responded or have otherwise refused treatment, are homeless, or have medical, mental health, or substance use comorbidities which are treatment limiting. For those in this untreated subset who wish to receive HCV treatment, it will be provided in FY 2019, assuming they do not decline treatment, fail to follow-up with their treatment plan, or have clinical contra-indications (such as unstable/uncontrolled/incurable co-morbidities) preventing such treatment.

Current program outreach efforts include the use of: Field-based VISN Hepatitis Innovation Teams deploying system redesign/LEAN at the majority of facilities to address gaps in HCV testing and treatment; informatics tools for patient tracking and monitoring clinical outcomes (HCV Clinical Case Registries/HCV clinical dashboards); national and local social media and advertising campaigns; patient and provider resources; and local outreach and prevention programs targeted for high-risk populations.

Question 36: How much money does VA anticipate spending in fiscal year 2019 on gender-specific services for male veterans?

VA Response: Gender-specific services for male Veterans include a variety of clinical services including Urology, Pharmacy, Prosthetics, and other services. VA does not have any specific data point to anticipate spending for gender-specific services for male Veterans.

Question 37: Written testimony indicated VA has "...critically assessed and prioritized our needs and aggressively pursued internal offsets, modernization reforms, and other efficiencies..." Please provide a copy of that assessment.

VA Response: As part of the Department's budget formulation process, the Administrations and staff offices assessed and prioritized needs and internal offsets and modernization reforms to focus resources for high priority functions or initiatives. Some examples of internal offsets and modernization reforms that are built into the FY 2019 Budget include VBA's repurposing of personnel from indirect support activities to Veteran-facing functions, reductions in VBA contracts, modernization of the EHR and

Financial Management System, prioritization of foundational services while redirecting to the private sector those services that they can do more effectively and efficiently, and \$30 billion in VBA administrative savings over 10 years.

Question 38: How does this budget represent a new prioritization of needs compared to prior budgets?

VA Response: This budget targets key areas in which we want to make significant improvements. Examples include full discretionary funding for Veterans Community Care starting in FY 2019; a significant investment for Capital Investment; new funding for the EHRM effort; and targeted resources for disability claim appeals, women's health and mental health to include suicide prevention which are all high priorities for the Administration.

Question 39: Please explain how the portion of the budget pertaining to the Financial Management Business Transformation relates to the Administration's proposal for a VA Center for Innovation for Care and Payment.

VA Response: The proposed VA Center for Innovation for Care and Payment would carry out pilot programs to develop innovative approaches for testing payment and service delivery models to reduce expenditures while preserving or enhancing the quality of care furnished by the Department. FMBT would support this effort by providing a comprehensive financial management system that enables VA to accurately measure progress from a financial aspect while complying with financial management legislation and directives.

Question 40: Would the Working Capital Fund legislative proposal allow VA to become a shared service provider for financial management systems modernization?

VA Response: While VA is already an internal shared service provider for financial management system modernization through its FMBT program, the Working Capital Fund (WCF) legislation will certainly strengthen and enhance the FMBT program. WCF legislation was proposed so that VA can finance critical financial management activities such as FMBT and the Stop Fraud, Waste, and Abuse initiative to improve payment integrity. Long term, the WCF legislation will support VA's centralization of financial services and eliminate costly redundancies.

Question 41: Why are medical care collections expected to decrease in fiscal year 2018 and 2019, compared to 2017?

VA Response: FY 2018 and FY 2019 medical care collections incorporate the full impact of the Tiered Medication Copayment Structure of \$5 for preferred generics/ \$11 for brand single source/ \$8 for all other medications, and a \$700 copayment cap for all priority groups. The tiered copayments and copayment cap, combined with the impact of Pharmacy utilization trends, resulting in lower First Party collections in FY 2018 and FY 2019.

Third Party payers are terminating and/or reducing reimbursement to VA for non-service connected care. Payers are reacting to current market conditions in commercial health care by attempting to reduce provider reimbursement rates across the board. To account for these payer trends, it's anticipated that collection estimates will continue to decline in FY 2018 and stabilize in FY 2019. MCCF estimates include an adjustment for the projected budget impact of changes to payer agreements. The estimated impact of the changes in reimbursement rates are reductions in potential Third Party collections of \$119M in FY 2018 and \$124M in FY 2019.

Question 41: Is it correct that VA's average Medical Care Collections Fund collection rate is based on billings, not another basis as commonly stated, is roughly 36.5 percent?

VA Response: VA has historically reported collections performance/efficiency using the Collections to Billing (CtB) ratio, which compares claim level collections to gross billed amounts. The CtB ratio did not account for the limitations based on payer maximum allowable charges or patient cost sharing responsibilities which are uncollectible by the VA.

Going forward, VA will report collections performance using Net Collections Ratio. For ease of monitoring and reporting third-party collection performance, VA developed the Net Collection Ratio, which is a measurement that is comparable to industry standard reporting on collection performance. Net Collection Ratio measures collections as a percentage of Total Collectible Amount instead of billed charges. The Total Collectible Amount is billed charges minus uncollectible amounts like payer discounts and other health insurance (OHI) patient responsibility (VA does not collect OHI patient responsibility). The national Net Collections Ratio as of January 2018 is 96.3 percent, which is in line with industry standards.

- a. How would initiatives in the budget proposal improve VA's ability to collect, and what is the expected collections rate, in percentage terms as well as dollars, after they are implemented?

VA Response: VA included five legislative proposals in the FY 2019 President's Budget that are intended to improve the efficiency and effectiveness of revenue operations. For all of the legislative proposals, the net collections ratio would remain stable.

1. Acceptance of VA as a Participating Provider by Third Party Payers would allow VA to be treated as a participating provider for reimbursement purposes whether or not an agreement is in place with a third party payer of health plan. If enacted, this legislative proposal will provide VA with the ability to collect at the participating provider reimbursement level. Currently, when VA provides services for a Veteran who has coverage under a third party payer who does not have an agreement with VA the out of network reimbursement is reduced or may be non-

existent if the third party payer does not offer out of network benefits. The anticipated increase in collections is \$105.9M.

2. **Aligning with Industry Standards by Eliminating Offsets of First Party Copayments** would allow VA to discontinue the practice of crediting the first party copayment due from Veterans for non-service connected care using the funds collected from third party health plan carriers. The legislative proposal would align VA with private sector practices. The anticipated increase in collections is \$53.9M.
3. **Mandatory Insurance Capture Enforcement** would create a mechanism to enforce the disclosure of third party health plan contract information as required by Public Law (P.L.) 114-315, section 604. This legislative proposal creates a mechanism for Veterans who fail to provide third party health plan coverage information necessary to VA for the purpose of billing and collecting from third party payers. The anticipated increase in collections is \$8.5M.
4. **Improving Timeliness of Billing by Authorizing the Release of Protected Patient Information for Health Care Services** would allow VA to disclose records of the identity, diagnosis, prognosis or treatment of a patient relating to drug use, alcoholism or alcohol abuse, infection with human immunodeficiency virus or sickle cell anemia to health plans for the purpose of reimbursement. Currently, VA is required to obtain a signed release of information from the patient before billing a claim for these services to a third party payer. This legislative proposal would bring VA in line with private sector practices and allow VA to submit claims for reimbursement without obtaining a written authorization from the Veteran. The anticipated increase in collections is \$42.4M.
5. **Third Party Payer Enforcement Provision (Recover Lost Collections from Third Party Payer)** provides a provision that will allow VA to institute administrative enforcement actions against third party payers who fail to comply with provisions of 38 USC 1729 and supporting regulations 38 CFR 17.101 and 38 CFR 17.106. Any funds collected through the administrative enforcement actions would be additional revenue returned to MCCF to provide additional services to Veterans across the Nation. The proposed legislation would allow VA to assess fines against third party payers for non-compliance with statutory and regulatory collection provisions. There is no anticipated increase in MCCF collections in FY 2019 until regulatory authority is in place.

Question 42: What is VA's official position on using third party collections entities to assist the Department in collecting revenues?

VA Response: Generally, VA can use third party collection contractors provided that it is not subject to transfer to Treasury, when it is in the government's financial interest, and it is consistent with the purposes of the Debt Collection Improvement Act of 1996 (DCIA) (31 CFR 285.12). In addition, VA has a separate authority under 38 U.S.C. §

1703 to award a contract to a third party collection entity to audit VA community care claims and payments and to initiate recovery of any overpayments.

Question 43: How many of the research projects that would be funded in this budget proposal involve canine test subjects?

VA Response: Based upon historical trends, 1-3 new research projects funded annually by VA would typically involve the use of research dogs. Continuing support of 7 existing VA-funded dog projects is anticipated as well.

Question 44: How does VA evaluate proposed research projects to ensure they are veteran-centered and veteran-focused?

VA Response: The VA Office of Research and Development (ORD) conducts scientific peer review to the highest standards similar to other science funding agencies and funding decisions are awarded based on their ability to meet our Service Mission and priorities for Veterans health care needs. In order to be reviewed, an application must align with one of the ORD Research Services scientific purview and advance scientific knowledge across the research continuum including biomedical, clinical, health services, and rehabilitative research. The review criterion is explicit in that research must address an important scientific question and supports and advances the health and health care of Veterans. Specifically, a proposed research project must meet the following criteria to clearly demonstrate it has significant impact:

- Significance – addresses important problem or critical knowledge gap in the field; supports or advances the health and health care of Veterans.
- Innovation – challenges existing paradigms, explores new concepts, methodologies, or technologies.
- Approach – incorporates current scientific and theoretical bases; hypothesis-driven; use of appropriate research design and methods for addressing hypothesis; feasibility of methods are clear.
- Investigators – utilizes investigators with appropriate expertise, experience, and record of accomplishments to enable successful completion of the proposed research.
- Resources – proposed research environment will enable successful project (e.g., facilities, equipment, and staff).

After scientific merit review, final funding decisions are made by ORD's Service Directors based on impact or priority scores, peer reviewer evaluations, ORD priority areas, and available budget.

- a. Are there some areas of VA research that could be scaled back or discontinued to make funds available for more veteran-centric research projects?

VA Response: No. ORD only supports projects that are veteran-centric funded.

Question 46: The budget proposal notes that VA research has a track record of transforming VA health care by bringing new evidence based treatments and technologies into everyday clinical care. Please provide 10 examples of VA research conducted in the last five years that directly produced treatments that VA providers are presently using to treat veterans.

VA Response: The following are key examples of evidence-based treatments that are currently being implemented in everyday VA clinical care that were based on VA-sponsored research published within the past 5 years. Links to the original research articles are also provided.

