

Questions for the Record
Committee on Veterans' Affairs
U.S. Department of Veterans' Affairs (VA) Budget Request for Fiscal Year 2019
February 15, 2018

Questions from Ranking Member Tim Walz

Question 1: One of VA's priorities for 2018/2019 is to "Focus Resources" by implementing reforms that will prioritize foundational services while redirecting to the private sector those services that can be done more effectively and efficiently. (VHA)

Question 1a: What type of reforms does VA hope to execute?

VA Response: VA will continue to assure the full array of services in the medical benefits package remain available to all enrolled Veterans. No aspect of the implementation of this priority will reduce the scope of services made available through a high performing integrated network. VA's community care program will complement and support VA's internal capacity for the direct delivery of care, with an emphasis within VA on the following foundational services:

- Primary care, including women's health;
- Urgent care;
- Mental health care;
- Geriatrics and extended care;
- Rehabilitation, to include spinal cord, brain injury/polytrauma, prosthesis/orthosis and rehab for the blind;
- Post deployment health care; and
- War-related illness and Injury Study Centers functions.

Question 1b: How will VA determine the effectiveness or efficiency of the private sector compared to the VHA?

VA Response: VA has developed a nationwide methodology that will empower Veterans Integrated Service Network (VISN) and VA Medical Center (VAMC) leaders to determine which non-foundational services would be best delivered by community partners. Using the methodology VISN and VAMC leaders will primarily consider:

- Expertise, and/or access to care is available in the local market;
- High quality, patient-centered, safe options exist in the local market;
- Facility operational efficiency may be gained by purchasing in the local market;
- Whether Military-specific cultural sensitivity is required for the service;
- Impact on all of VA's 4 missions including graduate medical education, medical research and assistance in times of national emergency.

Determinations whether to authorize care in the community for a particular Veteran will also be made in accordance with applicable community care authorities.

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Question 1c: What type of services does VA expect to send to the private sector?

VA Response: Because VISN and VAMC leaders will make decisions regarding which services will be offered by community partners and because such determinations are also governed by applicable community care authorities, there is no exclusive listing of services. However, VA does anticipate many specialty non-physician services will be more efficiently provided by partners in the community. These services might include:

- Acupuncture;
- Audiology;
- Chiropractic Care;
- Optical Care;
- Podiatry; and
- Speech Pathology.

Question 1d: How will this impact VHA's other statutory mission such as medical research and graduate medical education?

VA Response: A prioritization of VA resources towards foundational services will have predictable as well as second order effects on both current and planned medical research and graduate medical education activities. The precise effects of a resource reallocation are unknown at this time.

Question 2: In the FY19 budget proposal VISN leaders are being asked to assess additional, community options for "other health services that are important to Veterans."

Question 2a: Are these "other health services" inclusive of the previous VA foundational services?

VA Response: The foundational services focus on standard health care needs, with an emphasis on supportive services that address the unique needs of our Nation's Veterans. As indicated in previous answers, these services include:

- Primary care, including women's health;
- Urgent care;
- Mental health care;
- Geriatrics and extended care;
- Rehabilitation, to include spinal cord, brain injury/polytrauma, prosthesis/orthosis and rehab for the blind;
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“Other health services” and programs that are important to Veterans include:

- Acupuncture;
- Audiology;
- Chiropractic Care;
- Optical Care;
- Podiatry;
- Speech Pathology;
- Health care for homeless Veterans; and
- Veterans Resource Centers.

Question 2b: How will VA ensure foundational services continue to be delivered by VHA? (VHA)

VA Response: The national methodology that has been developed places a strong emphasis on maintaining VA provided foundational services.

Question 3: In January of this year, VA revised regulations concerning payment or reimbursement for emergency treatment for non-service-connected conditions. How much does VA plan to spend on for this in FY19 and FY20? Have these estimates been included in the FY19 and FY20 requests?

VA Response: In Fiscal Year (FY) 2019, the projected expenditures for claim payments as a result of this regulatory action is estimated to range from a low estimate of \$21 million to a high estimate of \$45.9 million. In FY 2020, expenditures are estimated to range from a low estimate of \$25.9 million to a high estimate of \$48.1 million. There was no allocation of expenditures for implementing regulatory action AQ08, Reimbursement for Emergency Treatment, in VA's FY 2019 and FY 2020 budget. Funding will come out of the medical community care budget.

Question 4: The explanation given for the need to merge the Medical Community Care and Medical Services accounts was that the delivery of healthcare is dynamic due to hiring and departures or emergencies such as the recent hurricanes. However, processes such as succession planning and emergency preparedness training and preparation that could be properly utilized to meet these dynamic needs. Has VA looked at succession planning and emergency preparedness as a way to plan and ensure it has the flexibility at the local facility level?

VA Response: The Budget proposes to merge the Medical Community Care and Medical Services accounts to allow provide greater funding flexibility to Medical Center Directors, so that they may expediently address care-related issues for Veterans.

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The Veterans Health Administration's (VHA) Office of Emergency Management (OEM) employs approximately 75 Emergency Management professionals across the nation to provide emergency management services (including risk analysis and succession planning) to 170 VAMCs. The organization takes numerous measures to ensure checks and balances are in place for emergency preparedness and succession planning. OEM provides technical assistance and consulting to VA medical facilities regarding all measures of emergency management, including succession planning.

VA chiefly utilizes three methods to validate that succession planning procedures and emergency preparedness activities are in place for medical facilities: the Joint Commission accreditation surveys, VHA's Disaster Emergency Medical Personnel System (DEMPS) and VHA's Emergency Management Capabilities Assessment Program (EMCAP).

The Joint Commission accreditation survey: Medical facilities maintain emergency preparedness and succession planning standards through a Joint Commission accreditation survey. This survey occurs every three years for each medical facility, using metrics based on Joint Commission Emergency Management Standards^[1] EM.01.01.01 and EM.02.01.01 EP 12. Through the Joint Commission Emergency Management EM.01.01.01 standard, facilities are required to document and analyze potential risks, to prepare for emergencies. This standard states: "For ambulatory surgical centers that elect to use The Joint Commission deemed status option and for rural health clinics and federally qualified health centers: The Emergency Management Plan includes documentation of potential risks in the community that could impact the organization's ability to provide care for its patients." Through the Joint Commission Emergency Management EM.02.01.01, EP 12 standard, facilities document and prepare for succession planning. This standard states, in relevant part: "For ambulatory surgical centers that elect to use The Joint Commission deemed status option and for rural health clinics and federally qualified health centers: The Emergency Management Plan includes a continuity of operations strategy that covers the following: "A succession plan that lists who replaces the key leader(s) during an emergency if the leader is not available to carry out his or her duties."

DEMPS: DEMPS is VHA's main deployment program for clinical and non-clinical staff. The DEMPS Program may be used for an internal VA mission, as well as supporting a mission after a Presidential Disaster Declaration under the National Response Framework's Emergency Support Function #8 (Public Health and Medical Services). Generally, DEMPS requests are for medical personnel (nurses, physicians, pharmacists, etc.), pharmaceutical (or other medical) supplies, and medical equipment. However, depending on the mission, VHA may deploy non-clinical staff to support the infrastructure of the deployment.

^[1] https://www.jointcommission.org/assets/1/6/Prepub_AHC_EM_Revisions_20171018.pdf

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EMCAP: The mission of the EMCAP program is to “evaluate the comprehensive emergency management programs at VA medical facilities to ensure resiliency and continuity of mission essential functions to deliver health care service to VA Patients.” EMCAP provides VA a gap analysis regarding a facility’s adherence to current National, VA and VHA emergency management requirements. EMCAP informs facility leadership of potential accreditation shortfalls within the emergency management discipline, which includes succession planning. From FY 2015 to FY 2017, EMCAP assessed 78 out of 170 facilities, and continues to evaluate facilities in FY 2018. The VHA EMCAP program is part of the Comprehensive Emergency Management Program implemented through VHA Directive 0320.01.

Question 5: VA is implementing a VISN-level Gap Coverage plan that will enable facilities to request gap coverage providers in areas that are struggling with staffing shortages.

Question 5a: When does VA expect this Gap Coverage plan to be fully implemented and available VHA-wide?

VA Response: In the first phase, VISNs 16 and 20 are integrating the Gap Coverage program for the purposes of rapidly filling vacancies in primary care, mental health and clinical pharmacy services. In subsequent phases, additional VISNs are expected to participate as their telehealth capacity grows. By 2020, the goal is for each VISN to have a telehealth hub at which time full implementation of Gap Coverage is expected. Currently, newly established tele-primary hubs are building the capability to engage with Gap Coverage in their VISN to ensure timely integration.

Question 5b: How will VA ensure Medical Centers and Clinics continue to seek full staffing levels while utilizing this new Gap Coverage plan?

VA Response: Monitoring will be done by local facility self-reporting and PCMM Web with oversight of the VHA Office of Primary Care. Medical centers will continue recruitment efforts using all available incentives while care is provided through Gap Coverage.

Question 5c: How does VA know it has the correct mix and number of professional medical and support staff at VA hospitals?

VA Response: VAMCs use a combination of tools to ensure the correct mix of staff. These tools include guidance for Patient Aligned Care Team models, