Questions for the Record
HAC MILCON/VA
FY 2019 Budget Hearing
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Questions from Chairman Charlie Dent

Question 1: What are the projected costs for the RAMP program in FY18 and FY19?

VA Response: Veterans Benefits Administration's (VBA) projected cost is $47.3M in fiscal year (FY) 2018 and $29.1M in FY 2019 for the RAMP program which includes FTE, mail, travel, outreach and printing costs associated with marketing materials.

Question 2: What is budgeted for scanning in FY17, FY18 and FY19?

VA Response: VBA obligated $224.6M in FY17, estimates $142.8M in FY18, and $129.5M in FY19 for scanning and centralized mail efforts.

Question 3: What is VA spending on Clay Hunt Suicide Prevention activities in FY17, FY18 and FY19?

VA Response: The Clay Hunt Suicide Prevention for American Veterans Act (Public Law 114-2) was signed into law on February 12, 2015. The cost estimates provided include direct costs and do not account for staff costs resulting from implementation.

FY 2017: $1,497,946
FY 2018: $1,690,113
FY 2019: $1,808,587

Question 4: In FY18 and FY19, what share of Office of Rural Health funding is expected to be committed to continuation of prior year programs?

VA Response: In FY 2018, 95 percent of Office of Rural Health funding is committed to continuation of prior year rural access programs, the remainder to new programs. In FY 2019, 99 percent is expected to be committed to sustaining existing programs.

Question 5: How many HUD-VASH vouchers are assumed in the FY19 VA budget? What is the estimated VA cost per voucher of associated services?

VA Response: HUD awarded 5,211 additional Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH) vouchers in April 2018 from FY 2017 HUD appropriations provided for this purpose. VA is working with HUD to allocate another $540 million in HUD funding for new HUD-VASH vouchers, estimated to be 5,000 new vouchers, by September 30, 2018 from FY 2018 HUD funds appropriated for HUD-VASH. This would increase the total number of HUD-VASH vouchers awarded since 2008 to approximately 98,000.

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VA currently funds over 3,900 full-time equivalents (FTE), not including contracted staff, to support Veterans in the HUD-VASH program. Veterans served by HUD-VASH utilize many Veterans Health Administration (VHA) services, including primary care, mental health, and specialty care services that are not factored into direct HUD-VASH staff costs. The average compensation for a Master-level prepared Social Worker (MSW), with benefits, for HUD-VASH is $98,286. The majority of HUD-VASH staff members are MSW.

Question 6: How much funding in the FY19 research request is identified for the Million Veterans genetics program? How close is VA to reaching its enrollment goal for the project?

VA Response: While the budget for the Million Veterans Program (MVP) is not specifically segregated in the Office of Research and Development budget submission, with the FY 2019 request, approximately $82M is expected to be obligated for MVP. This includes support for the infrastructure, recruitment/ enrollment, core staffing for supporting science, and contracts for genotyping and whole genome sequencing. In addition, $20M is requested for supporting the expansion of MVP-CHAMPION projects at the Department of Energy (DOE) through 2023 (VA requested funding for the VA/DOE collaboration with a Period of Availability through 2023).

As of March 29, 2018, 654,987 Veterans have enrolled in MVP. The program expects to reach its target of one million Veterans by 2021.

Question 7: What is the explanation for the request of an additional $1.4 billion for FY18 in Compensation and Pensions?

VA Response: VA is requesting a second bite of $1.4B in addition to the advance appropriation requested for Compensation and Pensions (C&P) for FY 2019. Each year, the C&P budget estimates are updated to reflect actual data from the previous fiscal year, current economic assumptions provided by the Office of Management and Budget (OMB),and any recently enacted legislation, published regulations, or VA initiatives that impact C&P benefits. The combined impact of these budget updates resulted in a $1.3B increase in estimated obligations for FY 2019, primarily for Veterans compensation. Additionally, these budget updates increased FY 2018 obligations, which in turn decreased the estimated carryover balance from FY 2018 into FY 2019 by $137.4M. The combination of decreased carryover into FY 2019 ($137.4M) and increased obligations ($1.3B) results in a second bite request of $1.4B for FY 2019.

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Question 8: What is the total annual spending projection (budget authority and reimbursements) for the new Financial Management System since inception and until completion?

VA Response: VA is developing an updated lifecycle cost estimate (LCCE) reflecting the way forward without the United States Department of Agriculture (USDA) as VA's Federal Shared Service Provider (FSSP) as well as the change of program leadership, moving the Financial Management Business Transformation (FMBT) program management office and Office of Information and Technology to VA's Financial Services Center (FSC). Both USDA's withdrawal from the effort and leadership transfer has resulted in significant changes. VA is in the process of evaluating those changes and making determinations on the way forward. These decisions will have an impact on the FMBT LCCE and must be finalized before accurate estimates can be determined. VA will provide an updated cost estimate which incorporates changes necessitated by leadership transfer and the withdrawal of USDA. A final draft of the LCCE will be ready by 30 Sept 2018 with updates to come as support contracts are awarded and the 90 day program assessment concludes.

FMBT ($M)	FY 16 Actuals	FY 17 Actuals	FY 18 Estimate	FY 19 PB	Total
General Administration	$4.8	$9.0	$11.1	$10.9	$35.8
Office of Information & Technology	$-	$44.3	$72.3	$72.8*	$189.4
Fair Share Reimbursable Agreements	$10.0	$30.8	$50.1	$48.8	$139.7
Total Funding	$14.8	$84.1	$133.5	$132.5	$364.9

Question 9: What is the explanation for the increase in mandatory advances from FY19 to FY20? An increase of $13.6 billion is far larger than the usual increase.

VA Response: The $13.6B represents the difference between the $107.7B VBA requested for 2019 in the 2018 Budget and the $121.3B VBA requested for 2020 in the 2019 Budget. However, the 2019 Budget also includes VBA's updated request of $109.2B for 2019, as shown in the chart below.

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Mandatory Appropriation Requests ($million)			
President's Budget Cycle:	2018	2019	2019
Funding for:	2019	2019	2020
Compensation and Pension	$95,768	$97,179	$107,120
Readjustment Benefits	$11,832	$11,832	$14,065
Housing	$0	$110	$0
Insurance	$109	$106	$111
Total VBA Mandatory	**$107,709**	**$109,228**	**$121,296**

The revised request for 2019 in the 2019 Budget is based on actual data from 2017, current economic assumptions provided by OMB, and any recently enacted legislation, published regulations, or VA initiatives that impact benefits. The 2019 Budget shows an increase of $12.1B in total mandatory appropriation requests from 2019 to 2020 due to the following:

- Compensation and Pension: Although the 2020 appropriation request is $9.9B greater than the current 2019 appropriation request, obligations are expected to increase by only $7.8B, which is consistent with historical increases of 7-8 percent annually. VBA expects an unobligated balance of $2.1B to carry over into 2019, which reduced the appropriation request for 2019. VBA does not expect to carry over any funding into 2020, so the appropriation request is equal to estimated obligations for the year.
- Readjustment Benefits: While the 2020 appropriation request is $2.2B greater than the 2019 request, obligations are expected to increase by only $606.1M. This is primarily due to an unobligated balances VBA expects to carry over into 2019 ($5.2B) and 2020 ($1.8B), which lowered the appropriation request for each year. A more detailed display of obligations, carryover, offsetting collections from DoD, and appropriation requests is available on page VBA-78 of Volume III in VA's 2019 Budget.
- Housing: Current law does not allow advance appropriations requests for VA's housing programs. The 2020 appropriation requests for housing will be included in the 2020 Budget.
- Insurance: The increased appropriation request from 2019 to 2020 is due to an increase in death claims and a resulting shortfall between obligations and collections in VII and Service Disabled Veterans Insurance (SDVI) funds. The revised 2019 appropriation request of $106M reflects small downward claims adjustments over the two budget cycles. For VII, premiums will remain about the same, but the number of death claims will increase as policies with a higher face

amount of insurance will mature through deaths. For SDVI, death claims will increase due to an increasing age of the general policyholders population leading to a higher than anticipated death experience. The offsetting SDVI premiums will grow only slightly.

Question 10: Members have heard much frustration among community providers about long delays in VA reimbursing them for providing non-VA care, to the point that some physicians are pulling out of the Choice program. In January, you announced a plan with the ambitious goal of increasing the number of claims paid in January by 300 percent and in April by 600 percent. The announcement didn't provide much detail about how you were going to accomplish that ambitious goal.

- **Did you meet your January goal?**
- **What changes are you making to the payment process to make these improvements possible?**

VA Response: VA is increasing the number of claims processed within 30 days of submission through use of additional contractor support. By February 9, 2018, the number of claims sent to the vendor supporting claims processing increased by 340 percent from the December starting point. Seventy (70) percent of those claims were fully processed, and the rest of those claims were being worked on by the vendor.

Since our January press release, VA has focused on the top 20 providers nationally with the highest dollar value of unpaid claims and created rapid response teams that are currently working with those providers to resolve those claims. Through these efforts, the number of claims processed since December has increased substantially, and we are well on our way to our goal of eliminating our claims backlog by September 2018. In addition to the claims processing support, VA is also implementing technology improvements to convert claims submitted via paper to electronic format. Several sites are now using this capability and will be implementing nationwide later this year.

VA is aware that smaller providers may not meet the "top 20" focus mentioned above but play key roles in more rural communities in providing continuity of care for our Veterans. In addition to the top 20 providers identified by VA, VA is working with facilities to identify smaller providers who are important providers of Veteran care and will also be working with them. Lastly, VA realizes that provider education about claims processing is important in assisting providers in submitting their bills accurately. VA has been providing education to the providers with the highest dollar value of unpaid claims as part of the outreach. We have seen the value of this outreach and will begin offering monthly training calls in April for the entire provider community. This will allow any provider to join in and learn about VA processes.

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Question 11: Multiple clinical studies have demonstrated the medical and health-economic benefits of high dose influenza vaccine, including a specific retrospective analysis conducted in collaboration with the VA. How does the VA plan to evaluate the extensive body of evidence supporting the superior efficacy and health outcomes of high dose influenza vaccine in persons 65 years and older to ensure it is incorporated into its procurement decisions?

VA Response: Every year, in preparation for the National Contract Solicitation for Influenza Vaccine, VA evaluates available clinical evidence regarding the safety, efficacy, and effectiveness of influenza vaccines, including high-dose influenza vaccine, as it becomes available in the published literature. The evidence is assessed based on the rigor of the scientific methods and the statistical and clinical significance of the results. In particular, VA considers the evidence presented to the Advisory Committee on Immunization Practices (ACIP), which advises the Centers for Disease Control and Prevention, including influenza vaccine research studies and seasonal influenza surveillance and efficacy data. Based on the ACIP recommendations, VA develops a procurement request for influenza vaccine to cover the bulk of the needs of the patient and health care provider population vaccinated by VA.