1. Providers in VISNs 7, 16, 20, and 23 are deploying Telemedicine Outreach for Posttraumatic Stress Disorder (PTSD), which is a program based on research conducted in the VA that demonstrated the effectiveness of virtual team-based care for rural Veterans with PTSD:
<https://www.ncbi.nlm.nih.gov/pubmed/25409287>.
2. Providers at the West Haven, Denver, and Palo Alto VAMCs are implementing stepped care for pain treatment, based on a model previously shown to be effective in pain management for Veterans:
<https://www.ncbi.nlm.nih.gov/pubmed/25751701>.
3. Providers in VISN 1, VISN 5 and VISN 19 were trained in the HUD-Veterans Affairs Supportive Housing and Homeless Patient Aligned Care Team staff on Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking (MISSION) Model. MISSION is an evidence-based Veteran-centric intervention developed within the VA and delivered by case managers and peer specialist to address mental health, substance use, and homelessness: <https://www.ncbi.nlm.nih.gov/pubmed/26018048>.
4. Providers at VA Boston and West Haven are implementing the VA National Bipolar Disorders Telehealth Program:
(<https://www.ncbi.nlm.nih.gov/pubmed/28665773>) which is based on a collaborative care model developed by VA researchers that was shown to improve health outcomes among individual with bipolar and other mental disorders: <https://www.ncbi.nlm.nih.gov/pubmed/27780336>.
5. VA has hired onto clinical teams over 1,100 mental health Peer Specialists (Veterans with mental illness who are trained to use their experience to help other Veterans with mental illness). This Peer Specialist model has been found to increase patient activation

(<https://www.ncbi.nlm.nih.gov/pubmed/23657754>) and are valued by Veteran patients and VA providers (<https://www.ncbi.nlm.nih.gov/pubmed/24091610>).

6. Providers at the VA Greater Los Angeles Healthcare System are also implementing an integrated care program previously established in VA research to improve mental health quality and outcomes among women Veterans with anxiety and depression treatment needs. This is an example of a larger program (Primary Care-Mental Health Integration) that was nationally implemented in VA and based on VA research on effectiveness of collaborative care for depression, PTSD, and substance use risk management in primary care:
<https://www.ncbi.nlm.nih.gov/pubmed/20695668>.
7. The Hospital-to-Home campaign initiative was implemented by providers and based on prior VA research (<https://www.ncbi.nlm.nih.gov/pubmed/?term=hospital+to+home+heidenreich+veterans+randomized>) and resulted in a decline in 30-day readmission rates and reduction of 21,000 hospital days each year, which translates to cost savings of approximately \$18 million per year.
8. In partnership with leaders from the VA National Center for Health Promotion and Disease Prevention, VA providers across the US are implementing the updated VA MOVE! weight management program guidance based on work by investigators at the Durham and Ann Arbor VAMCs:
<https://www.ncbi.nlm.nih.gov/pubmed/28747191> and
<https://www.ncbi.nlm.nih.gov/pubmed/25217098>.
9. Providing the most advanced upper extremity prosthetic arm to Veterans with limb loss. ORD was the clinical partner in Defense Advanced Research Projects Administration's (DARPA) Revolutionizing Prosthetics program. The industry partner under contract to DARPA was Dean Kamen (DEKA) Research and Development Corporation. ORD conducted optimization and take home-home trials of the DEKA arm (now known as LUKE arm). This led to research data for the Food and Drug Administration (FDA) submission and eventual approval by FDA in 2014, and ultimately led to commercialization of the LUKE arm by MOBIUS bionics for Veterans and the Nation. Two Veterans each received a LUKE arm in June 2017. An historical note of significance is that upper extremity prosthetics had not seen major improvements in over 50 years.
10. Increase in Employment for Veterans with Spinal Cord Injury (SCI). Return to work rates are very low following an SCI for the general population and even more so for the Veteran population. ORD investigators conducted research to develop and test a program intended to get Veterans back into working status. The Spinal Cord Injury Vocational Integration Program (SCI-VIP) was developed with some core principles in mind such as vocational training early

on in the overall rehabilitation process, deploy a highly integrated team approach, including vocational services, transportation services, training and adaptations to conduct work. Following research to develop and test SCI-VIP, a Predictive Model Over Time for Employment (PrOMOTE) study was conducted. It was found that the SCI-VIP/PrOMOTE program was effective in helping Veterans with SCI get jobs and stay employed (43 percent). After the research ended, six of the seven study sites continued to offer the program in their clinics, enabling Veterans with SCI to receive training and obtain gainful employment. The investigator is reaching out to others in VHA to describe the program and its successes.

Question 47: The budget proposal includes a 2018-2020 goal of “achiev[ing] efficiencies and alignment through deployment of strategic field-based councils, including integration with other foundational services, in support of VHA modernization and the agency’s priorities.” What are the “strategic field-based councils?”

- a. Which professionals make up these councils, and what functions are the councils expected to perform?
- b. How will these councils achieve increased efficiency and alignment, and how will that increase be measured?

VA Response: The creation of the strategic field based councils is in the concept planning phase. Strategic field based councils could meet several objectives which are currently in design but include improving change management and selection of and prioritization of new initiatives.

Question 48: Another 2018-2020 goal is “expand[ing] access by opening telehealth capacity for underproductive providers to assist access-challenged providers.” How does VA define and identify an “underproductive provider” and an “access-challenged provider”?

- a. How will “underproductive providers” be leveraged to assist “access-challenged providers,” and how will such assistance be measured?
- b. How will this assistance increase access to care for veteran patients, and how will increased access be measured?

VA Response: VA’s goal to expand access using this methodology defines an “underproductive provider” in primary care as a provider whose patient panel size, i.e., the number of patients enrolled for care with a given provider, is less than 80 percent of their goal for patient panel size. In mental health, an “underproductive provider” is defined as a provider whose individualized productivity is less than 80 percent of their productivity target. An “access-challenged provider” would just be the opposite, i.e. a provider who exceeds their patient panel size goal in primary care or exceeds their productivity goal in mental health; this type of provider can be

challenged to meet the needs of all the patients they are assigned to serve. VA will be using “underproductive providers” to support patient needs via telehealth (or sometimes via traditional face to face appointments) to support “access-challenged providers” and areas where there is a shortage of providers. This endeavor will increase access by adding clinic appointments at locations that would benefit from support of additional providers. For example: VA may be experiencing longer than average wait times at one location, but an “underproductive provider” at another location could see the patients waiting for care via telehealth and help reduce wait times. This assistance will be measured by assessing for increased panel sizes for the underproductive primary care providers and increased productivity for the underproductive mental health providers. Additionally, the sites that are being supported by this program should experience a decrease in wait times.

Question 49: Another 2018-2020 goal is “opening a third Veterans Crisis Line location to meet increased demands for crisis intervention services.” Where and when will the third location be opened?

VA Response: The third Veterans Crisis Line Call Center is located in Topeka, KS on the campus of the Eastern Kansas Health Care System. While it opened in early January 2018, a public grand opening/ribbon cutting ceremony occurred on May 25, 2018.

- a. Will the third crisis line location be a stand-alone facility or co-located with another facility or service?

VA Response: The third location is co-located on the campus of the Eastern Kansas Health Care System in Topeka, KS in Building 3.

- b. What is the third Veterans Crisis Line location's estimated cost?

VA Response: The estimated first-year start-up cost, including the costs for building renovation, staffing, training, and travel, is roughly \$28.5 million.

- c. How many more FTEs will be needed to properly staff the third crisis line location?

VA Response: With 57 responders, supervisors, and support staff already on board, there are 82 FTE positions that remain open. However, because of space constraints and pending construction, recruitment will pause at 90 FTE, with a target date of July 31, 2018. Recruitment for these positions is ongoing.

Question 50: How is demand for crisis intervention services measured?

VA Response: The Veterans Crisis Line (VCL) program assesses and measures its effectiveness in accordance with quality of care criteria and standards applicable to other, similar, non-VA crisis call centers by the American Association of Suicidology and

the Commission on Accreditation of Rehabilitation Facilities. The program also incorporates measures recommended by VA's Office of Inspector General in its report Office of Inspector General Report No. 14-03540-123, Healthcare Inspection: Veterans Crisis Line Caller Response and Quality Assurance Concerns, Canandaigua, New York, February 11, 2016 and Office of Inspector General Report No. 16-03985-181, Healthcare Inspection: Evaluation of the Veterans Health Administration Veterans Crisis Line, March 20, 2017.

More specifically, outcome measures used in the VCL program include key performance variables such as average speed to answer, customer satisfaction, call monitoring, and infrastructure reliability. Across these measures, the following data is relevant:

- VCL answers calls in less than 10 seconds.
- Over 99 percent of calls monitored for quality assurance meet established criteria for ensuring safety.
- VCL currently has an average rollover rate <1.0 percent and an average abandonment rate <5.0 percent.
- Customer Satisfaction is over 95 percent for Veteran and third party callers.
- Substantiated complaints about VCL service are received for less than .001 percent of all calls answered.
- All VCL service modalities (phone, online chat, text) are tested 3 times per day, around the clock.
 - a. How much increased demand for these services is anticipated within the next two years?

VA Response: Demand for VCL services may change based on factors such as business operation improvements, advertising, and national suicide prevention events and efforts. Based on call patterns of the last year, demand for VCL services is anticipated to increase at an annual approximated rate of 12 percent.

- b. How, if at all, does an increased demand for crisis intervention services correlate with expected suicide rates, and how would a demand increase impact veteran suicide rates?

VA Response: There are no industry-established criteria to assess the rate of suicide attempts and completions in direct correlation with crisis call center services or crisis call center effectiveness. Those outcomes are affected by many other variables. VA is committed to do all it can.

- The rate of suicide attempts and completions is critically important. It is best seen as an index of population health management across a health care system including the broad continuum of care including crisis intervention services, mental health care, and other healthcare services (primary care, pain management, etc).
- Combatting Veteran suicide requires continued attention to increased population coverage (access to care), improved continuity of care, and enhanced experience of care (satisfaction) across the entire VHA enterprise. This is why VHA measures and reports on population coverage, continuity of care, and experience of care as domains within the mental health Strategic Analytics for Improvement and Learning (SAIL) domain as applied to each facility.

Question 51: The budget proposal includes an Annual Performance Plan for VHA. One of the targets for “Progress in Cerner project implementation (percent milestones met)” is shown as “to be determined.” What will this target be?

- Other performance targets on the Annual Performance Plan appear low and seem to reflect modest expectations. The overall rating for hospitals is 66.5 percent, for primary care providers is 70 percent, and for specialty care providers 67.5 percent. How are these indicators measured and how were they developed?

VA Response: These indicators are derived from the Overall Provider Rating items in the Consumer Assessment of Health Providers and Systems (CAHPS) surveys that are administered to Veterans who use our hospital, primary care, and specialty care services. CAHPS is the industry standard questionnaire for assessing hospitals, health plans (e.g., Medicare Advantage Plans), and clinician group practices. The item is scored as the percentage of patients giving their provider a score of 9 or 10 on a scale of 1 to 10, where 10 represents “best care imaginable.” The targets therefore represent high expectations. The stated rate of increase – an overall of 1 percentage point per year – is commensurate with that seen in Medicare fee-for-service hospitals over the past several years under Value Based Purchasing, which provides financial incentives to private hospitals to improve their performance on this indicator.

Question 52: Does VA intend to utilize a third-party auditor employing analytics software, similar to that used by the Centers for Medicare and Medicaid Services, to detect fraud by community care providers, distinct from the existing recovery cost audit? If so, what are the estimated costs of this effort?

VA Response: VA is exploring multiple options in our efforts to combat fraud, waste and abuse. One new initiative is a partnership with Centers for Medicare and Medicaid Services (CMS) to share tools, techniques, and best practices related to combating fraud, waste and abuse. One CMS best practice we are researching is the CMS’

contract with their Unified Program Integrity Contractors (UPIC) that use their own data analytics tools, in addition to the CMS provided analytics, to detect and prevent questionable charges. The VA/CMS partnership is not yet mature enough for VA to make a determination on engaging third party auditors, such as the UPICs.

Question 53: If the requested additional 605 claims processing FTEs are granted, how long will it take to resolve the current claims backlog?

VA Response: The increase of 605 FTE is for VBA's implementation of appeals modernization, with the specific goals of resolving legacy appeals and timely processing decision reviews in the new system. Allocation of the FTE will be entirely to VBA's Appeals Management Office for purposes of accomplishing these goals. Current modeling indicates the legacy appeals inventory could be resolved in approximately 4-6 years based on current trends, assumptions and goals.

While it is anticipated that in FY 2019 VA will be authorized to hire an additional 605 FTEs toward these goals, the Appeals Management Office is maintaining a model to project the needed disposition of existing FTEs during the Rapid Appeals Modernization Program (RAMP) and after implementation of the new system, in order to most efficiently handle both the legacy appeals inventory and new framework decision reviews. During the RAMP program, VA will gather data and conduct trends analyses on aspects of Veterans' behavior, to include their decision to opt-in to the new system, employee productivity, processing timeliness, and inventory measures. Moreover, the model will account for varying RAMP opt-in rates and will help delineate the upper and lower bounds of the resource requirements to work both RAMP claims and reduce the legacy inventory. As actual data is available and analyzed, a more accurate prediction of capacity needs can be formed to make needed adjustments both during RAMP and into actual implementation to create efficient claims processes.

Question 54: Has VA considered reassigning some employees who have been working on processing of new claims to processing of appeals? If so, how many?

VA Response: While VA remains committed to addressing the pending inventory of legacy appeals, it must balance that commitment with the need to timely process new claims. As part of balancing limited resources, in early FY 2017, VBA realigned its appeals policy, and oversight of its national appeals operations, under a single office, the Appeals Management Office (AMO). Following this realignment, AMO provided guidance that appeals teams must work exclusively on appeals and cannot be used to perform non-appeals tasks such as processing new claims. This improved focus, prioritization, and oversight helped VBA increase its FY 2017 appeals production by 24 percent. Moreover, during this time VBA processed approximately 1.4 million claims. VA is continually re-assessing the best use of its limited resources, but at this time, VA does not intend to reassign any additional claims processing employees to appeals.

Question 55: The budget proposal includes about \$175 million for the Board of Veterans' Appeals, which is an increase of \$19.2 million over last year's budget request. Please explain why the Board requires this increase, and how the Board will use this increase to address the 162,000 appeals currently pending before it.

VA Response: Currently, there are approximately 158,000 appeals pending at the Board. Of those appeals, approximately 84,000 have not been activated by the Board and are eligible to participate in RAMP. The 2019 request of \$174.75 million for the Board is \$19.15 million above the 2018 Budget and will sustain the 1,025 FTEs. These employees have already yielded positive outcomes for Veterans since FY 2017. Specifically, the Board is currently on pace to produce over 81,000 decisions, which is an historic level of production.

Question 56: What lessons have been learned in setting up the Office of Accountability and Whistleblower Protection, and what conversations have taken place with other Cabinet secretaries about the need to expand this type of civil service reform government-wide?

VA Response: The Office of Accountability and Whistleblower Protection (OAWP) has learned several lessons for the implementation of the Act. The most significant is:

The Office, structure, mission and funding as a model does not exist anywhere in the Federal Sector, therefore, we were providing triage, investigative and assessment from the very first day. Each day we learn something new, each day we work harder to integrate with existing tools provided to VA within its current organization. But it is a change to "business as usual" so it hasn't come without the normal resistance that you find in any impact statement of a transformational piece of work or "disrupter." We are capturing these to ensure we are being transparent, but we are also working to provide the most efficient and effective process centric, fact and data driven organization that can be replicated across the Federal Sector if the Accountability Act gets redirected for all Agencies and Administrations to inculcate.

Question 57: The budget request flat-lines the estimated number of vocational rehabilitation counselors at 1,442, the same number for the last three years. The budget also recognizes that there will be a 12 percent increase in participants from fiscal year 2018 to 2019, increasing the ratio of veterans to counselors. How will a static number of counselors handle the increasing demand without degrading the program?

VA Response: Our budget projection of Vocational Rehabilitation and Employment (VR&E) participants, which is based on historical use and projected compensation claims from FY 2018 to FY 2019 (reflected in the FY 2019 President's Budget) is 144,661 to 149,747 (centerline); a 3.5 percent increase. While we expect continued future VR&E participant growth, we will continue to balance workload by achieving positive outcomes, reducing oldest cases (over 10 years), and using technology to enable our counselors.

Question 58: FTEs processing education, vocational rehabilitation, and home loan benefits continue to be flat-lined, or nearly flat-lined, despite significant increases in the volume of claims in all three business lines. What measures is VA taking to prevent increased processing times from resulting?

VA Response: Education Service continues to utilize overtime to address higher than usual processing times during peak workload periods. In addition, Education Service continues to leverage resources from other Regional Processing Offices (RPOs) through brokering in order to process claims and provide the best possible service to our claimants while minimizing delays in receiving benefits. In support of implementing the Forever GI Bill, Education Service is hiring 202 temporary FTEs. A portion of these FTEs will assist with the specialized work related to the Edith Nourse Rogers STEM Scholarship (Section 111), Restoration of Entitlement for School Closure (Section 109) and the Vet Tech Pilot (Section 116), and support processing additional claims because of changes in Forever GI Bill. VA expects to maintain some number of these FTEs through FY 2019, and will perform an initial assessment in December 2018. This preliminary assessment will take into account workload associated with the Forever GI Bill, what the FTE needs are, and whether or not the FTEs should remain temporary, convert to a permanent status, or a mixture of both.

VR&E remains committed to continue working with the Office of Information and Technology on the development and implementation of a new VR&E Case Management System (CMS). The implementation of a new CMS will serve to increase the overall efficiency of VR&E counselors, helping us to transform to a digital and paperless environment. VR&E continues to utilize National Service Contracts to provide counseling augmenting services to VR&E counselors. In FY 2017, VR&E obligated nearly \$3.5 Million for these contract services, in direct support of the VR&E program. For FY 2017, VR&E executed over 78 percent of our authorized allocation for these contract services in support of our vocational rehabilitation counselors. To date in FY 2018, VR&E is near or at the established standard of 45 days to process a claim and make an entitlement determination for Veterans applying to the VR&E program.

The VA Home Loan program has experienced a tremendous volume growth over the last 5 years, while staffing levels remained the same. In order to create efficiencies, VA took a major step in creating an electronic loan file review process as well as developing a national work queue for major processes and procedures in the housing program. This has helped the organization manage stakeholders, by receiving and analyzing data from each of those reviews. The VA Home Loan program will continue this effort in the coming years through modernization with the VALERI-R initiative. Through advanced data analysis and reporting, VALERI-R will provide improved oversight and transparency of lender and servicer performance, as well as improved efficiency in benefit delivery. This will enable Veterans to better evaluate loan options and statuses while VA addresses high-risk programmatic challenges with data driven solutions.

Question 59: Does the budget proposal fully support implementation of the Forever GI Bill, to include necessary IT improvements?

VA Response: VA does not foresee any delays in its implementation efforts for Forever GI Bill, and regularly reviews and updates its established project management schedule to highlight and mitigate any potential lapses. With the expected implementation of the most critical Forever GI Bill provisions through an IT solution – Sections 107 and 501 – VA hired 202 temporary FTEs in May 2018 to accommodate any increase in claims processing and the administration of new programs associated with the Forever GI Bill. The Office of Information and Technology is deferring IT solutions for the remaining Forever GI Bill sections until FY 2019, after the bulk of the Benefits Delivery Network is decommissioned to have a more modern technology stack on which to either make remaining changes or position the Department to be able to pursue alternative service offerings.

Questions for the Record from Rep. Bilirakis:

Question 60: The budget request includes \$727 million for direct medical research, a 14 percent increase over fiscal year 2018 levels. One of my priorities on the Committee is to examine efforts to improve research and treatment for veterans who may be experiencing negative health effects due to toxic exposure such as burn pit inhalation during their military service. What is the VA doing to further this goal?

VA Response: The Office of Research and Development (ORD) is undertaking multiple approaches in the effort to progress knowledge forward of long-term health effects caused by airborne and open burn pit hazards. Based on the Institute of Medicine, Research Advisory Committee, and physician-driven recommendations, investigator-initiated as well as intra- (VA) and inter- (National Institute of Health and DoD) governmental partnerships are ongoing. These efforts include prospective and longitudinal studies, molecular and biomarker discovery, genetic phenotyping, pre-clinical modeling, and clinical trials. In some studies, biorepositories have been developed to store biospecimens collected from Gulf War Veterans for ongoing and future research. Additional cost-estimate research has been initiated from the Health services research and development service. See below for highlights:

VA Investigator initiated projects:

VA ORD also solicits proposals from individual VA investigators for research projects related to the health of Veterans of Operations Enduring Freedom, Iraqi Freedom, and New Dawn. The request for applications issued by ORD is entitled “Merit Review Award for Deployment Health Research (OEF/OIF/OND),” and it lists the health effects of burn pits as a specific area of emphasis for this research.

VA ORD is currently funding the following single-site research projects which deal with respiratory health issues in this population:

- Targeting HSC-derived Circulating Fibroblast Precursors in Pulmonary Fibrosis; Investigator: Amanda C. LaRue, PhD; Charleston, SC (10/1/2013-9/30/2018): Exposure sand and other airborne particulates cause pulmonary fibrosis (scarring) which reduces the ability of the lung to function properly, and this study is designed to determine the mechanism by which fibrosis-inducing cells develop (in mice) from hematopoietic stem cells (HSCs) and to determine if their presence can be used as an early biomarker for this condition.
- Mechanisms of Cigarette Smoke-Induced Acute Lung Injury; Investigator: Sharon Rounds, MD; Providence, RI (7/1/2015-6/30/2019): This study is designed to understand the mechanism by which acrolein, a component of cigarette smoke and burn pit smoke, damages lung cells and leads to respiratory difficulties and conditions like Acute Respiratory Distress Syndrome (ARDS) and COPD.
- Pulmonary Vascular Dysfunction after Deployment-Related Exposures; Investigator: Michael Falvo, PhD; East Orange, NJ (10/1/2017-9/30/2021): Small particulate material can deposit in the lungs and prevent the lungs from properly exchanging oxygen with the blood. In this study, gas exchange will be measured, and in cases where there is damage to the lungs, changes in blood chemistry will be monitored to develop laboratory tests that will be useful for diagnosing the condition.

Intra-VA and Inter-partnership projects:

Based on a 2011 Institute of Medicine report, a prospective study of the long-term health effects of deployment-related exposures in military personnel was recommended. VA investigators have designed a study that aims to assess the link between land-based deployment in Iraq, Afghanistan, Kuwait, or Qatar with the current pulmonary health of a representative sample of Army, Marine, and Air Force personnel.

- Pulmonary Health and Deployment to Southwest Asia and Afghanistan; Study Chairs: Eric Garshick, MD and Susan Proctor, DSc, Boston, MA; Paul Blanc, MD, San Francisco, CA (5/1/2016-9/30/2022): This two-phase, cross-sectional cooperative study consists of a survey and clinical examination of a representative sample of Veterans (Army, Marine, and Air Force personnel). Phase 1 collects self-reported health and military service information from a national sample through a mail survey or telephone interview. Phase 2 consists of in-person data collection procedures, including more extensive health, military service, and exposure questionnaires and pulmonary function testing. A pilot study is determining the optimal methods for recruiting participants, assessing participation rates and other factors that may influence participation, and demonstrating the feasibility of the techniques being used to reconstruct the levels of individuals' past exposures to particulate matter. These techniques, recently reported on in three journal articles by VA researchers and colleagues from Harvard and other institutions, involve the use of satellite data and airport

visibility readings to help map pollution patterns and exposures that may have affected troops. Data from the National Aeronautics and Space Administration will be used to help with efforts to conduct this state-of-the-art approach to studying airborne exposures. Approximately 10,000 Veterans will be recruited at a total of six sites to participate in surveys and pulmonary function tests (PFTs). The results of current PFTs will be linked to each Veteran's exposure to particulate matter in the air during deployment.

Question 61: The budget request includes \$8.6 billion for veterans' mental health services. Part of this funding accounts for the critical one-year period following uniformed service and transition to civilian life. The Committee has had multiple hearings and roundtables on the transition assistance process. Please detail the measures VA expects to take over the next year to improve this transition process.

VA Response: VA plans to improve the transition process for Servicemembers during the critical 1-year period following uniformed service to civilian life through the following efforts:

- Developed a module within the revised Transition Assistance Program (TAP) VA Benefits I and II curriculum specifically addressing how transitioning Servicemembers can maintain their health following transition which includes a section on emotional wellness. Additionally, the section provides awareness of the growing number of people who are diagnosed with depression, and lists resources offered by VA for suicide prevention (e.g., crisis hotlines, websites, and support organizations).
- Implementing facilitated health care registration, which is an increased effort to register transitioning Servicemembers in VA health care by submitting their Application for Health Benefits (VA Form 10-10EZ) while they are in the VA Benefits I & II Briefings. This process will result in eligible Veterans having their applications adjudicated immediately after military separation or discharge.
- Leveraging VA Whole Health peer outreach and wellness groups to address transitioning Servicemembers' and Veterans' mental health needs, in addition to Transition Care Management and more traditional mental health services.
- Collaborating with interagency partners to collect feedback on post-separation outcomes via a post-separation assessment. Implementation of the assessment will give VA the opportunity to ensure TAP is employing the right tactics to help our Servicemembers transition successfully. It will also allow us to conduct data-driven evaluation of the effectiveness of TAP and the long-term impact of interagency transition services. Additionally, VA is working with interagency partners to review "at risk" populations for identification, tracking, and servicing to enhance effectiveness.
- VA and DoD are working collaboratively to extend the availability of Military One Source resources for a full year following discharge.

Question 62: The Bay Pines Health System recently experienced major facilities problems in a domiciliary housing homeless veterans; the building lacked heat and hot water for months. I escalated the issue to the Secretarial level and appreciate the swift action that was, at that point, taken. However, I am baffled as to why quicker action wasn't taken at the local level. Please further explain why this situation was allowed to develop and why the Health System or VISN did not address it earlier—was it a lack of dollars, or merely a lack of common sense in prioritizing dangers to the health and wellbeing of our most vulnerable veterans?

VA Response: VA has numerous contingency plans for mitigating any risk and ensuring the overall safety and well-being of Veterans; we also have access to numerous resources and expertise across the organization. The specific situation with Bay Pines VA Health System (BPVAHCS) was due to issues that occurred when powering up their outbuildings' post Hurricane Irma; which is a required and critical part of their emergency operations plan for sustainment. Appropriate oversight and guidance is sought through the appropriate channels, in this case additional technical guidance was sought through Contracting and Office Capital Asset Management Engineering and Support.

Mental Health leadership and care team members continually assessed Veteran concerns as they were raised. The total time from when the decision was made to replace the steam line end to end, to the time that a contract was awarded, was approximately 60 days. This is not an unrealistic timeframe as a full assessment of the project needed to happen to ensure it was appropriate in scope and complexity. This is a required element of the contracting process to ensure that all technical and safety specifications maintain compliance with industry and VHA standards.

Question 63: The budget proposal includes a narrative that the separate Community Care account, which has existed for the last several years, has restricted VA medical center directors from managing their budgets effectively. Please provide specific examples of this.

VA Response: The current multiple medical care appropriations structure presents an administrative burden to the Medical Center Directors. While not insurmountable, it does not permit the Medical Center leadership to easily leverage all the tools available for providing Veterans with the care they need. Having both Medical Services and MCC aligned under one appropriations account would allow Medical Center Directors the flexibility needed to expediently address care-related issues in ways that are beneficial to our Veterans.

Prior to the implementation of the MCC account, VA medical centers locally allocated funds between VAMC salaries and care in the community, ensuring Veterans had timely access to care. This flexibility was lost with the inception of the MCC account. This proposal allows the previous flexibility while ensuring timely access to care and to strategically and efficiently use the funds. Below are specific examples:

- a. A VA Medical Center has a physician vacancy that has been unfilled for some time, but is able to finally hire someone for that position. Because the workload associated with this new hire would have been reflected in community care in the recent past, the VAMC would like to move the funds back in house and provide the care at lower cost than purchasing it from the community. Under the current appropriation structure, this requires a time consuming transfer process, and until such a transfer could be accomplished, the VAMC must identify in-house funding offsets, possibility limiting clinical care in another area.
- b. A rural VAMC is providing 1,200 sleep studies each month through care in the community at the cost of \$864,000 a year. Total estimated staffing and supply costs to bring those services in-house is estimated to be \$450,000 a year, but the process of transferring funds between appropriations accounts is time consuming and administratively burdensome.
- c. A VAMC has sufficient operating room capacity, outpatient clinical space, and equipment to provide clinical services, but lacks the flexibility to convert community care funds to medical services funds in a timely manner.

