

**Questions for the Record of a Hearing
Regarding Pending Legislation
Committee on Veterans' Affairs
United States Senate**

August 1, 2018

Question from Senator John Boozman

QUESTION 1: I want to thank the VA for your foresight and leadership on S. 769, The Medicare Access to Radiology Care Act of 2017, to require Medicare to recognize RAs. The VA has indicated that they are in the process of authorizing Radiology Assistants at the VA to align Medicare requirements with state requirements. Will you provide a status update for this effort and your sense as to when this process will be completed?

VA Response: The Department of Veterans Affairs (VA) Office of Human Resources and Administration (HRA) is in the process of establishing a new qualification standard for the Registered Radiologist Assistant. Currently, the qualification standard is in the final stages of concurrence for approval and publication. The qualification standard provides that a Registered Radiologist Assistant practices under the direction and supervision of a physician. HRA is working towards having this qualification standard completed by November 2018.

Question from Senator Sherrod Brown

QUESTION 2: I am very happy the Committee will review two different pieces of legislation to address the needs of active duty servicemembers as they transition to civilian life. We need to do everything we can to ensure that they have the information and tools that they need to succeed. Additional days of training to pursue education, technical training, or entrepreneurship will help to set servicemembers up for good paying jobs when they reenter civilian life and I was pleased that this year's NDAA included a version of this provision in the final conference report. Under Secretary Lawrence, in your testimony, you say we need to do more to communicate with veterans after they transition because rapid identification of risk from transition does not present until much later. Are you referring to the VFW's suggestion that TAP programs should be offered to veterans once they have reintegrated in their communities? Are you referring to risk for medical/ mental issues, unemployment? Walk me through what you mean by that.

VA Response: VA agrees with our Veterans Service Organization partners that consideration must be given to assist transitioning Servicemembers to identify and

connect with resources within their new civilian communities – wherever they choose to live. However, VA is not referring to offering Transition Assistance Programs (TAP) to Veterans once they have reintegrated into their communities. To that end, VA and its TAP interagency partners are currently developing a Military Life Cycle module that will introduce transitioning Servicemembers to resources located in their civilian communities and inform them on how to connect with those resources. VA will complete development of this module by December 2018 and will be ready to pilot in coordination with the Department of Defense (DoD) and the military services beginning in January 2019.

Moreover, with regard to Servicemembers who are at-risk for challenges during their transition, VA and its TAP interagency partners recognize the need to be available during the entire transition to civilian life. As such, we are working to implement Executive Order 13822, “Supporting Our Veterans During Their Transition from Uniformed Service to Civilian Life,” to ensure these at-risk transitioning Servicemembers are identified and receive a warm handover to the support they need. However, VA notes that the signs and symptoms associated with these areas of risk do not always appear or begin until after transition from military service. The delayed onset of symptoms presents challenges for VA and other agencies, as there are times when the Government does not have regular contact with the transitioning Servicemember/Veteran.

In keeping with our enduring commitment to those who have worn the uniform, VA and its Federal partners have developed a Joint Action Plan which, when fully implemented by July 2019, will improve our ability to provide a seamless handoff to VA and ensure early and consistent contact with Veterans to keep them informed of access to peer support, availability of mental health care after separation, and eligibility for health care and VA benefits.

Questions from Senator Joe Manchin

QUESTION 3: In your testimony on S. 1592 VA Financial Accountability Act of 2017, you stated an independent review of VA financial processes would be redundant and that the VA’s Enrollee Health Care Projection Model (EHCPM) has been extensively reviewed. The two reports you cited, a GAO report and a report by The RAND Corporation are from 2008 and 2011 however, i.e. well before the VA Choice Program was enacted. One of the conclusions of the 2008 RAND report was that the EHCPM model could yield misleading results, especially in a changing policy and budgetary environment.

Question 3a: Has the EHCPM been updated to model the changing demand for healthcare obtained outside of the VA system through Choice and other community care initiatives?

VA Response: Yes. The 2016 Enrollee Health Care Projection Model (EHCPM) that informed the 2019 President's Budget was enhanced to differentiate health care provided in VA facilities and care purchased in the community. Key enhancements included developing unit costs that reflect what VA is expected to pay for purchased care and differentiating reliance and other assumptions in the EHCPM by location of care.

The EHCPM has been enhanced to model changes in Veteran demand for VA health care recognizing that greater access to care in the community closer to the enrollee's home is expected to increase enrollee reliance on VA health care and the proportion of that care expected to be met outside of the VA system through community care. Since enrollees currently rely on VA for less than 40 percent of their health care, small changes in reliance can have a significant impact on expenditure requirements.

The total enrollee demand for VA health care projected by the EHCPM can be reported separately for care expected to be provided in VA facilities and expected to be purchased in the community. However, the proportion of total care that will be provided in VA facilities and purchased in the community can vary significantly depending upon eligibility criteria, operational guidelines, and resource availability.

Question 3b: Has EHCPM been reviewed, by an independent body, since the VA Choice program was enacted?

VA Response: The EHCPM has been reviewed extensively by independent stakeholders, including the Office of Management and Budget, Congressional staff, the Congressional Budget Office, and the Government Accountability Office (GAO). GAO, which reviewed the EHCPM in 2011, is currently reviewing the EHCPM as part their review of the VA Community Care Budget (GAO Report 102732). VA is providing extensive information on the enhancements to the EHCPM in order to differentiate health care provided in VA facilities and purchased in the community and will address any recommendations included in GAO's final report.

Question 3c: Given the sweeping reforms that are part of the VA MISSION Act doesn't make sense to have a new, independent review of the VA's cost projection models?

VA Response: Please see response to Question 3b.

QUESTION 4: In your testimony, you state that the Blue Water Navy bill would add significantly to the number of benefit claims pending over 125 days and additional employees would have to be hired to handle the case load. How many people would you need to hire if the bill passed into law?

VA Response: The Veterans Benefits Administration (VBA) would require an additional 803 full-time employees (FTE) for 2019 to successfully and timely address any new reviews and claims that would be a result of the bill passing into law.

QUESTION 5: In the introduction of the 2011 Institute of Medicine (IOM) report on Blue Water Navy, they say the following in the introduction: “The committee was surprised and disheartened to find a dearth of information on environmental concentrations of TCDD during the Vietnam War, in spite of large volumes of Agent Orange sprayed throughout South Vietnam. Such information is vital to determining possible exposures not only of Navy veterans but also veterans who served on the ground and on the land waterways of Vietnam.” Can you elaborate on ways the Department of Defense and Department of Veterans Affairs have improved service record keeping and transfers of information so that they accurately reflect possible toxic exposures while in service?

VA Response: VA defers to DoD for a full description of initiatives and efforts to improve recordkeeping of military exposure events. However, VA and DoD work closely to identify situations where Servicemembers may be at risk. The Deployment Health Working Group, comprised of both DoD and VA officials, meets monthly to discuss ongoing and emerging environmental issues and oversees development of initiatives to improve interagency sharing of vital information.

The Individual Longitudinal Exposure Record (ILER) is an example of an ongoing joint enterprise initiative between DoD and VA. The purpose of this initiative is to establish a complete record of every Servicemember’s exposure over the course of his or her career. ILER will provide a real-time, long-term exposure record matched to health status and matched to a Servicemember to a place, time, location, and event.

Question from Senator Mazie Hirono

QUESTION 6: Dr. Lawrence, you state in your testimony that increasing the amount of DIC benefits payment will help survivors continue to live a sustainable life, which I wholeheartedly agree with. Are there any other programs under your purview which need a fresh look at changing the formula for calculating payments similar to how S. 1990 does for DIC payments?

VA Response: Yes, the VA legislative proposals published in the Fiscal Year 2019 President’s Budget address identified areas for improvement in how VA calculates and provides benefits, including proposals pertaining to: (1) the reissuance of VA benefit payments to all victims of fiduciary misuse; and (2) the removal of annual income from net worth calculations for pension benefits.