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Ranking Member Nita Lowey

Question 1: The VA OIG report dated July 31, 2017 included four recommendations for the VA to address the opioid epidemic. Has the VA fully addressed these items, and if not, what is the timetable for completion?

VA Response: Recommendations 1-3 are closed as of December 28, 2017. Closure of recommendation 4 hinges on the finalization of the Patient Safety Guidebook becoming an appendix to the National Center for Patient Safety's handbook and has a target completion date of July 31, 2018.

Since 2013, when the Department of Veterans Affairs (VA) established its Opioid Safety Initiative (OSI), VA has made significant progress in reducing opioid prescribing and thereby reducing risks for Veterans. VA is making headway treating opioid addiction by providing programs nationwide to support Veterans. VA offers medication reduction therapy, alternatives to medication, including Complementary Integrative Health (CIH) approaches, mental health support, and education.

VA has seen a significant change in opioid use amount its patients. Results of key clinical metrics measured by the OSI from Quarter 4, Fiscal Year 2012 (beginning in July 2012) to Quarter 2, Fiscal Year 2018 (ending in March 2018) there are:

- :
  - 280,477 fewer patients receive opioids (41 percent reduction).
  - 85,695 fewer patients receive opioids and benzodiazepines together (70-percent reduction).
  - 203,937 fewer patients are on long-term opioid therapy (47-percent reduction) with a 90 percent reduction in new starts.
  - 35,531 fewer patients receive greater than or equal to 100 Morphine Equivalent Daily Dose (60-percent reduction).

- VA has provided clinicians and the public access to our STOP PAIN Toolkit. STOP PAIN involves the following:

  S. Stepped Care Model
  T. Treatment alternatives/complimentary care
  O. Ongoing monitoring of usage and education of providers
  P. Practice Guidelines
  P. Prescription monitoring
  A. Academic Detailing
  I. Informed consent for patients
  N. Naloxone distribution

- Since September 30, 2017, through VA's Opioid Overdose Education and Naloxone Distribution (OEND) program, over 105,000 naloxone prescriptions have been dispensed to Veterans.

- VA is publicly posting information on opioids dispensed from VA pharmacies and VA's strategies to prescribe these pain medications appropriately and safely. VA is the first and only health care system to fully disclose facility level prescribing data. See https://www.data.va.gov/story/department-veterans-affairs-opioid-prescribing-data.

- VA offers free medication take-back services to Veterans through mail-back envelopes and on-site receptacles in accordance with Drug Enforcement Administration (DEA) regulations.
  - As of September 30, 2017, Veterans have returned over 53 tons (107,822 pounds) of unwanted or unneeded medication using these services.

- VHA has responded to growing demands for opioid use disorder treatment by increasing access to Medication-Assisted Treatment (MAT). MAT includes counseling or psychotherapy, close patient monitoring, and the use of medications such as buprenorphine/naloxone, methadone (administered through an Opioid Treatment Program), or extended-release injectable naltrexone.

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

- CIH approaches are being expanded as options beyond the use of standard models of care in the treatment of chronic pain. CIH focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic and lifestyle approaches, health care professionals, and disciplines to achieve optimal health and healing. This includes evidenced-based treatments such as acupuncture, yoga, and progressive relaxation.

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Ranking Member Debbie Wasserman Schultz

Choice Program vs. Community Care

Question 1: The FY 2019 budget request folded the Community Care account back into the Medical Services account. Why is VA rolling that function back into medical services and second, doesn't statue direct that there be a separate account for Community Care?

VA Response: The FY 2019 VA President's Budget proposes to merge the Medical Community Care and the Medical Services appropriations, as was the case prior to FY 2017. The separate appropriation for Medical Community Care required by section 4003 of the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 (Public Law 114-41) requires each budget of the President for FY 2017 and each fiscal year thereafter to include an appropriations account for non-Department provider programs. In effect, this provision has restricted VA medical center (VAMC) Directors as they manage their budgets and make decisions about whether the care Veterans require can best be provided within their facilities or must be purchased from community providers or Federal partners.

This requirement would be superseded if Congress enacted the President's Budget request to re-combine the VA Medical Services and Medical Community Care appropriations.

This is intended to address the dynamic nature of health care management, as the loss of a key clinical staff position, such as a general surgeon, requires that the care that provider furnished instead be provided temporarily by a community provider until VA can hire a replacement, which can be a lengthy process. This can also occur when VA facilities must be temporarily closed because of damage, such as from the recent hurricanes, or even more localized disruptions to care. This change would enable VA field staff to respond rapidly and effectively to unanticipated changes in the health care environment throughout the year and will maximize VA's ability to focus our resources on the services Veterans most need.

Conversely, if a position has been vacant for a period of time but analysis shows that it would be more effective for Veterans to provide the care in-house, the care should be realigned from the community back to the VAMC. This process was previously referred to as "fee recapture" and served as an incentive for VAMC Directors to identify areas where additional investment in VA's in-house capacity to provide health care for Veterans could be enhanced to provide expanded services at lower cost than those services could be purchased from community health care providers. This incentive was effectively eliminated by the mandate for a separate Community Care appropriation because of the administrative processing time required to transfer funds between appropriations. In short, rather than creating a potential incentive to determine where

care is delivered based on funds available in the two separate appropriations, this proposal allows each VAMC Director to determine where they can effectively enhance the capability of their facilities with the confidence that funds will be available to accomplish that goal.

The accounting structure to capture and identify care purchased from the community will remain in place to enable VA to identify and report separately on the costs of VA-provided care and for care from community providers and Federal partners. For example, in the following tables, which were included in the revised FY 2019 Congressional Justification volume, display the detail available under the new proposal, which mirrors the detail currently reported for the separate Community Care appropriation (Volume II, VHA 216-217).

Care in the Community Obligations by Program
Includes Veterans Choice Program
(dollars in thousands)

	2017 Actuals			2018 Budget Estimate			2018 Current Estimate		
Description	Veterans 2/ Choice Fund (0172)	Medical Community Care (0140)	Subtotal	Veterans Choice Fund (0172)	Medical Community Care (0140)	Subtotal	Veterans 2/ Choice Fund (0172)	Medical Community Care (0140)	Subtotal
Health Care Services:									
Ambulatory Care	$3,068,201	$1,589,371	$4,657,572	$1,203,111	$2,342,023	$3,545,134	$2,179,984	$2,530,720	$4,710,704
Dental Care	$103,406	$133,401	$236,807	$45,100	$101,300	$146,400	$72,900	$157,229	$230,129
Impatient Care	$971,966	$2,043,692	$3,015,658	$1,551,789	$1,551,789	$3,103,578	$685,994	$2,209,990	$2,895,984
Mental Health Care	$34,179	$176,436	$210,615	$0	$315,099	$315,099	$24,100	$204,700	$228,800
Prosthetics	$14,052	$0	$14,052	$5,200	$0	$5,200	$22,203	$0	$22,203
Rehabilitation Care	$0	$0	$0	$0	$0	$0	$0	$0	$0
Health Care Services [Total] 1/	$4,191,804	$3,942,900	$8,134,704	$2,805,200	$4,310,211	$7,115,411	$2,985,181	$5,102,639	$8,087,820
Long-Term Services and Supports Community Care:									
Community Nursing Home	$0	$869,690	$869,690	$0	$1,032,400	$1,032,400	$0	$892,889	$892,889
Community Non-Institutional Care	$592,765	$655,158	$1,247,923	$694,800	$805,000	$1,499,800	$680,672	$687,128	$1,367,800
State Nursing Home	$0	$1,252,899	$1,252,899	$0	$1,290,362	$1,290,362	$0	$1,225,026	$1,225,026
State Home Domiciliary	$0	$58,086	$58,086	$0	$54,400	$54,400	$0	$54,400	$54,400
State Home Adult Day Care	$0	$944	$944	$0	$1,195	$1,195	$0	$1,195	$1,195
Community Long-Term Services and Supports [Total]	$592,765	$2,836,777	$3,429,542	$694,800	$3,183,357	$3,878,157	$680,672	$2,860,638	$3,541,310
Other Health Care Programs Community Care:									
CHAMPVA, Spina Bifida, FMP, & CWVV	$0	$1,287,571	$1,287,571	$0	$1,639,249	$1,639,249	$0	$1,397,281	$1,397,281
Caregivers (non-CHAMPVA)	$0	$1,171	$1,171	$0	$3,373	$3,373	$0	$1,208	$1,208
Camp Lejeune Family	$0	$1,368	$1,368	$0	$6,664	$6,664	$0	$1,398	$1,398
Other Health Care Programs community care [Total]	$0	$1,290,110	$1,290,110	$0	$1,649,286	$1,649,286	$0	$1,399,887	$1,399,887
SubTotal Obligations	**$4,784,569**	**$8,069,787**	**$12,854,356**	**$3,500,000**	**$9,142,854**	**$12,642,854**	**$3,665,853**	**$9,363,164**	**$13,029,017**
VA Prior-Year Recoveries	$699,650	$0	$699,650	$0	$0	$0	$0	$0	$0
Total Obligations	$5,484,219	$8,069,787	$13,554,006	$3,500,000	$9,142,854	$12,642,854	$3,665,853	$9,363,164	$13,029,017

1/ Includes cost of proposed CARE Act
2/ Excludes OI&T components

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Care in the Community Obligations by Program
Includes Veterans Choice Program
(dollars in thousands)

Description	2019 Advance Appropriation			2019 Revised Request			2020 Advance Appropriation		
	Veterans Choice Fund (0172)	Medical Community Care (0140)	Subtotal	Veterans Choice Fund (0172)	Medical Community Care (0160)	Subtotal	Veterans Choice Fund (0172)	Medical Community Care (0160)	Subtotal
Health Care Services:									
Ambulatory Care	$1,187,907	$2,344,979	$3,532,886	$1,152,215	$3,483,460	$4,635,675	$0	$5,857,622	$5,857,622
Dental Care	$60,304	$101,300	$161,604	$37,800	$167,386	$205,186	$0	$177,730	$177,730
Impatient Care	$1,551,789	$1,361,860	$2,913,649	$344,947	$1,816,429	$2,161,376	$0	$2,889,287	$2,889,287
Mental Health Care	$0	$320,145	$320,145	$12,500	$199,400	$211,900	$0	$299,900	$299,900
Prosthetics	$5,200	$0	$5,200	$11,152	$0	$11,152	$0	$0	$0
Rehabilitation Care	$0	$0	$0	$0	$0	$0	$0	$0	$0
Health Care Services [Total]	$2,805,200	$4,128,284	$6,933,484	$1,558,614	$5,666,675	$7,225,289	$0	$9,224,539	$9,224,539
Long-Term Services and Supports Community Care:									
Community Nursing Home	$0	$1,104,700	$1,104,700	$0	$963,651	$963,651	$0	$1,033,734	$1,033,734
Community Non-Institutional Care	$694,800	$928,600	$1,623,400	$341,386	$1,110,099	$1,451,485	$0	$1,529,900	$1,529,900
State Nursing Home	$0	$1,367,993	$1,367,993	$0	$1,245,709	$1,245,709	$0	$1,274,975	$1,274,975
State Home Domiciliary	$0	$54,206	$54,206	$0	$61,764	$61,764	$0	$61,196	$61,196
State Home Adult Day Care	$0	$1,317	$1,317	$0	$1,322	$1,322	$0	$1,417	$1,417
Community Long-Term Services and Supports [Total]	$694,800	$3,456,816	$4,151,616	$341,386	$3,382,545	$3,723,931	$0	$3,901,222	$3,901,222
Other Health Care Programs Community Care:									
CHAMPVA, Spina Bifida, FMP, & CWVV	$0	$1,774,076	$1,774,076	$0	$1,463,185	$1,463,185	$0	$1,529,841	$1,529,841
Caregivers (non-CHAMPVA)	$0	$3,439	$3,439	$0	$1,620	$1,620	$0	$1,624	$1,624
Camp Lejeune Family	$0	$7,630	$7,630	$0	$1,429	$1,429	$0	$1,460	$1,460
Other Health Care Programs community care [Total]	$0	$1,785,145	$1,785,145	$0	$1,466,234	$1,466,234	$0	$1,532,925	$1,532,925
Total Obligations 1/ 2/	**$3,500,000**	**$9,370,245**	**$12,870,245**	**$1,900,000**	**$10,515,454**	**$12,415,454**	**$0**	**$14,658,686**	**$14,658,686**

1/ Includes cost of proposed CARE Act

2/ The Budget includes $12.4 billion in total obligations for Choice/Community Care in FY 2019. Programmatic resources total $14.2 billion, 9.1 percent above 2018 after adjusting for the impact of the change in timing of obligations.

In addition, VA is requesting modification of the current process required to manage funds for purchasing Community Care. Under section 106 of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113-146), all Community Care funds are centrally managed by the Deputy Under Secretary for Health for Community Care (DUSHCC, formerly the Chief Business Officer).

Concurrent with the VA proposal to merge the Medical Community Care and Medical Services appropriations, this proposal would allow each VAMC to receive all funding for its enrolled Veterans and manage those funds locally, thus providing the flexibility each VAMC needs to effectively deliver health care in a dynamic environment.

This proposal would allow VA to establish a community care funding model that mirrors the successful model currently used for VA's Consolidated Mail Outpatient Pharmacies (CMOP). Under this model, each VAMC and the DUSHCC would determine an estimated amount of funding for community care at the beginning of the fiscal year, and the VAMC would preposition those funds with the DUSHCC to manage the purchase of and payment for care purchased by VA from community providers. During the course of the year, each VAMC and the DUSHCC would monitor the initial funding amount and make appropriate adjustments based on changes in actual demand as the fiscal year progresses.

Oversight of VA Medical Care budget execution would occur at all leadership levels, culminating at the Monthly Management Review chaired by the Deputy Secretary. VA would also be able to provide periodic execution reports, similar to the reports currently provided for Choice funding, to Congress if desired, to monitor the relative funding of care provided in VAMCs and purchased from community providers.

This model would enhance each VAMC's ability to rapidly respond to changes in clinical staffing and readily realign funds to or from the DUSHCC to reflect changes in the VAMC's ability to efficiently provide the care in VA facilities as opposed to purchasing that care from the community. As with the request to combine the Medical Community Care and Medical Services appropriations, rather than creating a potential incentive to determine where care is delivered based on funds available in the two separate appropriations,this proposal allows VAMC Directors to enhance the capability and efficiency of their facilities with the confidence that funds will be readily available.

Question 2: Over the past few years Congress has given Veterans the freedom to pursue care in Community, but I am concerned that this has started us down the road of privatized care which I strongly oppose. Has this Administration been pushing you to move VA in that direction?

VA Response: No. VA cannot provide health care alone – as we learned from the access crisis of 2014. We have to have a rational system that allows Veterans to understand what choices they have and to get the best care from VA. VA is doing important work on behalf of Veterans. The right choice is a system that allows for a strong internal VA that is working properly, as well as taking advantage of working with the private sector when Veterans can benefit from that system as well.

Question 3: The Budget Deal passed with the agreement that four billion dollars would be invested in VA infrastructure of FY18 and FY19. However, the FY 2019 budget requests $1.9 billion in discretionary funding for the Veterans Choice Fund and additional funds for Community Care. Which again looks like a push to privatization. Can you explain why the additional funds were not used for infrastructure?

VA Response: Recognizing the substantial needs of VA's aging infrastructure, our FY 2019 request of $3.3B (including major and minor construction and non-recurring maintenance) is the largest request in the last 5 years. Delivery of Veteran health care services has many competing priorities, and we believe that we are striking a reasonable balance between funding the critically-important Veterans Choice/Community Care Program and medical facility infrastructure needs.

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Electronic Health Records (EHR)

Question 4: VA took a "strategic pause" in negotiations between EHR giant Cerner and VA on December 13, 2017, while MITRE performed an independent assessment of the national interoperability language laid out in the proposal request awarded to Cerner. MITRE submitted its final report in January. Can you provide the Committee with some background on this report, for example, how many recommendations did MITRE make and how many were accepted by Cerner and VA?

a. **Have your concerns about interoperability been addressed and will VA be able to share records with the private sector and will the private sector be able to share with VA?**

VA Response: Upon receipt of the MITRE report on January 31, 2018, each of the comments was fully adjudicated/reconciled with the MITRE team by our VA technical/functional requirement owners. VA then re-entered into direct negotiations with Cerner Corporation to solidify the requisite modifications to the EHR Request for Proposal (RFP). Though important interoperability updates/changes were introduced, the proposed modifications spawned no proposal/contract price increase by Cerner Corporation and were incorporated appropriately into the RFP.

As final measure, the RFP was reviewed utilizing a myriad of industry subject matter experts, executives, Chief Information Officers, and clinicians to conduct a final review of the RFP language. The comments submitted were primarily high-level lessons learned from their own past experiences. VA was effectively able to re-validate the RFP language based on these inputs from the industry executives. No substantive changes were introduced by this additional review, but the review was valuable in reconfirming a number of programmatic risk areas and the critical importance of the Program Management Office (PMO) in overseeing this complex EHR modernization effort.

Two post-award contract elements, confirmed by this external review include the following:
(1) our creation of a senior advisory council comprised of industry experts to continue to advise the VA Team on EHR modernization/implementation/ deployment strategies as well as on clinical/technical innovation, technological and standardization;
(2) our development and use of an interoperability sandbox/test bed during Initial Operating Capability efforts to test clinical scenarios, domain structures, and various evolving interoperability strategies.

The Cerner contract incorporates significant interoperability requirements, including: maintenance of Office of the National Coordinator (ONC) certification for health IT products, standards-based, open APIs (Application Program Interface) built off of the

FHIR (Fast Healthcare Interoperability Resources) specifications, Web Access to DICOM (Digital Image and Communication in Medicine) Persistent Objects (known as WADO), Integrating the Healthcare Enterprise (IHE) standards for document-based exchange, and other Government designated standards. The movement towards modern, standards-based, open APIs will promote innovating third party development of tools that will enable clinicians and veterans to use data in more useful ways. Further, when VA updates a standard in the contract or ONC updates its Health IT Certification program, Cerner must update such standards in its product and make the functionality available in production within 18 months.

Question 5: DoD has taken an eight-week pause. Does VA know the reason for DoDs pause?

VA Response: The challenges the Department of Defense (DoD) is experiencing have been shared with VA for future mitigation throughout the contract planning process. Knowing the potential challenges with large-scale information technology (IT) projects, both VA and DoD's approach involves deploying the solution at Initial Operating Capability (IOC) sites to identify problems and correct them before deploying to additional sites. IOC will be used to further hone governance, configuration management, and solidify processes in support of adherence to VA Central Office directives and other enterprise initiatives associated with the Electronic Health Record Modernization (EHRM).

By learning from DoD, VA will be able to proactively address these challenges to further reduce potential risks at VA's IOC sites. VA and DoD are working closely together to ensure lessons learned at DoD sites will enhance future deployments at DoD as well as VA. In addition, VA has proactively engaged stakeholders to identify requirements critical for the success of Cerner implementation. As challenges arise throughout the deployment, VA and DoD will work closely and urgently to mitigate the impact to Veterans health care. VA strongly believes that implementing a single electronic health record will improve seamless care for our Nation's Servicemembers and Veterans.

Question 6: I would believe that DoD has gained valuable experience implementing Cerner technology during its recent deployment of MHS Genesis. How is VA going to approach to transfer DoD's best practices and lessons learned?

- **What governance process is the VA prepared to execute to ensure that we capitalize on DoD's lessons learned and best practices?**

VA Response: By understanding lessons learned from DoD, VA will be able to proactively address these challenges to further reduce potential risks at VA's IOC sites. VA and DoD are working closely together to ensure lessons learned at DoD sites will

enhance future deployments at DoD as well as VA. In addition, VA has proactively engaged stakeholders to identify requirements critical for the success of Electronic Health Record Modernization (EHRM) implementation. As challenges arise throughout the deployment, VA and DoD will work closely and urgently to mitigate the impact to Veterans' health care. VA strongly believes that implementing a single EHR will improve seamless care for our Nation's Servicemembers and Veterans.

VA is devoted to ensuring proper governance for the EHRM program. EHRM Governance includes five governance boards consisting of senior executive stakeholders from across VA. The governance boards include a Steering Committee, Governance Integration Board, Functional Governance Board, Technical Governance Board, Legacy-EHRM Pivot Working Group, and EHR Councils. These governance boards will work together to provide strategic leadership, advance VA's interoperability goals, and successfully implement the new EHR.

Question 7: What oversight mechanisms will VA put in place to ensure that the VA has sufficient understanding of existing business processes and avoid costly customization to the Commercial off the Shelve (COTS) product?

VA Response: The PMO employs highly trained Government and Contractor personnel to provide expert oversight in a myriad of professional disciplines including the following: clinical, technical, engineering, information assurance (IA), security, testing, acquisition, contracting, data migration, communication, independent validation and verification (IV&V), training, change management, governance, and many more. Together, these technical disciplines will manage the contract's adherence to cost, schedule, and performance objectives, and the corresponding management of associated project risks.

The implementation of the new EHR is based on commercial best practices while allowing some configuration to meet VA's needs. The Department intends to select and use Cerner best practices wherever possible and standardize to the extent possible across all implementation sites.

The Cerner methodology is iterative in its approach. Decisions are built upon each other across eight workshops that incorporate participants from the national, VISN, and local levels. System design and configuration will be done primarily at the national/VISN level. The iterative approach allows for the enterprise foundation and design to be locally validated prior to the next national/VISN workshop, as opposed to designed nationally upfront, and then subsequently pushed to local sites. Involvement early and often with local sites will increase buy in and ensure the EHR is reflective of practice at the local level, while encouraging standardization that will support wide spread innovation. The focus in the local workshops will be on validation and training, not customization.

Question 8: The EHR modernization is a huge investment, is there a backup plan or an exit strategy should VA run into problems with this system?

- **Is there any chance that this choice to go with Cerner will change?**

VA Response: VA is fully committed to the successful implementation of the new EHRM, ensuring interoperability at VA and with DoD and community providers. As evidenced by the extensive preparation and governance in place, VA is confident in the plans to adopt the Cerner Millennium solution.

Female Veterans

Question 9: We have acknowledged time and again, the ability for our veterans to receive various medical services at a VA center greatly increases the likelihood, our veterans are receiving the care they need. With that in mind and with the growing population of women veterans, does VA meet the standards established in 2010 by the Advisory Committee on Women Veterans for healthcare services for female veterans?

VA Response: VA provides full services to women Veterans, including comprehensive primary care, gynecology care, maternity care, specialty care, and mental health services. VA has enhanced provision of care to women Veterans by focusing on the goal of developing Designated Women's Health Primary Care Providers (WH-PCP) at every site where women access VA. By end of fiscal year (FY) 2017, VA reached the milestone of training more than 5,000 Veterans Health Administration (VHA) providers and nurses in the women's health mini-residency. In addition, to increase the number of WH-PCP and nurses serving rural women Veterans, VA has developed a mobile women's health training for rural VA sites. VA has at least one WH-PCP at all of VA's health care systems. In addition, 90 percent of community based outpatient clinics (CBOCs) had a WH-PCP in place. VA is in the process of training additional providers to ensure that every woman Veteran has the opportunity to receive her primary care from a WH-PCP.

VA is proud of high quality health care for women Veterans. VA is on the forefront of information technology for women's health and is redesigning its EHR to track breast and reproductive health care. Quality measures show that women Veterans are more likely to receive breast cancer and cervical cancer screening than women in private sector health care. VA also tracks quality by gender and, unlike other health care systems, has been able to reduce and eliminate gender disparities in important aspects of health screening, prevention, and chronic disease management.

In 2014, VA established a hotline specific for women Veterans. The Women Veteran Call Center (WVCC) makes outgoing calls to women Veterans to provide information

about VA services and resources and responds to incoming calls from women Veterans their families and caregivers. The call center implemented a chat feature in May 2016 to increase access for women Veterans and has responded to 1,412 chats. As of March 28, 2018, the WVCC has received 71,408 calls and has made 1,098,499 calls with 564,812 of these calls being successful (spoke with Veteran or left a voice message).

Question 10: During visits to VA Medical Centers in DC and Miami, I had the chance to tour the women's clinic. Both were exceptional facilities, and I wanted to know, what is the VA doing to set up separate spaces, within the larger medical building, where women veterans have their women-oriented appointments?

- Has a plan to include these type of spaces in all VA Medical Facilities been implemented?

VA Response: For each site of care, the local community of Veterans must have input into how care will be delivered. VA has found that for some women Veterans, separate clinic space is very important, however, for other women such clinics are seen as not ideal because they are being isolated from other Veterans. In accordance with VHA Directive 1330.01, *Health Care Services for Women Veterans* (published 2017), a VHA facility may choose one or more of the following Comprehensive Primary Care Clinic Models to best meet the needs of women Veterans and to achieve the standards for Comprehensive Primary Care for Women Veterans:

a. Model 1. General Primary Care Clinics. Comprehensive primary care for women Veterans is delivered by a designated Women's Health Primary Care Provider (WH PCP) who is interested and proficient in women's health. Women Veterans are incorporated into the WH PCP panel and seen within a general gender-neutral Primary Care clinic. Mental health services for women should be co-located in the general gender-neutral Primary Care Clinic in accordance with the Primary Care-Mental Health Integration. Efficient referral to specialty gynecology service must be available either on-site or through fee-basis, contractual or sharing agreements, or referral to other VA facilities within a reasonable traveling distance (less than 50 miles).

b. Model 2. Separate but Shared Space. Comprehensive primary care services for women Veterans are offered by designated WH PCP(s) in a separate but shared space that may be located within or adjacent to Primary Care clinic areas. Gynecological care and mental health services should be co-located in this space and readily available.

c. Model 3. Women's Health Center (WHC). VHA facilities with larger populations of women Veterans are encouraged to create Women's Health Centers (WHC) that provide the highest level of coordinated, high quality comprehensive care to women Veterans.

(1) WHC offers comprehensive primary care services by a designated WH PCP(s) in an exclusive separate space. Whenever possible, a WHC needs to have a separate entrance into the clinical area and a separate waiting room with attention to privacy, sensitivity, and physical comfort.

(2) Specialty gynecological care, mental health, and social work services must be co-located in this space.

(3) Other sub-specialty services such as breast care, endocrinology, rheumatology, neurology, cardiology, nutrition, etc., may also be provided in the same physical location.

(4) Women Veterans receiving comprehensive primary care through general primary care clinics in sites with WHC need to be referred to the WHC for gynecological care, mental health treatment, and other sub-specialty care.

To summarize, Model 3 clinics are Comprehensive Women's Centers that have dedicated separate space. Model 2 clinics are women's clinics that also have a separate space, but the space may be shared with other services when the women's clinic is not in session. All Model 2 and Model 3 clinics are defined as "women's clinics". Model 1 clinics provide women's health primary care in integrated settings. All three models should have Designated WH-PCPs and can be available at either medical centers or CBOCs.

According to the fiscal year 2017 Women's Assessment Tool for Comprehensive Health (WATCH) survey, VHA reported the following number of Women's Clinics:

Total Model 1 = 992 clinics
Total Model 2 = 67 clinics
Total Model 3 = 80 clinics

In addition to the many projects planned in support of improvements to VA outpatient facilities, the FY 2019 Strategic Capital Investment Plan (SCIP) includes 12 Minor Construction projects, with a total investment need in excess of $138 Million, specific to improving or expanding facilities in support of women's health needs. The VA FY 2019 Budget Request includes funding requirements for the design phase of 6 of these Minor Construction projects. In addition, VA is working to improve standards and maintain its facilities to provide gender-specific healthcare delivery in a sensitive and safe environment. The VA FY 2019 Budget Request includes 8 Non-Recurring Maintenance (NRM) projects providing $21 Million in support of the women's health program, and there are 85 NRM projects providing $340 Million in support of patient environment/privacy.

Questions for the Record
HAC MILCON/VA
FY 2019 Budget Hearing
March 15, 2018

General Budget Questions

Question 11: Mr. Secretary, the VA continues to receive tremendous increases in its budget. For example, the VA medical care accounts have grown from $36.7 to 64.6 billion dollars, and the overall discretionary accounts have increased from 43.6 billion dollars to 74.4 billion dollars. At what point do we ask if this continued growth is unsustainable?

- **Does this budget provide you all the resources you will need to provide high-quality care for our Veterans, if not where do you need more resources?**

VA Response: The FY 2019 President's Budget for the Department is a strong demonstration of the President's commitment to ensuring Veterans and their families have the care and benefits they have earned and deserve. This budget will allow us to continue the progress we are making to reorient the Department around Veterans' needs and focus on services from the Veteran's perspective. Our discretionary budget request would fully fund all community care entirely with discretionary resources, including the care provided under the Veterans Choice Program for the first time since that program's inception.

The FY 2019 VA budget would initiate several reforms that would implement efficiencies and savings to curb our recent growth and prioritize our foundational services while redirecting to the private sector those services that they can do more effectively and efficiently.

Question 12: Mr. Secretary, as you know you have a substantial backlog in infrastructure how much does this budget provide for non-recurring maintenance and is that enough?

VA Response: While there is a backlog to correct VA's aging infrastructure, the FY 2019 request of $3.3 billion for capital (including major and minor construction and non-recurring maintenance) is the largest in at least the last five years. This request would provide $1.4 billion in non-recurring maintenance for ongoing and new projects.

Veterans Blood Program

Question 13: The Navy Blood Program Office has deployed Pathogen Reduction Technology for Platelet Components to improve blood safety and prevent transfusion transmission infection and the Armed Services Blood Program Office has issued guidance on PRT. It is expected by servicemembers and veterans alike that when transitioning from one medical system to the other, there would be parity in the standard of care, especially as the VA population is more medically fragile than their active duty counterparts. Why has the VA not sought

to adopt the Armed Services Blood Program office guidance or implement similar requirements for their transfusion sources? Moreover, what kind of outreach (if any) has the VA done to coordinate with the ASBPO?

VA Response: Pathogen reduction is being implemented throughout the United States (U.S.) to mitigate transfusion-transmitted infectious risks. Multiple U.S. blood centers, including the Armed Services Blood Program, are either already distributing or are preparing to distribute pathogen reduced platelets to hospitals. VA does not have "blood collection and processing centers" as it is not a feasible operation for VA. Instead, VA has Transfusion Services at VA medical centers (VAMC) to provide safe blood components for transfusion in a professional, timely, and cost effective manner to all of our Veterans.

Some VA facilities are already receiving pathogen reduced products from blood centers and/or the Armed Services Blood Program. As the prevalence of pathogen reduced blood products increases, so will their use throughout health care system. It should be noted that the physical employment of Pathogen Reduction Technology is applied at the donor collection center (manufacturing) and not at the transfusion services (actual administration/transfusion).

VA has on going collaboration with Armed Services Blood Program through Memorandum of Agreement between Army Blood Program and Navy Blood Program for the distribution of surplus products from their respective programs to VAMC Transfusion Services. These agreements provide mutual benefits to both VA and the Department of Defense (DoD) in making conscious and proactive efforts to share and preserve lifesaving resources.

Question 14: There are 153 VA medical centers in the US. Only four have partially adopted Pathogen Reduction Technology for Platelet Components. What are the barriers the VA is facing in adopting pathogen reduction technology for platelet and plasma components?

VA Response: See answer in Question 13. Pathogen Reduction Technology is applied at the donor center where they collect the blood product and not at VA Transfusion Services.

Question 15: The Armed Forces have an integrated blood program under the Armed Services Blood Program Office. Why doesn't the VA have an integrated program to institute best practices and emerging technology to ensure the highest safety of blood products?

VA Response: The Pathology and Laboratory Medicine Services (P&LMS) National Program Office has, as one of its primary responsibilities, the establishment of VA national policies applicable to VA clinical laboratories, including Transfusion Services.

In addition, the national program office provides P&LMS guidance to the senior leadership in VA and the VA laboratory community to help ensure that timely, cost effective, and high quality anatomic and clinical pathology services are provided for both VA patients and caregivers. Through its National Enforcement Office, P&LMS has a legislated responsibility to oversee the quality of services provided by VA Clinical Laboratories, as well as laboratory compliance with regulatory, accreditation, and policy guidelines.

The P&LMS National Program Office accomplishes its mission by the efficient utilization of organizational resources and in collaboration with the Centers for Medicare and Medicaid Services, DoD, the U.S. Food and Drug Administration (FDA), the various accrediting organizations, and other Federal and civilian external agencies. The P&LMS Program Office is committed to providing support for and promoting the delivery of quality laboratory and transfusion services to eligible Veterans.

VA Transfusion Services are registered and inspected by FDA, accredited by College of American Pathology (CAP), and meet the requirements of the American Association of Blood Banks (AABB) Standards. VA developed its own Blood Establishment Software (VBECS) that is FDA 510k cleared to ensure the highest safety of blood products to our Veterans. In addition, VA P&LMS has a representative on the Advisory Committee on Blood and Tissue Safety and Availability (ACBTSA). The ACBSTA is a 31-member Federal Advisory Committee that provides advice to the Secretary of Health and Human Services through the Assistant Secretary for Health on a range of policy issues related to blood, blood products, and tissues. The VA P&LMS Program Office participates in professional accreditation (CAP, AABB) activities for DoD Blood Centers and DoD Transfusion Services, as well as accreditation activities of Armed Services Blood Bank Fellowship at Walter Reed where military training for Specialists in Blood Banking occurs. Overall, VA P&LMS is aggressively engaged and works collaboratively with others to identify and promote best practices and emerging technology to ensure the highest safety of blood products and the best care to our Veterans.

Questions for the Record
HAC MILCON/VA
FY 2019 Budget Hearing
March 15, 2018

Congressman Sanford Bishop

Question 1: This budget request funds $172 million for the Office of the Inspector General, which would be an increase from the FY2019 budget of + $12 million. However, there is a loss of 28 Full-Time Equivalents from the previous year. Can you please elaborate on how this increase in funding will be utilized to help ensure better oversight within the VA? Additionally, can you explain why it is justified, given recent Inspector General Reports, to eliminate 28 Full-Time Equivalents?

VA Response: OIG response will be sent directly to Member and HAC offices

Question 2: Recently, the VA's Office of the Inspector General published a report on the Washington D.C. Veterans Affairs Medical Center which found that critical deficiencies were pervasive and persistent—often spanning many years—but were not successfully remediated by leaders at multiple levels within VA. Some Details in this report showed that patients were placed under anesthesia for an operation before realizing they did not have the equipment to perform the surgery. Additionally, this report identified financial and supply mismanagement, among other concerns. What steps is the VA taking to ensure our veterans are receiving the top quality care they deserve, not only here locally in D.C but around the country as well?

VA Response: The Office of Inspector General (OIG) report, *Critical Deficiencies at the Washington DC VA Medical Center (DCVAMC)*, Report #17-02644-130 (March 7, 2018) (the "DCVAMC OIG Report") identified systemic and oversight failures at all three levels of our VHA organization, i.e., at the facility, VISN, and VHA Central Office (VHACO) National Program Office levels. While there have been a number of strong improvements made in the performance at that facility, there is more work to be done. The VHA Executive in Charge is strengthening key governance processes and will personally be leading a newly formed Management Council. This Management Council is predicated on clearly articulated roles and responsibilities for each level of the organization and will:

- provide oversight of complex multidimensional concerns;
- ensure timely, consistent implementation of policies and processes;
- deploy well-designed communication methods for critical practice changes; and
- leverage the lessons learned from the DCVAMC to develop early warning systems, with the goal of reducing the likelihood of recurrence.

The Management Council will monitor the progress against the 40 recommendations identified by the OIG and ensure that VA is on track across the enterprise. The Secretary also announced a multi-point plan to address key findings beyond the

DCVAMC OIG report, to impact each of our facilities, VISNs, and VHACO. It calls for independent audits to be conducted at health care facilities to enhance our assessment of organizational performance.

The Secretary's VHACO restructuring plan, mentioned during his March 7 press conference at the DCVAMC, will significantly decrease the number of individual program offices and policies while ensuring Central Office leadership has clear visibility and oversight over these programs and their outcomes. Further, the National Leadership Council will re-examine our current governance model and identify opportunities to ensure we are using the best, most effective models available to provide oversight to VHA. We will be partnering with academic medical center partners to support our pursuit of best practices and a member of one of the VISN leadership teams, Dr. Bryan Gamble, Brigadier General (ret.), who has extensive experience in leading complex health care organizations, will work with our medical centers and VISNs to ensure that our Veterans are achieving the outcomes so richly deserved.

Question 3: The FY 2019 Budget requests $510 million, +$7 million above the FY 2018 estimate to support over 27,000 Caregivers. Currently, this is only available for Post-9/11 Veterans. As our Veterans continue to age and require additional care, would you support legislation for expanding this for veterans outside of the Post 9-11 era?

VA Response: VA believes an expansion of benefits that are currently limited by era of service would result in equitable access to the Program of Comprehensive Assistance for Family Caregivers for long-deserving caregivers of those who have sacrificed greatly for our Nation. While VA supports section 161 of the VA MISSION Act, if enacted, VA believes future appropriations must reflect the cost of this expansion to prevent a negative impact on other VA programs, including health care services provided to Veterans.

Question 4: There are a significant number of critical leadership vacancies within the VA, like the absence of an Undersecretary for Health or Benefits, to name one. Those key leadership vacancies are coupled with numerous other vacancies within the Department, which include primary care providers, which remain a top concern for many Veterans. Can you explain why there is such a difficulty in filling some of these key positions? Additionally, could these vacancies attribute to the leadership turmoil that is being reported inside the VA?

VA Response: The Department of Veterans Affairs (VA) has 12 politically appointed Senate confirmed positions of which 75 percent are filled. Of the three not filled, as of August 1, 2018, one just became vacant (Deputy Secretary, Veterans Affairs) on June 15, 2018. For the other two positions (Under Secretary for Health and Chief Information Officer (CIO)), VA is actively vetting candidates to ensure the nominee is of the highest quality and committed to serving our Nations Veterans. These professions (Healthcare

and information technology (IT)) are highly competitive and VA is up against some of the best private hospitals and tech firms to attract talent. The VA looks forward to working with Congress and the Administration on any forthcoming nominations for these positions.

In the interim, VA has well-qualified executives leading VHA and the Office of Information and Technology. They continue to support VA's highest priorities and lead change to drive positive performance outcomes.

Status of the vacant positions are:

Deputy Secretary: VA is currently working closely with the Administration to identify a suitable nominee.

Assistant Secretary for Information and Technology and Chief Information Officer (CIO): Mr. Camilo Sandoval has been designated Executive-in-Charge for the Office of Information and Technology effective April 18, 2018. Recruitment efforts for a permanent Assistant Secretary are ongoing.

Under Secretary for Health: Dr. Richard Stone, Principal Deputy Under Secretary for Health, has been designated Executive-in-Charge of the Veterans Health Administration effective July 19, 2018. VA is currently working closely with the Administration to identify a suitable nominee.

VA looks forward to working with Congress on the forthcoming nominations for these mission-essential positions.

<u>Question 5</u>: Secretary Shulkin, since the signing of the VA Accountability and Whistleblower Protection Act, last June firings at the VA have risen 60 percent during the second half of 2017, after the law took effect, compared to the first half of 2017. Since June, the VA has removed 1,704 of its 370,000 employees. You were quoted as saying that you "do not see this as a tool that's going to lead to mass firings. That it would be a tool that's going to be used on a small number of people, who clearly have deviated from accepted practices and norms." Since, it took effect, the VA has fired four senior leaders. The other 1,700 terminated people were low-level staffers with titles such as housekeeper (133 lost their jobs), nursing assistant (101 lost their jobs) and food worker (59 terminated), according to a data post by the VA. It's not just junior VA staffers who are losing their jobs. Whistleblowers and people who filed discrimination complaints are among those being fired. This is a law intended to protect whistleblowers may be doing the opposite. What are you doing to ensure this law is used for its intended purpose and that policy driving leadership within the VA is being held accountable?

VA Response: The Office of Accountability and Whistleblower Protection (OAWP) is very focused on the performance of all VA staff, including senior executives and senior leaders. OAWP is working closely with the Offices of General Counsel (OGC) and Human Resources and Administration (HR&A) to ensure policies and practices comply with the law, and as VA's corporate experience grows, we are providing revised guidance to assist in effective implementation.

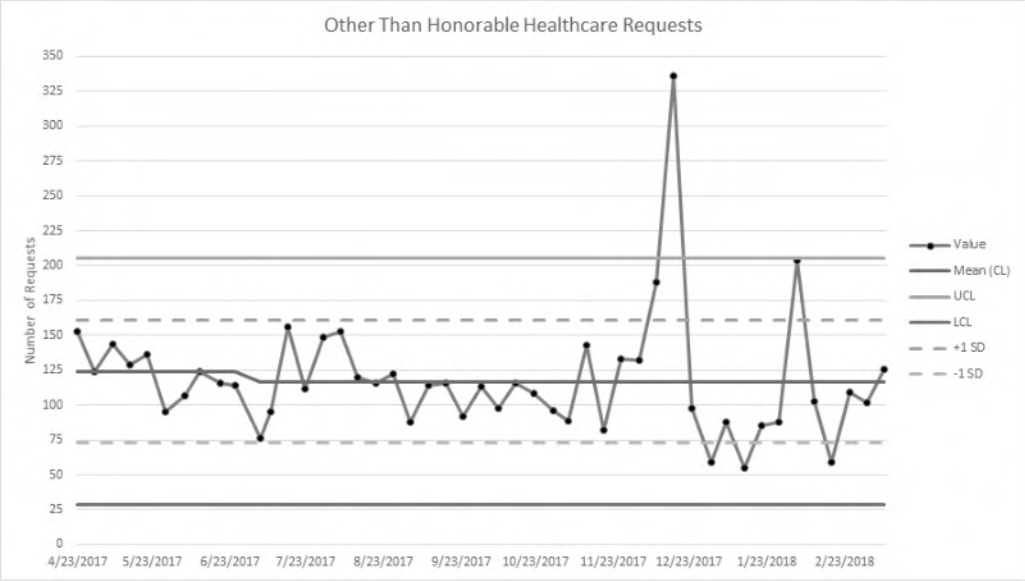
OAWP provides a robust triage of disclosures to ensure allegations of wrongdoing involving senior leaders are assessed and addressed as quickly as possible. Any resulting investigations follow the facts wherever they lead, and provide the basis for recommendations regarding appropriate accountability actions.

