Post-hearing Questions for the Department of Veterans Affairs (VA)
From Chairman Johnny Isakson
The Fiscal Year 2019 Budget for Veterans' Programs
March 21, 2018

Question 1. The fiscal year (FY) 2019 budget request for Vocational Rehabilitation and Employment discretionary appropriations shows a reduction of $59.3 million in "Other Services" and attributes this change to more favorable pricing in the Transition Assistance Program (TAP) contract.

a. **Please provide specific information on the total dollar amount of that contract; the number of individuals and services provided under that contract; and how dollars, individuals, and services under this contract have changed from FY17 to the expected FY19 requirements.**

VA Response: The TAP contract was competitively awarded to Booz Allen Hamilton in September 2017. The total value for the 9-month base year and four, 12-month options is $230,963,330. The duties under the contract remain the same from fiscal year (FY) 2017 to expected FY 2019 requirements: to provide training, information, and services to help transitioning Servicemembers, their families, and caregivers achieve their personal post-military goals. TAP is funded at a level that provides VA benefits briefings and assistance to 100 percent of Servicemembers when transitioning from active service.

FY 2018 is funded at $111 million, but based off prior years of execution (see below), the FY 2019 request was reduced to $51.4 million, a reduction of $59.6 million in Vocational Rehabilitation and Employment's (VR&E) other services. This decrease, combined with other non-pay inflationary increases, totals the reduction of $59.3 million in VR&E's total obligations. The original TAP legislation required VA and the Department of Defense (DoD) to collaborate on Military Lifecycle (MLC) training. This portion was not part of the prior contract as VA and DoD were not prepared to execute. This resulted in an unexecuted balance of an average of $44 million annually from FYs 2014 to 2017. The unobligated funding was used for overtime to support reducing the backlog of rating claims—this resulted in VA completing an average of 1.3 million rating claims per FY. This FY, we will begin executing this portion of TAP. At the time of budget development, we made an adjustment for the new contract as well as the MLC not coming to fruition.

When the MLC portion of TAP is executed, additional funds may be required to cover full execution across over 300 military installations. As a need is identified, these funds will be resourced internally in the year of execution and requested in future budget submissions.

b. Please also provide any other changes in personnel and services outside of the TAP contract that have also contributed to the $59.3 million reduction in the appropriations request.

VA Response: No other changes in personnel and services outside of the TAP contract are attributed to the overall $59.3 million decrease for VR&E in the FY 2019 Budget request.

Question 2. The Department of Veterans Affairs (VA) testimony submitted for the hearing highlights VA's participation in the White House Infrastructure Initiative to explore ways to modernize and obtain upgrades to VA's real property portfolio. Please provide additional details on the proposed Infrastructure Initiative specific to VA.

VA Response: VA supports the White House Infrastructure Initiative as it will provide authorities needed for VA to help modernize its real property portfolio and make much needed capital improvement to Veterans facilities. The specific details of the authorities are explained below.

Authority to Retain Proceeds from Sales of Properties:
Under current law, VA has very limited and restricted authority to retain the proceeds from sales of its properties and cannot exchange its existing facilities for the construction of new facilities. Under current law United States Code (U.S.C.) 38, section 8118, the Secretary may transfer real property under the jurisdiction or control of the Secretary to another department or agency of the United States, to a state, or to any public or private entity, including an Indian tribe. The authority is limited as related proceeds need to first be re-appropriated and can only be used for other disposal activities, minor medical construction, and historic properties. This authority has been in place since 2004 and expires in December 2018, due to the various constraints it has never been utilized by the Department.

Authorizing expanded authority for VA to retain proceeds from sales of its properties and exchange its existing facilities or land for new construction would provide VA flexibility to better fulfill its mission, including making much needed capital improvements for new construction and renovations and for funding lease or service costs in a facility. Authorizing the retained funds to remain available until expended would allow VA to make these investments without the need for further authorization and appropriation.

Exchange Property for Construction of New Facilities:
Under current law, VA cannot exchange its existing facilities for the construction of new facilities. This hinders VA's ability to provide upgraded infrastructure for our Nation's Veterans. Authorizing VA to exchange its existing owned land and facilities for construction of new Federal facilities, provided VA identifies such facilities as a capital requirement in its annual budget submission, would provide VA additional flexibility to construct new facilities for our Nation's Veterans.

Pilot for VA to Exchange Land or Facilities for Lease of Space.
Currently, VA cannot exchange its existing land or facilities for a lease of space in a private facility to be built on former VA land. This hinders the VA's ability to provide upgraded infrastructure for our Nation's Veterans. Creating a pilot program for up to five projects would allow VA to exchange existing VA land or facilities for a lease of space in a private facility to be built on the former VA land would provide additional flexibility to better meet the needs of our Nation's Veterans. Under this pilot, VA-occupied space would be built to the same commercial standards as the remainder of the facility. The space could be in a stand-alone building or part of another building.

The terms of the lease arrangement would include, but not be limited, to the following:

- VA would get the value of the exchanged facility in rent credits or rent credit plus services for equal to the value of the exchange.
- The private sector financing (construction financing or loan) could not be based on the full faith and credit of the U.S. Government or guaranteed U.S. Government tenancy.
- The lease term, after credits, would be a maximum of 7 years. Any future lease or lease extension after the initial term also would be limited to 7 years.
- The lease and service rates during the credit timeframe and any subsequent lease term would be at market or less.
- The explicit dollar amount of termination (e.g. 1 year of rent payments) would be required to be included in the agreement, and VA would budget rent and termination in accordance with Office of Management and Budget (OMB) circular A-11.
- The lease would be structured to assure that VA had exit privileges and that VA would have an exclusive right, but not the obligation, to renew or extend the term of the lease.

Increase Lease Authorization Levels:
Current law requires VA to obtain congressional authorization for any lease above $1 million in annual rent. This differs from the General Services Administration (GSA) prospectus threshold which currently carries a threshold of $3.095 million and is reevaluated periodically. These differing thresholds require VA to seek authorization for more leases. Increasing the authorization threshold for VA major medical leases (38 U.S.C. 8104) from the current threshold of $1 million in annual rent to the current GSA prospectus threshold of $3.095 million and updating it periodically would reduce the number of VA authorization requests and keep VA in sync with GSA, whose delegation of authority VA uses to execute these medical leases. This would streamline VA's lease process, which could shorten the initial approval timeline and increase speed to market for all VA Major Leases.

Question 3. The FY18 omnibus appropriations bill includes $685 million for state veterans home construction grants, a significant increase over the $90 million request. The Committee has not yet received the FY18 state veterans home construction grant priority list. Please provide the FY18 priority list as well as an

estimate of the number of projects that will be completed with the additional funding provided in FY18.

VA Response: VA plans on funding the projects ranked from 1-52 in the funding order column on the far right of the priority list. Attached is the signed list.

FY18 State Home Priority List SIGNED.p

Question 4. The Federal Acquisition Regulation states that if at all possible, orders of $3,500 or less (micro-purchases), should be distributed equitably among qualified suppliers that offer reasonable prices. Please provide VA's methodology for determining whether a supplier is deemed qualified and its prices are considered reasonable.

VA Response: Under VA Financial Policy – Purchase Card Policy – Volume XVI – Chapter 1, this determination is made by the purchase card holder and approvers. It is addressed in policy which states:

> 010202 COMPETITIONS AND SOURCES
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> A. VA purchase cardholders shall ensure only authorized purchases are made. An authorized purchase is defined as a purchase that satisfies a bona fide need at a fair and reasonable price that meets all legal and regulatory requirements in accordance with the Competition Requirements (FAR Part 6 and VAAR Part 806) and Acquisition Planning (FAR Part 7 and VAAR Part 807).
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> B. Section 508 of the Rehabilitation Act: All micro purchases, including open market buys and those made through Government contract vehicles (e.g., GSA Advantage), will be subject to the provisions set forth in Section 508 of the Rehabilitation Act, unless an exception applies (see FAR Subpart 39.2, Electronic and Information Technology). The Buy Accessible Wizard, a Web-based application (www.buyaccessible.gov) makes it easier to buy products and services that comply with Section 508 of the Rehabilitation Act.
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> C. VA shall purchase green products and services to the maximum extent practicable and advance sustainable acquisition for the supply of products and for the acquisition of services (including construction) to meet the requirements of the Green Purchase Program in accordance with FAR Section 23, Environment, Energy and Water Efficiency, and Renewable Energy Technologies, Occupational Safety, and Drug-Free Workplace.

Question 5. Although there are two years left on the contract, the Committee understands VA is moving forward with a new national broker contract, expected to be awarded by the end of FY18. Please provide answers to the following:

VA Response: To clarify VA's forecasted award date, VA forecasts award by end of Calendar Year 2018, not end of FY 2018.

a. **What are the training requirements and basic certifications that companies and their leasing staff must have/maintain, prior to and after award?**

   VA Response: VA is continuing the process of market research to determine the training and certification requirements companies and their leasing staff will need prior to and after award. VA is using market research to draft the requirements documents prior to entering the solicitation portion of the acquisition process. All training and certifications requirements that companies and their leasing staff must have and maintain prior to and after award will be provided in the solicitation, which will be posted to FBO.gov during the procurement process for vendors to respond.

b. **What, if any, prior completed work with the federal government must a company show to be considered a qualified vendor?**

   VA Response: VA is continuing the process of market research to determine any requirements for a company to show prior completed work with the Federal Government. VA is using market research to draft the requirements documents prior to entering the solicitation portion of the acquisition process. The final requirements will be stated in the solicitation, which will be posted to FBO.gov during the procurement process for vendors to respond.

c. **How do you conduct market research to ensure that a best value competition takes place?**

   VA Response: VA conducts market research using techniques described in Federal Acquisition Regulations and VA Acquisition Regulations to inform VA's acquisition strategy. VA posted a Sources Sought notice on FBO.gov for vendors to respond by February 21, 2018, and conducted an Industry Day on February 15, 2018. Additionally, VA continues to conduct market research through researching Vendor Information Pages database for Service Disabled Veteran Owned Small Business or Veteran Owned Small Business concerns, as well as researching through Government and commercial information resources to continue to define requirements and promote competition.

Question 6. VA's testimony submitted for the hearing indicates VA is implementing a Veterans Integrated Service Network (VISN) level gap coverage plan that will enable facilities to request gap coverage providers in areas that are struggling with staffing shortages. Please provide the following information:

a. **The process that will be used to request additional resources;**

VA Response: The" Gap Coverage" VISN initiative is a partnership with V-IMPACT (Virtual Integrated Multi-Site Patient Aligned Care Team), a tele-primary care hub and spoke model catering specifically to filling vacancies within a VISN, as well as the tele-mental health hubs, Clinical Pharmacy Services, and the Interim Staffing Program. A LEAF (LIGHT, ELECTRONIC, ACTION, FRAMEWORK) request portal has been developed by the Gap Coverage team, streamlining the process to request staffing coverage in primary care, mental health, and clinical pharmacy. The Symphony platform has added capabilities to allow VISN leaders to easily identify the location of clinical staffing capacity as well as where the demand is located.

b. **The approval process for those requests and a breakdown of the offices and individuals with oversight over the gap coverage plan; and**

VA Response: VISN executive leadership will be responsible for designating staff to process and coordinate these requests with relevant service lines in their VISN. VISN leadership teams may identify staffing using the tools identified above, and currently in pilot use.

c. **The types of resources expected to be provided in addition to telehealth services such as temporary staff, additional funding, etc.**

VA Response: The tools above will be made available to VISNs requesting additional resources. Eight V-IMPACT Hubs (funded by the Office of Rural Health (ORH)) serving seven VISNs are currently operational in the Veterans Health Administration (VHA). In order to sustain and grow these eight hubs for FY 2019, we have requested $35.1 Million from ORH. To optimally cover vacancies across the enterprise, VHA would benefit from VISN-level hub expansion. We have identified six additional VISNs that are prepared to implement V-IMPACT Hubs in FY 2019. This will require approximately $15 million in additional funding. There is currently no funding mechanism identified in VHA for this expansion.

Question 7. The budget request indicates that an additional 5,500 HUD-VASH vouchers would be available to veterans in late 2017 or early 2018. How does the budget request for case management ensure a sufficient number of case managers to support the number of active vouchers?

VA Response: The FY 2018 Presidents Budget (PB) includes additional U.S. Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH) case management funding of $38.3 million to support the approximately 5,500 new HUD-VASH vouchers included in HUD's FY 2017 appropriation. These new vouchers are in the process of being awarded by HUD to various Public Housing Authorities

(PHA). With the addition of these new vouchers, VA will be providing case management support for approximately 93,000 vouchers, in total, by the beginning of 4th quarter FY 2018.

In addition, the 2018 Omnibus bill includes funding for another addition of 5,000 new HUD-VASH vouchers to be awarded to various PHA by the end of FY 2018. This would increase the total HUD-VASH voucher allocations to approximately 98,000 vouchers in total. Due to differences in VA and HUD budget cycles, the current VA budget for FY 2018 and FY 2019 does not take into consideration these additional 5,000 new vouchers. However, VA is committed to providing case management support for all HUD-VASH vouchers awarded by HUD and is currently reviewing the budget needs to support case management services for these additional vouchers. The HUD-VASH program will make a request for any additional funding, should it be needed, to support case management services for these additional vouchers.

Question 8. The FY19 revised request for the Program of Comprehensive Assistance for Family Caregivers is nearly $180 million less than the advance appropriation request. What factors contributed to the revised request?

VA Response: VA has developed updated budget estimates to more accurately reflect the funding needs for FY 2019 and beyond. The original estimates that were provided for FY 2019 were based on assumptions in FY 2015 that are no longer accurate. The estimates derived from the assumptions that Veterans would continue to apply for the Program of Comprehensive Assistance for Family Caregivers (PCAFC) at the same rate of previous years, new admissions and discharges would continue at the same rate, and Veterans would remain in the same tier levels; however this is not the case. The percentage of Veterans and caregivers applying and being approved for PCAFC decreased from 24 percent growth in FY 2015 to 3 percent growth in FY 2016. Also the number of Veterans in tier level 3 decreased 10 percent in FY 2016. These two factors caused the reduction of total monthly stipend payments. Caregiver Support Program partnered with the Office of Community Care to make changes to the current model. The changes were accounted for in the new estimates and a new trend line was established.

The updated estimates also exclude the costs of care in the community and more accurately reflect the funding needs for VA services in current FY 2018 and the 5-year projection.

Question 9. The budget request for the Veterans Benefit Administration includes a request for an additional 605 full-time equivalent (FTE) employees to assist with processing appeals and reducing the notice of disagreement inventory to less than 7,000.

a. **How was the number of additional FTEs determined?**

VA Response: The 605 FTE was based upon modeling that indicated a need for additional FTE to both reduce the legacy inventory and allow for timely processing of the new appeals system.

b. By what date does VBA expect to meet this goal of reducing the notice of disagreement inventory?

VA Response: There are several variables that could affect the legacy inventory and a timeline concerning when it will be reduced. Early estimates generated with assumptions and Rapid Appeals Modernization Program data indicate a reduction of the legacy inventory over the next 3 to 5 years with the addition of the 605 FTE in FY 2019. Once the new legislation is implemented, the Appeals Management Office (AMO) will have more complete workload data, allowing AMO to more accurately track the reduction timeline of the legacy inventory.

Question 10. The budget request projects that the Board of Veterans' Appeals' appeals inventory will increase by 31 percent by the end of 2019. Please explain how this request will support the Board in continuing to reduce its appeals inventory while also implementing the new system under the Appeals Improvement and Modernization Act.

VA Response: The Board's pending inventory is contingent upon the rate of certification of appeals by Veterans Benefits Administration (VBA) to the Board, as well as the Board's productivity. With VBA requesting an additional 605 FTE in its 2019 budget, the Board expects an increase in its legacy inventory in FY 2019. The Board continually monitors workload projections and requirements and adjusts its resource requirements as necessary. While the Board projected to end 2018 with 165,660 pending appeals, it is pleased to report that through March 31, 2018, the Board's inventory was 157,656, which is 4,078 appeals below its projected inventory level of 161,734 for March. VBA's RAMP effort, allowing Veterans to withdraw their legacy appeal in order to opt into the new framework, will also decrease the number of appeals from the legacy process.

The Board has experienced tremendous growth over the last 3 years and the 2019 President's Budget request of $174,748,000 would represent a 76-percent increase in budget authority from 2015 levels. The Board hired over 300 employees in FY 2017, with plans to hire another 150 new employees in FY 2018. With the Board currently behind on its hiring targets in 2018, it projects to continue its upward hiring into 2019. The Board plans to continue to monitor its workload measures very closely and adjust its resource requirements presented to OMB and Congress as it has done in the past.

Question 11. The budget request for the Office of Mental Health and Suicide Prevention lists a number of goals for the 2018–2020 period. The goals include increasing mental health hiring, expanding collaborative partnerships with the private sector, and reducing negative perceptions of seeking mental health care.

a. **Please describe in detail how VA plans to achieve each of the goals for the 2018–2020 period.**
b. **Please provide the funding resources needed, aggregated by fiscal year, to achieve these goals.**

VA Response:

Goal 1: Reduce and eliminate death by suicide among Veterans through a public health approach across communities, by promoting health and well-being, and by providing ready access to high quality mental health care.

VA's comprehensive approach to suicide prevention is organized according to a public health prevention framework consistent with that developed by the National Academy of Medicine, which sorts prevention strategies into three levels: 1) universal strategies to reach all U.S. Veterans, 2) selective strategies intended for some Veterans known to be generally at elevated risk of death by suicide (e.g. Veterans living in rural areas, Servicemembers transitioning to the community), and 3) indicated strategies for the relatively few specific Veterans identified as being at elevated risk (e.g. those with a history of an attempt or active suicidal ideation).

To achieve this goal for the 2018-2020 period, specific key activities over the next 2 years related to each of the three levels of prevention strategies are outlined below.

ALL	SOME	FEW
Caring contact programs for transitioning Veterans	Universal screening and assessment for suicide risk	Veterans Crisis Line (VCL)
Universal lethal means education and training	Transition readiness assessment and warm handoffs for care	Suicide Prevention Coordinators at every VA facility
Broad messaging campaigns to increase awareness of mental health services and to reduce stigma	BeThere peer support call center	Use of predictive modeling to identify and reach out to Veterans at highest risk (REACH-VET)
Education materials for all community members on recognizing and responding to signs of distress	Training for a broad range of community health care providers on suicide assessment, prevention, and intervention	Further predictive modeling efforts across DoD/VA
Promote the establishment of Whole Health "clinics" that will provide services for any Veteran who wishes to participate	Build and expand partnerships for access to mental health services throughout the community	Clinical Practice Guidelines
Promote responsible media		Safety planning training and

reporting about suicide		standardization
Participate in inter-agency suicide prevention efforts	Provide immediate and easy access to evidence-base mental health services, promote a recovery model of mental health care, incorporate families into Veterans' care (consistent with law), and implement Measurement Based Care	
Build community partnerships to support and expand efforts for all levels		
Incorporate program evaluation into all efforts		
Set a National Strategy for Suicide Prevention for Veterans		
Support and Expand Mayor's Challenge program[1] in all three areas		
Create and disseminate resources, tool kits, and technical support for local VA facilities and regions to develop, implement, and evaluate a comprehensive suicide prevention strategy		
Lead efforts to set, promote and support a national research agenda for suicide prevention for Veterans		

Approximate annual expenditure is $20,000,000.

Goal 2: Advance predictive analytics through intergovernmental and non-VA partnerships to expand this groundbreaking approach to addressing Veteran self-harm.

VA will engage in two predictive analytics projects: one with a community partner, and the other with a fellow Department. First, VA has a partnership with Johnson & Johnson (J&J) to advance suicide prevention efforts, among other things, and one of the first major projects in this partnership will be work in predictive modeling. One project in this arena will be the addition of wearable devices (e.g. Fitbit-style devices) to an existing VA depression study to explore whether data that can be obtained from wearables can contribute to the accuracy of existing predictive models. VA and J&J also will explore other sources of data that might meaningfully contribute to the fit and performance of the models. Second, a work group with representatives from both DoD and VA will develop and implement a proof of concept initiative that builds the necessary data streams and infrastructure to support advanced analytics in a single predictive model that serves service members and Veterans. The REACH VET initiative will continue to address needs of those Veterans at highest statistical risk and predictive risk information will be used more broadly in assessing Veterans needs through expansion of risk based dashboards to support clinical decision making.

Approximate annual expenditure is $3,500,000.

[1] The Mayor's challenge is a collaborative effort between Substance Abuse Mental Health Services Administration and VA to engage cities (mayors, government staff, and community partners) to establish and implement a strategic plan for the elimination of suicide in their city.

Goal 3: Open a third VCL location to meet increase demands for crisis intervention services.

VCL is continuing to expand to meet the needs of Veterans and Servicemembers in crisis, including full implementation of the automatic transfer function that directly connects Veterans who call their local VA Medical Center (VAMC) to VCL by pressing a single digit (7) during the initial automated phone greeting. More than 650 Community Based Outpatient Clinics also offer this feature, with additional sites planned. In January 2018, VCL opened a third call center on the campus of the Eastern Kansas Health Care System in Topeka, Kansas. Funding of $28.5 million was allocated in FY 2018 to cover the opening.

Goal 4: Increase Veterans' access to care through increased mental health staff hiring and expansion of telehealth services.

VHA Workforce Management and Consulting in partnership with the Office of Mental Health and Suicide Prevention have established the Mental Health Hiring Initiative upon the request of former VA Secretary David Shulkin. The Initiative seeks to add 1,000 net new providers in Mental Health by the end of December 2018.

- Additional providers will ensure VAMCs continue to meet access expectations for crises, engagement into care, and sustained treatment.
- Facilities with mental health staffing lower than the recommended minimum and that also have poor access, quality, and satisfaction performance are receiving additional Human Resources support and planning.
- Additional Educational Debt Repayment Program funding has been made available through existing resources.
- Telemental Health Services continue to expand through VA video connect and tele Hub Services.
- Tele Services continue to expand, providing rural veterans increased access and convenience.

Funds are being allocated within current facility budgets.

Goal 5: Promote the development of skills in VA providers to diagnose and assess Posttraumatic Stress Disorder (PTSD) by developing a computer-based training using simulated virtual patient technology that will allow clinicians to practice and receive customizable feedback on giving CAPS-5 to a lifelike virtual patient.

The Clinician-Administered PTSD Scale (CAPS), developed at the National Center for PTSD more than 20 years ago, is the gold standard interview for diagnosing PTSD. CAPS training has traditionally relied on face-to-face instruction followed by practice cases with supervision. Live training is time intensive and demand has surpassed what is feasible to deliver in person, particularly since a 2013 revision to the CAPS to align with revised diagnostic criteria by the American Psychiatric

Association. Technology offers a more flexible, scalable, solution that is less expensive in the long term. In FY 2017 the National Center created an online course to describe requirements for administering and scoring the CAPS-5, but the course does not help clinicians practice the CAPS in order to become proficient. In 2018, the Center plans to develop an additional CAPS-5 course that uses cutting-edge Responsive Virtual Human Technology to create an online virtual interview environment. The new course will allow clinicians to verbally administer the CAPS to a virtual patient who will respond naturalistically (like an actual patient). A virtual coach will give feedback during the administration, and feedback will be provided at the end specifying whether the learner is proficient or needs further practice. In FY 2018, the Center budgeted $1.5 million to build the course with a virtual male combat Veteran patient. In FY 2019, the Center is planning to add a second virtual patient, a woman Veteran who has experienced military sexual trauma, for a cost of $1.2 million. Over the next 3 years, there will be ongoing maintenance and enhancement costs of approximately $400,000 per year, which the Center will support from its recurring budget.

Goal 6: Continue expansion of Brain Bank activities and promote research to enhance the assessment and treatment of PTSD through the identification of biomarkers and novel treatment strategies.

VA's National Posttraumatic Stress Disorder Brain Bank (PTSD Brain Bank) was formally established in 2014, thanks in part to Congressional support led by U.S. Senator Patrick Leahy (D-VT). It is the first and only facility of its kind devoted exclusively to PTSD and consists of a consortium of five VA Medical Centers as well as the Uniformed Services University of Health Sciences.

The PTSD Brain Bank currently has 168 brains, including 56 PTSD brains, and has received commitments of more than 100 additional brains by the end of 2018. Donors can be either Veterans or non-Veterans. Because of the importance of acquiring suitable comparison tissue, the PTSD Brain Bank also collects tissue from donors who had no psychiatric illness during their lifetimes, or who suffered from a non-PTSD disorder such as depression.

Donations of tissue to the PTSD Brain Bank can occur in two ways. In many cases, consent for donation is obtained from next-of-kin shortly after their loved one dies. Other tissue comes from individuals who enroll in advance and personally consent to have their brain tissue go to the PTSD Brain Bank after death (called antemortem donors). The advantage of acquiring commitments from antemortem donors is that detailed data can be collected on their medical and psychological histories while they are alive.

The National Center for PTSD will continue to acquire more brain tissue for the Brain Bank. Acquisition of post-mortem tissue will be through arrangements with medical examiner networks, organ donation facilities, and the Duke Autopsy Program. The Center will also continue to recruit potential donors through strategic partnerships with longitudinal research registries and with organizations that support the Center's mission.

Additionally, the Center will continue to invest in research staff and facilities to allow multimodal analyses of brain tissue. Toward the broader goal of identifying biomarkers and novel treatment strategies, the Center will continue to provide salary support for investigators engaged in this work (e.g., imaging, genetics, treatment development, clinical trials) and facilitate collaboration between investigators within and beyond the National Center. The Brain Bank receives a recurring budget of $1.5 million per year; this budget is supplemented when additional funds become available. Other research efforts are supported through the Center's recurring budget; high priority projects and infrastructure are further supported as additional funds become available.

Goal 7: Expand collaborative partnerships with the private sector to enhance and complement VA's efforts to improve Veterans' mental health and reduce Veteran suicide.

As a key component of our strategy to prevent Veteran suicide across the all, some, and few domains, VA is developing a national network of public and private partnerships aimed at Veterans both inside and outside VA's system to inform them about mental health resources and care that are available to them through VA and community resources. These partnerships allow each party to continue to provide services to Veterans under its own respective authority, but each agrees to do so in a manner that effectively complements the contemporaneous or coordinated delivery of each party's services, thereby maximizing outcomes for Veterans and their families.

VA Suicide Prevention, program within the Office of Mental Health and Suicide Prevention, currently has 20 public private partnerships across the following sectors: Veterans Service Organizations (VSO), Federal Agencies, Employers, Health care Organizations (including those providing physical, mental health and substance abuse care), Lethal Means Education and Suicide Prevention, Communication and Media, Technology and Innovation, and Broad Sector Engagement. Over the next 2 years, VA suicide prevention will continue to expand its public private partnerships portfolio in alignment with of our strategic priorities.

Approximate annual funding is $1,500,000 to cover VA overhead and other costs associated with the implementation of these agreements, as they do not include an exchange of funds.

Goal 8: Continue outreach efforts to increase awareness of mental health services and resources, reduce negative perceptions about seeking mental health care and improve mental health literacy among Veterans and their families and friends.

As the largest integrated health care system in the country, VA is committed to providing timely access to high-quality, recovery-oriented mental health care that anticipates and responds to Veterans' needs, such as treatment for PTSD, substance use disorders, depression, and suicidal ideation. Recovery empowers the Veteran to take charge of his or her treatment and live a full and meaningful life. Encouraging

more Veterans to seek mental health treatment by providing accurate information about the evidence-based care that VA provides is a primary goal of VA's mental health education and outreach efforts. VA's mental health communication materials are strategically developed and refined using best practices and lessons learned and are then distributed nationally via event and conference attendance, website and webpages, social media platforms, television, and radio to directly confront and combat common misperceptions and inaccurate information about mental health and suicide in this country and eliminate the stigma many Veterans associate with these topics and with seeking mental health care.

Specific programs to increase awareness of mental health services and resources used to reduce negative perceptions about seeking mental health care and improve mental health literacy among Veterans and their families and friends are outlined in the table in the response to Goal 1 above. Specifically, these include 1) outbound calls to transitioning service members to provide information on access to peer support, VA mental health care, eligibility for health care and for VA benefits, lists of local and national resources, and names and contact information for immediate needs; 2) a broad communications campaign targeting all service members, Veterans and family members with key messages about access to mental health care; and 3) a broad communications strategy to change attitudes and behaviors about suicide prevention, reduce the stigma associated with seeking help, and increase knowledge of important protective factors that reduce risk; and 4) active promotion of responsible media reporting on suicide and suicide-related issues.

For example, VA's award-winning Make the Connection national outreach program was specifically developed to reduce negative perceptions about seeking mental health care and improve mental health literacy among Veterans and their families and friends. VA will continue this campaign to increase awareness of mental health services and resources. Specific activities include: developing and maintaining existing relationships with VSOs, Community Based Organizations, and, other government departments and agencies who have supported the campaign and distributed messaging; executing online advertising employing keyword, display banner, social media and video advertisements; producing and distributing public service announcements; and, promoting Veterans' stories of resilience and recovery across a variety of platforms.

VA's communication/outreach work on this topic encourages more Veterans to reconsider their attitudes and beliefs about mental health and seeking mental health care and to consider VA as the best resource to contact should a mental health issue arise. VA is dedicated to increasing the number of Veterans who receive mental health care, preventing Veteran suicide, and ensuring every Veteran who needs assistance with a mental health challenge or crisis is aware of and educated about VA's programs and resources.

Approximate annual expenditure is $7.5 million.

Question 12. The budget request for FY19 proposes to merge the Medical Services Appropriations Account with the Medical Community Care Appropriations Account. The proposal suggests that having two accounts hampers Medical Center Directors from properly managing their budgets and, therefore, make decisions of where to provide care when there are temporary personnel shortages. However, the Medical Community Care Appropriations Account was created to ensure a dedicated funding stream for community care and provide Congress with better oversight of the funds spent on care provided inside and outside VA.

a. Should Congress merge the two accounts, what oversight processes are in place to ensure funding intended for community care is actually spent on community care?

VA Response: 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 which mirrors the detail currently reported for the separate Community Care appropriation.

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
Inpatient 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

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
Inpatient 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.

VA is proposing to establish a community care funding model that mirrors the successful model currently used for VA's Consolidated Mail Outpatient Pharmacies. Under this model, each VAMC and the Deputy Undersecretary for Health for Community Care (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 will 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 pathway to increased privatization of VA health care, this

proposal allows VAMC Directors to enhance the capability and efficiency of their facilities with the confidence that funds will be readily available.

b. What processes are currently in place to help VA Medical Center Directors better manage their budgets?

VA Response: VHA instituted the Veterans Equitable Resource Allocation (VERA) Model in April 1997 to allocate funds to VISNs. VERA ensures that the allocation of funds is equitably distributed based on Veterans who use VA's health system rather than simply being based on historic funding patterns. The implementation of VERA aided in the transformation of VA's health care system from individual medical centers and clinics focused primarily on inpatient care to a fully integrated system with expanded primary and ambulatory care capability. VERA has been, and will continue to be, a critical component of VA's success in implementing the mission and vision of VHA.

The VERA Model gives each network a "tailored" allocation price that reflects the unique characteristics of each network. For example, network funding is based on a combination of the number of patients, adjustments for regional variances in labor and contract costs, high cost patients, education support, research support and equipment. While VERA has significantly improved the allocation of the Veterans' health care budget, VHA will continue to review and examine the VERA Allocation Model to assure its continued relevance and to identify needed improvements.

Since VERA was introduced in 1997, there have been nine external assessments of VERA. These independent reviews validated that the VERA methodology is meeting its objectives and the original intent of Congress under Public Law 104-204. The process for refining the VERA methodology can be internally generated by VA users of the VERA system or externally generated by outside VERA evaluators.

The three reports below are used by VHA Office of Finance as part of the financial metrics routinely used to ensure sound financial performance.

- VHA Directive 1733, The Financial Quality Assurance Reviews, establishes the requirements for performing and conducting the finance quality assurance program, performing self-assessment reviews, and evaluating the quality of work within finance operations and related activities. These self-assessments are submitted to the VHA Office of the Chief Financial Officer (CFO) for compilation and data analysis.
- The financial indicators were developed to provide a means of evaluating performance and promoting improvements in financial management within VHA. This is a monthly report that includes indicators for potential issues that alerts leadership at medical centers to review.

- The Expenditure Pace Report is a VHA CFO established report identifying open obligations that have been identified as requiring action based on criteria established by the VHA CFO Finance staff. Medical center staffs review the information and must provide a justification for obligations remaining open or they are closed by the VHA CFO staff.

In addition, VHA Office of Finance uses many formal and ad hoc reports based on the needs identified by financial statement audits, data analysis, investigations, improper payment reviews, external requests, and cost accounting audits. Below is a sampling of additional reports and audits routinely used within the VHA Office of Finance.

- Fund Availability Reports are monthly reports prepared by the VHA Office of Budget staff to identify available funds at each VAMC and identify obligations rates to highlight any anomalies.
- Operational Plans are prepared by each VISN identifying their spending plan by category and month for the year. VISNs are required to account for actual obligation-to-plan differences greater than 3 percent each month with results tracked by VHA senior leaders.
- The Medical Center Allocation System was established to standardize the methodology for distributing VISN-level VERA Model funds to medical centers within each VISN. We require VISNs to document and substantiate any differences with the system proposed allocations and identify any expected outcome changes.
- Financial Statement Audit and Office of Inspector Corrective Action Plans – When reviews identify deficiencies, VAMCs are required to provide corrective action plans on a regular basis until corrections are completed.
- Improper Payments Review requires that VAMCs provide samples of payment documents that are reviewed. Once the review and analysis are completed, VAMCs are required to prepare and implement corrective action plans to improve the payment processes.
- The Managerial Cost Accounting Office oversees audits on a regular basis that identify areas where costs are outliers compared to other facilities. They work with the VAMC until costing errors are corrected.

Oversight of VAMC budget execution will continue to occur at all leadership levels, culminating at the Monthly Management Review chaired by the Deputy Secretary. VA would continue 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.

c. If Congress does not merge the two accounts, what other options could VA employ to more effectively manage the two accounts?

VA Response: VA uses an actuarial model, the Enrollee Health Care Projection Model (EHCPM), to develop health care requirements for Veterans. EHCPM develops estimates for both community care and care provided in VAMCs. VA will continue to include separate estimates for community care funded within the Medical Services appropriation in the President's Budget request. VA will also continue to discretely account for community care obligations using the same underlying accounting structure currently in place for the separate Medical Community Care appropriation. VA is submitting a legislative proposal to allow VA to use a model similar to that used for the Consolidated Mail Outpatient Pharmacy program, where the funds will initially reside with each VAMC, but will be provided by the VAMC to the DUHUCC to manage during the year. Based on the demand for community care and the ability of the VAMC to provide more care in house at lower cost, the amount provided can be rapidly adjusted to meet changes in each VAMC's ability to provide care in-house.

As stated earlier, oversight of VA Medical Care budget execution will 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.

Question 13. The budget request for FY19 and the advance appropriation request for FY20 for the Medical Support and Compliance Appropriations Account support a total FTE of 51,097 for both fiscal years. This appropriations account provides funding for the Veterans Health Administration (VHA) Central Office; VA Medical Centers, VISN headquarters, and other activities.

a. **Please provide the total FTE for VHA Central Office; the VA Medical Centers; VISN and other field activities; and VHA National Consolidated Activities.**
b. **For each total above, please break the totals out by General Schedule grade or Title 38 employees.**

VA Response: See the following table "Employment Summary, Medical Support & Compliance, FTE by Grade, FY 2017 - FY 2020." FY 2018-FY 2020 assumes similar relationship as found in the FY 2017 actuals.

Employment Summary, Medical Support & Compliance
FTE by Grade, FY 2017 - FY 2020

	FY 2017[1]				
	VHA Central Office	VAMC	VISN	National Consolidated Activities	Total
SES[2]	30	113	13	4	160
Title 38	207	3,027	130	497	3,861
GS-15	153	138	81	116	488
GS-14	540	623	269	451	1,883
GS-13	435	2,100	199	1,083	3,817
GS-12	205	3,718	92	1,484	5,499
GS-11	98	3,896	48	932	4,974
GS-10	0	96	4	2	102
GS-09	62	3,886	46	1,025	5,019
GS-08	1	1,961	17	309	2,288
GS-07	34	4,970	33	2,211	7,248
GS-06	6	6,364	8	2,524	8,902
GS-05	4	3,164	0	699	3,867
GS-04	0	1,662	0	67	1,729
GS-03	1	92	0	1	94
GS-02	0	20	0	0	20
GS-01	0	1	0	1	2
Wage Grade	1	963	0	22	986
FTE Sub Total	1,777	36,794	940	11,428	50,939
	Grand Total		50,939		

	FY 2018 - 2020[1]				
	VHA Central Office	VAMC	VISN	National Consolidated Activities	Total
SES[2]	30	113	13	4	160
Title 38	208	3,036	130	499	3,873
GS-15	154	138	81	116	489
GS-14	542	625	271	452	1,890
GS-13	436	2,107	200	1,086	3,829
GS-12	206	3,730	92	1,489	5,517
GS-11	98	3,908	48	935	4,989
GS-10	0	96	4	2	102
GS-09	62	3,898	46	1,028	5,034
GS-08	1	1,967	17	310	2,295
GS-07	34	4,985	33	2,218	7,270
GS-06	6	6,385	8	2,532	8,931
GS-05	4	3,174	0	701	3,879
GS-04	0	1,667	0	67	1,734
GS-03	1	92	0	1	94
GS-02	0	20	0	0	20
GS-01	0	1	0	1	2
Wage Grade	1	966	0	22	989
FTE Sub Total	1,783	36,908	943	11,463	51,097
	Grand Total		51,097		

Footnotes:
1/FY 2017 through FY 2020 Full Time Equivalents (FTE) are estimates
2/SES = Senior Executive Service

Question 14. According to the budget request, VA providers have difficulty in querying state Prescription Drug Monitoring Programs (PDMP) databases and incorporating PDMP data into a veteran's electronic health record. To improve the ability to check and integrate data from the PDMPs, VA will need to utilize technology based solutions.

a. How much funding resources does VA estimate will be needed to make these improvements?

VA Response: The first 2 years of implementing a VA Enterprise Wide Interface between VA's EHR (CPRS) and the State PDMPs is estimated to cost just over $9 million, and the first 8 years are estimated to cost just

over $33 million. These estimates are for all of VA (Enterprise Wide Cost), largely due to software licensing fees (priced currently at around $37.50 per VA staff member query user per year).

b. Please describe in detail the VA's plan to improve VA provider's interaction with PDMPs.

VA Response: The multi-program office, enterprise wide endeavor to implement a VA Enterprise Wide Interface between VA's EHR (CPRS) and the State PDMPs, if approved for funding, will serve to more readily provide State PDMP query information within VA's EHR in real time, and at the point of care, for prescribing VA health care providers and their allied health staff and clinical delegates.

Similar endeavors with non-VA health care organizations have led to dramatic increases in prescriber queries, as well as dramatic decreases in opioid prescriptions, as evidenced by the February 2017 report by the Centers For Disease Control regarding the PDMP Electronic Health Records Integration and Interoperability Expansion program. Moreover, there are a handful of private vendors that have emerged as top candidates for collaborating with VA for the creation and maintenance of such an interface, and VA Office of Information and Technology (OI&T) is aware of these possible vendors so that they can commission a very high yield and successful competitive solicitation and bid process for a contracted vendor (or sole source award at their discretion), should this project be approved for funding and resourcing consideration.