The current multiple medical care appropriations structure negatively impacts existing sharing agreements with adjacent university hospitals. VA sharing agreements are funded with the Medical Services appropriation. When medical centers exceed the annual allotted budget for the sharing agreement(s), the medical center is required to send Veterans for care in the community for the remainder of the FY. For specialty care, such as orthopedic surgeries, the cost is frequently much more costly than through the sharing agreement.

Strategic investment in capital equipment and staffing is limited without the flexibility to transfer funds expeditiously between appropriations. With the combined appropriation medical center directors will have more flexibility to reallocate the MCC funds to purchase necessary equipment as well as to fund necessary salaries. As one specific example, a VAMC currently sends out all low-dose Computerized Tomography scans to the community. The VAMC would like to realign the community care funds to provide this service in-house at lower cost.

Question 64: What measures is VA taking to involve community health centers in the planning of community care consolidation, and what role is envisioned for them when consolidation is implemented?

VA Response: The VA Community Care Network (CCN) Contract Request for Proposal (RFP) provides language for the CCN contractors to make every reasonable attempt to ensure access to Federally Qualified Healthcare Centers as part of CCN. The CCN RFP does not specifically address community health centers (CHC). The CCN RFP does require the CCN contractor to customize the network for each VA Facility therefore the VA Facility leadership can request the CCN Contractor to engage local CHCs.

Question for the Record from Rep. Bost:

Question 65: The budget includes a request for \$172 million for the Office of Inspector General to strengthen accountability. Will this level of funding be sufficient to properly enforce accountability throughout the VA?

VA Response: *OIG will respond directly to Rep. Bost and will provide OCLA with a copy (Gromek).*

Question 66: Do you need any new authority to establish clearer cut qualifications for positions within VA, such as Human Resources?

VA Response: The Human Resources Management - GS-0200 series is under Title 5 and as such, is covered by the Office of Personnel Management's (OPM) General Schedule Qualification standards. These standards are written broadly for Government-wide application and are not intended to provide detailed information about specific qualification requirements for individual positions at a particular agency. It is important to note that all Federal agencies use the OPM approved qualification standards, and creating VA specific standards, would negatively impact VA's ability to recruit human resources (HR) professionals from other Federal agencies and retain current HR staff. OPM states that such information (i.e., a description of the specialized experience requirements for a particular position) should be included in the vacancy announcements issued by the agency. As such, rather than standardized qualification requirements across VA, individual vacancy announcements are customized to reflect the specialized experience (qualification requirements) for the particular position itself. VA already utilizes this method of applying specialized qualification requirements in all HR job announcements. Additionally, performance standards are developed on an annual basis for each HR position in the Department. These performance standards are aligned with the specific functions and specialized area of HR being performed by each HR professional.

Question for the Record from Rep. Poliquin:

Question 67: The budget request includes \$25 million to reimburse the Judgment Fund. Will this zero out VA's liabilities to the Judgment Fund?

VA Response: No. The outstanding Judgment Fund reimbursement to Treasury is \$229.9 million for nine projects. The FY 2018 appropriation of \$10 million for the Judgment Fund will leave a balance of \$219.9 million. The FY 2019 requested appropriation of \$25 million will leave a balance of \$194.9 million and serves as a down payment to address the overall requirement.

Questions for the Record from Rep. Dunn:

Question 68: VA's suggested Major Construction appropriation language includes the following. Please explain the intended meaning and effect of, "regardless of the estimated costs of the project..."

...of which \$400,000,000 shall be available for seismic improvement projects and seismic program management activities regardless of the estimated costs of the project...

- a. Please explain how VA has changed the prioritization of seismic projects in the existing SCIP process.

VA Response: The use of the word "regardless" is a technical change to clarify that major funds could be used for seismic needs/projects that were partially funded by the Minor, Medical Facilities and National Cemetery accounts:

"...and of which \$480,000,000 shall remain available until expended, of which \$400,000,000 shall be available for seismic improvement projects and seismic program management activities regardless of the estimated costs of the project..."

In order to address that concern, VA could propose the following revised language:
"...and of which \$480,000,000 shall remain available until expended, of which \$400,000,000 shall be available for seismic improvement projects and seismic program management activities, including for projects that would otherwise be funded by the Construction, Minor Projects, Medical Facilities, or National Cemetery Administration accounts..."

Seismic is still a high priority and included in the SCIP process – as it has been in previous years. For 2019, seismic projects shown in the SCIP 2019 prioritized list were not included in the minor or NRM funding request and would be funded out the newly created seismic fund.

- b. Please explain why, after this change, creation of a separate seismic fund and project ranking list is necessary.

VA Response: A separate seismic initiative fund is necessary to more effectively and efficiently meet significant critical seismic corrections for VA buildings at various locations across the Nation. VA has identified a seismic risk in excess of \$7 billion at its facilities. The proposed seismic fund would correct singular buildings, as opposed to campus wide corrections. Projects would be limited to providing similar functions and maintain original purpose. Further, the reduction of some legislative requirements will allow for quicker correction of documented deficiencies. This initiative will allow VA to move forward quickly and without delay to address the critical seismic issues that are currently putting Veterans, staff, and other VA visitors at-risk.