Question 6: I would like to applaud the efforts of the VA expanding mental health care to more than 500,000 Service Members who were separated through other than honorable circumstances. As of December, the VA received approximately a little over 3,000 requests for health care under this program. This program has since been expanded to provide one year of mental health care to Service members after separation from service.

Since the expansion of care last summer, how would you report on the effectiveness of this program in expanding mental health for our veterans and what more can be done in order to assist this specific population of veterans in receiving the mental health care that they may need? Additionally, since January, what is the VA doing to provide this mental health care to our separated service members for that additional period?

VA Response: Overall, the number of former Servicemembers seeking mental health care has remained generally stable since July 5, 2017, when the Other than Honorable (OTH) Mental Health initiative began. VA has focused on educating Servicemembers at the time of their discharge, as many may believe they are not eligible for VA care if they receive discharge under conditions that are not honorable. We note that section 258 of Division J (the Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2018) of the Consolidated Appropriations Act, 2018 (Public Law 115-141) requires VA to provide information on mental and behavioral health care services to individuals eligible under that authority within 180 days of enactment or 180 days of discharge. It further requires coordination with the Secretary of Defense to ensure Servicemembers and those separating are provided appropriate information about programs, requirements, and procedures. VA is working to implement this new authority. Although the January Executive Order did not alter VA's legal authorities to furnish care, there has been a renewed emphasis at all VA medical centers on meeting the mental health needs of all presenting Servicemembers, particularly in the first year after separation or discharge, by fully utilizing VA's existing statutory authorities. VA encourages all former Servicemembers seeking mental health care to enroll in VA health care, and VHA Member Services continues to reach out to transitioning

Servicemembers to facilitate applications for enrollment. In addition, VA has certain statutory authorities that allow it to furnish mental health care to individuals who otherwise are ineligible for enrollment in VA health care. Facilities have been encouraged to apply these authorities to the maximum extent to provide needed mental health care to former Servicemembers. Additional actions are being taken within VA and jointly with DoD to ensure every transitioning Servicemember has access to needed mental health care during that critical first year following separation or discharge, including connecting former Servicemembers with resources in the community as appropriate when VA does not have authority to provide the care.



<u>Question 7</u>: Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injuries (TBIs) continue to affect our service members at increasing rates. Researchers from the VA linked PTSD and TBI as a risk factor for suicide. Additional studies indicate that approximately 20 veterans, on average, die by suicide each day and 14 of those did not receive mental health care, for any reason. Mr. Secretary, suicide continues to plague our veterans at alarming rates. There is a 5.8% increase in the budget for mental health with $190 million being allocated for suicide prevention and outreach. What more can be done to address these concerns and better assist many of our Veterans who struggle with Mental Health? In addition, what is the VA's plan of action in this regard?

<u>VA Response</u>: Suicide is a national public health issue. Veterans constitute 8.5 percent of the adult population in the United States but account for 18 percent of all deaths by suicide among that group. Both male and female Veterans have a higher rate of suicide (Male: 35.6 deaths / 100,000 people; Female: 19 deaths / 100,000 people) compared to the adult civilian rate of suicide (Male: 25 deaths / 100,000 people; Female: 7.2 deaths / 100,000 people). Of the 20 Veterans who die by suicide

each day, only 6 Veterans were enrolled in VA's health care system. Thus, as noted, VA is working to reach all transitioning Servicemembers at the time of separation and to expand partnerships and engage communities through efforts like the Mayor's Challenge, which is described in more detail below. Ending Veteran suicide is a long-term commitment, not just on the part of VA, but on the part of the entire Nation.

As a part of a public health model to prevent Veteran suicide, we are collaborating with partners on five key strategies:

- Strategy 1: Improve transition from active duty to Veteran status
- Strategy 2: Know all Veterans
- Strategy 3: Partner across communities
- Strategy 4: Increase safety with lethal means
- Strategy 5: Improve access to all services that can reduce suicide

One example of VA's public health approach is the recent deployment of the Mayor's Challenge Program, in partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA), in 7 initial cities. These cities are developing plans to prevent Veteran suicide targeted towards the specific needs of their Veteran community. Each participating city will implement a targeted public health approach and evaluate their initiative to determine its impact and outcome.

VA is also maximizing the use of predictive modeling in order to enhance care to Veteran patients at high risk for suicide. VA has already deployed a clinical program guided by predictive analytics, the Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment (REACH-VET) program, to 100 percent of VAMCs. This effort will be augmented through progressive updates in the predictive analytics algorithm and deployment of additional predictive models into other key clinical areas, such as opioid safety. In order to determine REACH VET's impact, VA reviews the percentage of Veterans identified through predictive analytics that are receiving recommended interventions. Through programs like the Mayor's Challenge and REACH VET, VA is leading innovative approaches to preventing Veteran suicide.

<u>Question 8</u>: The Opioid crisis is a major problem within this country. This Budget request allocates $382 million, +$15 million above the FY 2018 estimate to reduce over-reliance on opioids for pain management and to promote the safe and effective use of opioid therapy when clinically indicated. According to a VA study, Veterans are nearly twice as likely to die from an accidental opioid overdose. Georgia ranks in the top eleven states with the most prescription opioid overdoses. Could you please expand upon the VA's plan to help reduce these risks to our Veterans with the Opioid Crisis? In addition, are you in coordination with any other agency, such as Health And Human Services or the Food and Drug Administration?

VA Response: Since 2013, when VA established its Opioid Safety Initiative (OSI), VA has made significant progress in reducing opioid prescribing and, thereby, reducing risks for Veterans. VA is making headway treating opioid addiction by providing programs nationwide to support Veterans. VA offers medication reduction therapy; alternatives to medication, including complementary integrative health (CIH) approaches; mental health support; and education.

Since its launch, OSI has demonstrated success in lowering dependency on this class of drugs. OSI incorporates a team approach with the goal of reducing opioid use by alleviating a Veteran's pain using alternatives to medication and non-opioid medications. VA has seen a significant change in opioid use among its patients. Results of key clinical metrics measured by the OSI from Quarter 4, Fiscal Year 2012 (beginning in July 2012) to Quarter 2, Fiscal Year 2018 (ending in March 2018) there are:

- 296,319 fewer patients receive opioids (44 percent reduction). 90 percent of our reduction can be attributed to fewer new patients on long-term opioid therapy.
- 88,462 fewer patients receive opioids and benzodiazepines together (72 percent reduction).
- 214,788 fewer patients are on long-term opioid therapy (49 percent reduction).
- 37,502 fewer patients receive greater than or equal to 100 Morphine Equivalent Daily Dose (63 percent reduction).

OSI emphasizes patient education, close patient monitoring with frequent feedback, and methods of pain management such as physical therapy and CIH practices like acupuncture and yoga. In addition, VA developed an "Opioid Taper Decision Tool" to provide guidance on implementing opioid dosage reduction, if clinically indicated, in a careful and cautious approach that takes the Veteran's individual situation into account.

VA is publicly posting information on opioids dispensed from VA pharmacies and VA's strategies to prescribe these pain medications appropriately and safely (see: https://www.data.va.gov/story/department-veterans-affairs-opioid-prescribing-data). VA offers an educational Website for Veteran and public use and free medication take-back services to Veterans through mail-back envelopes and on-site receptacles in accordance with Drug Enforcement Administration (DEA) regulations. As of March 31, 2018, Veterans have returned over 74 tons (149,118 pounds) of unwanted or unneeded medication using these services. Also as of March 31, 2018, VA's Opioid Overdose Education and Naloxone Distribution (OEND) program, over 146,000 naloxone prescriptions have been dispensed to Veterans. In addition:

- VA is providing data to and querying state Prescription Drug Monitoring Program (PDMP) databases to increase safety when prescribing opioids

- VA has implemented nationwide, interdisciplinary, high-risk case reviews through the use of VA tools like the Stratification Tool for Opioid Risk Monitoring (STORM), OSI and Opioid Therapy Risk Report (OTRR) dashboards, and Pain Management/OSI teams.

- VA has responded to growing demands for opioid use disorder treatment by increasing access to Medication-Assisted Treatment (MAT). MAT includes counseling or psychotherapy, close patient monitoring, and the use of medications such as buprenorphine/naloxone, methadone (administered through an Opioid Treatment Program), or extended-release injectable naltrexone.

VA staff members actively participate in the President's Opioid Cabinet, which meets weekly and gives agencies a forum to discuss opioid topics and coordinate efforts. In addition, VA has appointed a representative to the Department of Health and Human Services' (HHS) Pain Management Best Practices Inter-Agency Task Force, as mandated by section 101 of the Comprehensive Addiction and Recovery Act (CARA) of 2016 (Public Law 114-198). It is anticipated the Task Force will have its first meeting in late spring.

VA also works with HHS and the Department of Defense (DoD) as part of the Interagency Task Force on Military and Veterans Mental Health (ITF) to improve mental health and substance use disorder treatment services for Veterans, Servicemembers, and their families. Since 2015, VA has partnered with DoD to provide DATA-2000 waiver training on buprenorphine treatment for qualified providers in VA, DoD, HHS, and the community, and to inform VA providers of additional no-cost waiver trainings, as well as ongoing mentoring and support through the Provider Clinical Support System for Medication Assisted Treatment (PCSS-MAT). VA also collaborates with the Office of National Drug Control Policy (ONDCP) through participation in the National Drug Control Strategy and in the National Heroin Coordinators Group to share information on drug use trends and best practices in prevention and treatment of substance use disorders. Additional collaborations and partnerships include work with:

- HHS and SAMSHA on the implementation of the National Pain Strategy and National Strategy for Suicide Prevention.

- DoD to develop evidence-based clinical practice guidelines for the management of substance use disorders and for management of opioid therapy for chronic pain. These guidelines are available to the public at the following URL: https://www.healthquality.va.gov/

- VA/DoD guidelines for Opioid Management Practice are similar to the Centers for Disease Control Guidelines but tailored to Veterans' needs.

- Collaboration with DoD through the Joint Executive Committee to improve pain management practices for Servicemembers and Veterans and to improve substance use disorder treatment.

- Partnership on the Federal Interagency Workgroup (FIW) for Opioid Adverse Drug Events (ADE). VA and other Federal partners collaborate to implement the National Action Plan for Adverse Drug Event Prevention (ADE Action Plan) and to coordinate and share information across Federal partners. This includes opioid surveillance, prevention, and training providers.

Question 9: The most recent Point-in-Time (PIT) Count was conducted in January 2017. The results were that just over 40,000 Veterans were experiencing homelessness, with only over 15,000 of these Veterans being unsheltered or living on the street. Between 2016 and 2017, there was a 1.5 percent increase in the estimated number of homeless Veterans nationwide; however, the majority of the country continued to make progress reducing Veteran homelessness in 2017. And still, the estimated number of Veterans experiencing homelessness in the United States has declined by nearly 50 percent since 2010. The FY 2019 Budget invests $1.8 billion, +$26 million above the 2018 Budget to assist homeless Veterans and prevent at-risk Veterans from becoming homeless. The latest Point in Time count was conducted in January of this year, do you the results and are rural areas included in the findings? Additionally, would you expound on this year's budget request and how it will work to help combat veterans homelessness?

VA Response: We do not yet know the results of the 2018 PIT Count but we can confirm that rural areas will be included in the findings when they are released by HUD later this year.

Regarding this year's budget request and how it will help combat Veteran homelessness, the budget provides for a comprehensive set of programs and services designed to prevent and end Veteran homelessness. In FY 2018 there is $543M devoted to Permanent Housing through the Housing and Urban Development - Veterans Affairs Supportive Housing (HUD-VASH) Program. The FY 2018 budget includes additional funding to support the addition of approximately 5,500 new HUD-VASH vouchers bringing the total vouchers being supported to approximately 98,000. In FY 2018 there is $418M targeted for Transitional Housing, $257M in the Homeless Providers Grant and Per Diem Program (GPD), and $161M in the Health Care for Homeless Veterans (HCHV) programs. On November 2, 2017, VA published two Notices of Funding Availability (NOFA), the first for Transition in Place model of transitional housing and a second NOFA under the Per Diem Only award that will

feature Bridge, Hospital to Housing, Low Demand, Clinical Treatment and Service Intensive transitional housing. GPD will begin the distribution of this funding on October 1, 2018, and it is anticipated this will create approximately 2,000 transitional housing beds. In FY 2018, HCHV will provide outreach services to over 138,000 Veterans, case management services to over 10,000 Veterans and serve over 80,000 Veterans through Stand Down events.

In FY 2018 there is $378M devoted to Preventive Services via our Supportive Services for Veteran Families (SSVF) and The Veterans Justice Outreach (VJO) programs. SSVF will distribute approximately $343 million in grants designed to rapidly re-house homeless Veteran families and prevent homelessness for those at imminent risk due to a housing crisis. These grants will go to 288 non-profit organizations in all 50 states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands by keeping a focus on high need communities. VA has funded 53 additional VJO Specialist positions for FY 2018, bringing the national total to 314 FTE. These outreach staff will enhance VA's ability to work effectively with criminal justice entities, including Veterans Treatment Courts, toward the shared goal of facilitating justice-involved Veterans' access to needed VA clinical services. In FY 18 $75M has been devoted to employment and job training. In FY 2017 approximately 7,000 Veterans exited homeless residential programs with employment with the assistance of The Homeless Veterans Community Employment Services (HVCES). This represents a consistent upward trend in these employment rates over the past four (4) years and it is anticipated that the positive trend will continue.

Question 10: There is a growing population of women enrolling in VA care. Just last summer, the VA's Inspector General recommended in a report, that the Office of Women's Health Services review and strengthen the requirements for all facilities and providers when appropriate. Additionally, a study by GAO a little over a year ago stated that although some progress has been made since 2010, VA facilities are having problems complying with VHA's environment of care requirements, which are intended to protect the privacy, safety, and dignity of women veterans when they receive care. This budget requests a $511 million in increased gender-specific women Veteran's health care. That is an increase of nearly $30 million from the FY2018 budget. How is the VA dealing with the ever-increasing number of women that are falling under your purview and what steps is the VA taking to address our needs for our Veteran female population?

VA Response: VA is improving access, services, resources, facilities, and workforce capacity to make health care more accessible, more sensitive to gender-specific needs, and of the highest quality for the women Veterans of today and tomorrow. VA specifically wants to ensure that every eligible woman Veteran receives high-quality comprehensive care that includes reproductive health care (such as maternity and gynecology care) and treatment for all gender-specific conditions and disorders, as well

as mental health care, basic preventive care, acute care, and chronic disease management.

Security and privacy for women Veterans is a high priority for VA. In order to review facilities in terms of accommodations for women Veterans, including required privacy and security, VHA has adopted Environment of Care (EoC) clinical standards;created and set by the Joint Commisssion. Moreover, facilities' use of the EOC assessment and compliance tool allows for management planning for correction of deficiencies. These clinical standards are now incorporated into a tablet-based EoC survey that is conducted regularly at every facility. The facility Women Veteran Program Manager is a member of the EoC team. All deficiencies detected must have a remediation plan attached, and the correction of these is tracked electronically. .

VA is training providers and other clinical staff, enhancing facilities to meet the needs of women Veterans, and reaching out to inform women Veterans about VA services. By the end of fiscal year (FY) 2017, VA reached the milestone of training more than 5,000 VHA providers and nurses in the women's health mini-residency. VA has at least one WH-PCP at all of VA's health care systems. In addition, 90 percent of community-based outpatient clinics had a WH-PCP in place. VA continues to train additional providers to ensure that every woman Veteran has the opportunity to receive her primary care from a WH-PCP. VA has implemented women's health care delivery models of care that ensure women receive equitable, timely, high-quality primary health care from a single primary care provider and team, thereby decreasing fragmentation and improving quality of care for women Veterans.

VA is proud of high quality health care for women Veterans. VA is on the forefront of information technology for women's health and is redesigning its electronic medical record to track breast and reproductive health care. Quality measures show that women Veterans are more likely to receive breast cancer and cervical cancer screening than women in private sector health care. VA also tracks quality by gender and, unlike other health care systems, has been able to reduce and eliminate gender disparities in important aspects of health screening, prevention, and chronic disease management.

In 2014, VA established a hotline specific for women Veterans. The Women Veteran Call Center (WVCC) makes outgoing calls to women Veterans to provide information about VA services and resources and responds to incoming calls from women Veterans their families and caregivers. The call center implemented a chat feature in May 2016 to increase access for women Veterans and has responded to 1,412 chats. As of March 28, 2018, the WVCC has received 71,408 calls and has made 1,098,499 calls with 564,812 of these calls being successful (spoke with Veteran or left a voice message).

<u>Question 11</u>: Secretary Shulkin, I am particularly concerned regarding how the choice program is working in our smaller communities in rural areas like my district, which does not have immediate access to VA facilities, or healthcare

resources? The VA health system consists of roughly 170 medical centers, 1,200 community-based outpatient clinics, and a total of nearly 1,700 points of care to provide timely and high-quality health care to our Veterans. What steps is the VA taking to clearly outline the qualifications for the adjudication of whether or not a Veteran receives care at a VA facility or in the community? How are you communicating with veterans regarding the program, particularly for rural veterans?

VA Response: VA currently administers multiple community care programs. Each program entails a separate set of criteria for eligibility for care. VA's proposed consolidated community care program, Veteran Coordinated Access & Rewarding Experiences (CARE) would replace these multiple programs with a single, easy-to-use program. New eligibility criteria will replace all existing eligibility criteria from current programs.

VA works closely with HHS' Health Resources and Services Administration (HRSA) and their Federally Qualified Health Center (FQHC) program. FQHCs reach the Veteran population through community-based organizations that serve as a critical component of the VA health care safety net, especially in rural and highly rural areas. FQHCs can provide care for Veterans who need local primary care, mental health, and some specialty care and can serve as valuable partners as part of the VHA Community Care Network. VA has conducted specific outreach activities such as presentations to the Florida Association of Community Health Centers (FACHC) Webinar in November 2017 and the National Association of Community Health Centers (NACHC) in March 2018. In addition, the Office of Community Care distributes program communications to Veterans (including those in rural locations) through our website, which can be navigated at the following address: https://www.va.gov/communitycare/.

Question 12: Dr. Shulkin, a recent audit by the Government Accountability Office identified $1.1 billion in wasted spending on two VA projects from 2011 to 2016, the Integrated Electronic Health Record and Veterans Health Information System and Technology Architecture. The audit and spending trail on failed IT projects is important as VA embarks on its fourth attempt to modernize its health IT and records systems—this one an expected $10 billion sole-source contract to Cerner Corp. Cerner ranked as the 13th highest-paid contractor in VA's failed iEHR and VistA programs, according to GAO, receiving $13.4 million from the agency. However, as GAO's audit warns, this is VA's fourth attempt at modernizing its health records system. In the previous three instances, the agency's planning, management and execution led to billions of dollars wasted. Can you please elaborate on the recent reports that there are delays once again with the contract for the Electronic Health Records and what your plan is to get it back on track? How are you assuring our subcommittee that we are not going down another rabbit-hole, of wasted federal resources on Electronic Health Records?

VA Response: VA is invested in providing the appropriate oversight over the Electronic Health Record Modernization (EHRM) Program to ensure taxpayers' dollars are used efficiently and appropriately through EHRM's Program Executive Office (PEO). VA is diligently reviewing the contract so that the new EHRM program is able to provide Veterans with a seamless health care experience. Therefore, VA worked with the MITRE Corporation to conduct an independent assessment to identify potential gaps in interoperability with community providers. To further ensure a seamless health care experience, VA incorporated feedback from private sector leaders (e.g., Johns Hopkins, Mayo Clinic, Intermountain, Cleveland Clinic, among others), who have experience implementing new EHR systems. During this review, we were able to identify and address any gaps in the request for proposal and capture lessons-learned from the private sector to ensure VA is able to adopt the best solution possible for our Veterans. Acting Secretary Wilkie officially signed the Cerner contract on May 17, 2018.