Section 134 of the Mission Act will support the implementation of a VA Enterprise Wide Interface, as this act considers any licensed VA health care provider or their delegate within VA to be an authorized recipient or user for the purpose of querying and receiving data from the national network of State-based prescription drug monitoring programs, to support the safe and effective prescribing of controlled substances to covered patients. This Act further prohibits States (notwithstanding any general or specific provision of law, rule, or State regulation) from restricting access or sanctioning the licenses of licensed VA health care providers or their delegates when accessing that State's prescription drug monitoring programs.

In summary, the Mission Act (notwithstanding any superseding law, rule or regulation) allows for Federal Supremacy and Team Based health care delivery with respect to the querying of a national network of State-based prescription drug monitoring programs, and the current marketplace supports the pursuit of a VA Enterprise Wide Interface, as at least one private non-VA software vendor has developed an electronic gateway that connects or will connect 48 State-based prescription drug monitoring programs as of July 2018.

c. What factors will VA utilize to determine whether a commercial-off-the-shelf product could be used to improve the interaction with the PDMPs?

VA Response: There are a few private vendors who have emerged as quite proficient in this realm of building interfaces between Health care Institution EHRs and the State PDMPs. The group convened by VA that is working on the National Service Request for a VA Enterprise-wide interface has made some pricing inquiries with one or more of these vendors to assist with budget forecasting for VA and for our colleagues in OI&T, but they have otherwise purposefully kept their distance from interacting more meaningfully with any particular vendor. VA sincerely hopes (with approval and funding for implementation) that a fair and unbiased solicitation could ensue to develop the VA Enterprise-wide interface with a contract awarded vendor (vs. a sole source solicitation if VA OI&T's contracting teams felt this was in VA's best interests and could legitimately justify such an action). To that end, VA has not met/discussed project-related thoughts and ideas with any one particular vendor or another, to avoid creating an unfair level of competition for any future projects that VA OI&T would send for solicitation.

Senator Dan Sullivan
SVAC Questions for the Record
Fiscal Year 2019 Budget for Veterans' Programs
and Fiscal Year 2020 Advance Appropriations Requests
March 21, 2018

Question 15. Future of Community Care in Alaska: Sec. Shulkin, now that the VA is moving from a 2 region model (Triwest/HealthNet) towards the CARE concept and a 4 region model, it is my understanding that the Community Care (CC) office received successful bids for Regions 1-3, but not for Region 4 – which includes Alaska. Please provide an update on what happened during that bid, some of the contributing factors for why it failed and what the VA is planning to do moving forward.

VA Response: VA determined it was not in the best interest of the Government to make an award in CCN Region 4. Unfortunately VA cannot release the specific details of what happened or contributing factors. The updated draft solicitation for CCN Region 4 was posted to FedBizOpps on Friday, May 25. Alaska is not included in CCN Region 4. VA understands the unique challenges of Alaska and is taking this opportunity to explore possible options for providing community care to these Veterans.

Question 16. Tribal Sharing Agreements: When you became Secretary, you promised early and thorough engagement with our Alaska Native healthcare partners to work out some of your differences in serving these rural Veterans. I understand there has been some turnover and that there are critical vacancies

that still need to be filled, but, can you tell me who you currently have leading on this important issue, if they are able to make commitments on your behalf and what progress has been made on the VA's end to come to an agreement with all parties?

VA Response: VA has established and continued partnerships with Alaska Tribal Health Programs (THPs) through signed reimbursement agreements. Under these agreements, VA reimburses Alaska THPs for Direct Care Services provided to eligible American Indian (AI)/Alaska Native (AN) Veterans and non-Native Veterans. In early 2017, VA and the Alaska THPs renewed these agreements through June 30, 2019, and VA would like to renew them again, if renewal is agreeable to the Alaska Tribal Health Programs, in the future.

VA U.S. Department of Veterans Affairs	SUMMARY AND APPROVAL SHEET		
NAME OF ORIGINATOR Angela Prudhomme 1-6471	VIEWS NO 00076838	DATE 07/09/2018	DATE DUE 07/12/2018
NAME OF EXECUTIVE SECRETARY STAFF Katie Dugan	SUBJECT Draft Response to QFRs from March 21 SVAC Hearing on VA's FY 2019 Budget		

ROUTING	INITIALS	DATE	COMMENTS
☒ EXEC SEC	MW	7/9/18	
☐ SENIOR ADVISOR			
☒ DEPCOSVA	CS	7/10/18	
☒ COSVA	[illegible]	7/10/18	
☐ DEPSECVA			
☒ SECVA			

CONCURRENCE

BVA/ 01 - Cheryl Mason 4/25, OALC/003 – Stella Fiotes 5/10, OTGR/075F – Stephanie Birdwell 5/29, OAEM/044 – Jim Sullivan 5/31, VBA/20 – Brandy Terrell 6/1, OCLA/009 – David Balland 6/18, OGC/02 – Susan Blauert 6/25 OM/041 – Laura Duke 7/6, VHA/10 – Lisa Pape 7/6.

EXECUTIVE SUMMARY

Purpose - Discussion - Recommendation

Purpose: To obtain OSVA approval of proposed VA responses to SVAC Budget QFRs.

Discussion:

- Attached are the proposed responses to the QFRs submitted by SVAC from the March 21 hearing on VA's FY 2019 Budget.
- There are 16 QFRs. Draft responses were provided by subject matter experts within BVA, VBA, VHA, OALC, OM, and OTGR and cleared by the respective Administrations and staff offices.
- Responses were initially due to SVAC on June 1. However, we requested additional time and were granted an extension. Responses are now due to the Committee on **NLT July 20, 2018.**
- Please review and clear for submission to OMB on or before July 12.

Recommendation: Approve proposed QFR responses for submission to OMB.