Questions for the Record
HAC MILCON/VA
FY 2019 Budget Hearing
March 15, 2018

Congressman David Valadao

Question 1: Last week, the VA Office of Inspector General released an audit of veteran wait time data. As you should be well aware, the audit revealed that the VA incorrectly reported wait times experienced by veterans seeking first-time care from VA doctors. The report estimated that new patients waited on average about 18 days for an appointment. Additionally, 36% of veterans had to wait longer than a month for an appointment, despite the VA scheduling system saying only 10% had waited that long. Due to this inaccuracy, nearly 13,800 qualifying veterans were wrongly made ineligible for the Veterans Choice Program. Have those responsible for misreporting wait times been properly dealt with and what do you plan to do to fix this serious ongoing issue?

VA Response: In the words of the Office of Inspector General (OIG), the identified inaccuracies in wait times occurred because of "inconsistent understanding among staff about using the clinician's clinically indicated date when scheduling new appointments." VA has been aware of this issue and has been focusing on resolving this situation. To improve knowledge about accurate scheduling processes, in 2017, VA required all staff that schedule appointments, including Veterans Integrated Service Network (VISN) 15 staff, to complete face-to-face scheduler training that included hands on scheduling exercises with supervisory feedback and the requirement to pass a final examination. Also in 2017, VA implemented an enhanced scheduler audit system ensuring 100 percent of scheduling staff undergo auditing of a sampling of the appointments they schedule. Such audits enable direct feedback to individual schedulers and also aggregated audit results provide target areas for future educational focus.

Over approximately the six months prior to the publishing of the OIG report, VA has been implementing two scheduling system software fixes to assist with reducing scheduling errors: one fix ensures that the provider recommended date (Patient Indicated Date) for appointment referrals to a specialist (consults) automatically gets transferred into the scheduling system. The second fix automatically transfers the provider recommended date for follow-up appointment into the scheduling system. Both of these software fixes prohibit schedulers from altering the automatically transferred date when making an appointment and thereby prevent these frequent prior causes of scheduling errors identified by OIG.

Finally, in April 2017, VA began to publicly report new patient appointment wait times from the date an appointment is requested at www.accesstocare.va.gov. The "date an appointment is requested" method also includes data that cannot be altered by schedulers and has been shown by a commissioned research study to accurately reflect wait time patient satisfaction and thereby Veteran experience with wait times. VA believes these system changes will improve the accuracy of wait time reporting including identification of patients eligible for the Veterans Choice Program.

Questions for the Record
HAC MILCON/VA
FY 2019 Budget Hearing
March 15, 2018

Question 2: Mr. Secretary, as we have discussed in previous hearings, since 2002 the VA has continued to deny claims from Blue Water Navy veterans, despite studies showing higher rates of cancer and non-Hodgkin's Lymphoma among shipboard veterans than those who fought on the ground in country. I have brought this up in prior hearings with you and you replied that you were requesting additional recommendations from the VA on this issue. Additionally, I wrote a letter to you in August to address this issue. In September of 2017 you responded to my letter and said that you were going to be "receiving additional subject matter expert recommendations on the matter" and would update me and my fellow signers of the letter "in the coming months". So my question is, nearly six months later, have you come to a decision on the Blue Water Navy veterans? If not, what is your status update and when exactly can we expect a response as to whether your department plans to afford these brave Americans the benefits they have fought for and deserve.

VA Response: VA continues to study the issue of whether to extend the presumption of exposure to an herbicide agent for Blue Water Navy (BWN) Veterans but currently there is a lack of scientific evidence to support this decision. VA has launched a nationwide study, the Vietnam Era Health Retrospective Observational Study (VE-HEROeS), which is designed to assess the current health and well-being of Vietnam Veterans, including 1,000 BWN Veterans who are part of the study. VA researchers are currently analyzing data from the VE-HEROeS effort. After the analysis is completed, the results will be delivered to the Agent Orange Task Force and then to the Secretary for consideration. Timeline for initial results is expected to be in 2019, with publication of results within 1-2 years. In addition, VA expects to receive the biennial Agent Orange report from the National Academy of Medicine in fall/winter of 2018.

Questions for the Record
HAC MILCON/VA
FY 2019 Budget Hearing
March 15, 2018

Congresswoman Barbara Lee

Question 1: For FY2019, the Department's budget requests $8.6 billion for mental health services to serve the increasingly diverse

Please detail any trainings or courses available to VHA health care providers to help them develop culturally competency to service veterans of color?

VA Response: According to the VA Talent Management System (TMS), VHA Employee Education System is identified as the responsible organization in the development of one live virtual classroom (VA 34981-*2018 Homeless: LGBT Cultural Competence and Veteran Homelessness*) and serves as the VA TMS Administrator for one commercially available training (NFAD 13472-Caregiver Training: Cultural Competence (Caregiver Training Series). These are VHA wide training opportunities.

When applying specific search terms criteria "cultural competency" and "color" in VA TMS, only one course is identified: *Veterans of color – VA4308840 PRE-Cultural Competency: Native Americans*. This was a facility developed classroom course at the Prescott VAMC for healthcare professionals. There are 39 facility developed courses in addition to the Prescott VAMC course about developing cultural competency.

Question 2: In December 2017, the VHA issued directive 1315, which included policy stating that in order "to comply with Federal Laws such as the Controlled Substances Act (Title 21 USC 801 et. al), VHA providers are prohibited from completing forms or registering Veterans for participation in a State-approved marijuana program…"

Can you tell us specifically which sections of the CSA would be violated if a doctor were to provide such recommendations?

VA Response: The Drug Enforcement Administration (DEA) is responsible for enforcement of the provisions of the Controlled Substances Act (CSA) that pertain to the manufacture, distribution, and dispensing of controlled substances. We recommend that questions regarding CSA be directed to DEA.

In 2008, VA reached out to DEA to ask whether completion by VA providers of forms that help patients procure marijuana under state-approved marijuana programs is a violation of CSA. In DEA's 2009 written response, attached, they explained that knowing and intentional manufacture, distribution, or dispensing (or possession with the intent to do any of these things) of marijuana is a violation of 21 U.S.C. 841(a)(1). They further explained that anyone who aids, abets, counsels, commands, induces or procures the commission of the violation of CSA is in violation of federal law, citing 18 U.S.C. 2(a), as is any person who attempts or conspires to commit a CSA offense, citing 21 U.S.C. 846. DEA advised that "a physician who acts with the 'specific intent to provide the means' by which his/her patient may obtain marijuana does so in violation of

21 U.S.C. 841(a)(1), and is subject to the enforcement provisions of the CSA." Decisions whether to pursue prosecution are within the discretion of the U.S. Attorney's Office with jurisdiction over the conduct.

Further information on this can be found in page 2 and 3 of the attached DEA guidance.

DEA guidance-Letter to Will Gunn 10-19-09

Question 3: As you know, the Small Business Administration (SBA) annually negotiates prime and subcontracting goals with each federal agency. Each Fiscal Year, each agency receives a score card with grades based on the agreed upon goals.

As you may already know, in FY2017, VA had $26.1 billion eligible for small business contracts:

Of this amount, the VA had a goal of awarding 28.5% of all contracts to small businesses; it exceeded this and awarded 29.38% of contracts, or $7.7 billion to small businesses. However, VA continues to miss its goal of awarding:

- **5% of contracts to woman-owned businesses and**
- **3% of contracts to small businesses in HUB zones**

Additionally, the amount of contracts awarded to service-disabled veterans has dramatically decreased.

What is your plan to ensure that the VA continues to engage with and work with small business contractors to meet its SBA goals?

VA Response: Although VA did not meet its contracting goals in FY 2017 for HUBZone and Women-Owned Small Businesses (WOSBs), we did meet goals for all small business, Service-Disabled Veteran-Owned Small Businesses (SDVOSBs), Veteran-Owned Small Businesses (VOSBs), and Small Disadvantaged Businesses (SDBs).

Data from the Federal Procurement Data System (FPDS) indicate that VA's contracting with SDVOSBs and VOSBs achieved a record high in FY 2017, after achieving a previous record high in FY 2016. In FY 2017, VA's contracts to these types of businesses totaled over $5 billion for the first time, after achieving over $4 billion for the first time in FY 2016. These data indicate that the amount of VA's contract dollars for these firms has increased rather than decrease.

The FPDS also showed that VA continued to lead the Federal government in SDVOSB procurements, exceeding all combined civilian agencies in this category as a result of the required preference for SDVOSBs and VOSBs mandated by 38 U.S.C. § 8127. In addition to providing authority for sole-source and set-aside procedures for SDVOSBs and VOSBs, this statute mandates a hierarchy among small business programs for VA. Under section 8127(i), VA prioritizes awards to SDVOSBs followed by VOSBs. Only after considering SDVOSBs and VOSBs may a VA contracting officer consider HUBZone awards and awards under section 8(a) of the Small Business Act, which have equal status as the third priority under this legislation. Finally, a VA contracting officer may then consider other small business preferences, including the general small business set-aside.

While this statutory hierarchy is consistent with VA's Veteran-centric mission, it also has an unavoidable consequence, of limiting VA's use of the set-aside and sole-source authorities available to other Federal agencies in other programs. Only if market research indicates insufficient SDVOSB or VOSB sources may a contracting officer pursue set-aside to a lower priority socio-economic group. Since there are nearly 14,000 verified firms in the VA Veterans First Contracting Program, there are few instances where procurements that lend themselves to small business performance do not have capable SDVOSBs or VOSBs from which to choose. As a result, VA mainly receives credit toward the HUBZone and WOSB goals by awarding contracts to SDVOSBs and VOSBs that have dual eligibility: i.e., those eligible for these other programs in addition to being a verified SDVOSB or VOSB.

In order to adhere to the requirements of section 8127, VA seeks to increase the number of VOSB firms with dual eligibility in the HUBZone or WOSB programs that participate in the VA Veterans First program. Since contracting officers cannot require participation in multiple socioeconomic categories, VA is conducting more aggressive outreach to dually eligible firms by hosting outreach events specifically targeting women-owned VOSBs as well as those located in HUBZones to encourage them to apply for verification of their VOSB status. VA is also reaching out to Veterans at WOSB and HUBZone events to encourage them to compete for VA contracts.

In FY 2017, VA's Office of Small and Disadvantaged Business Utilization (OSDBU) participated in outreach efforts focused on WOSB and HUBZone participants. At the National Veterans Small Business Engagement (NVSBE), OSDBU conducted activities focused on VOSBs that were also WOSB or HUBZone firms. Moreover, in the invitation to the NVSBE, VA made a special effort to invite VOSBs that had dual certification.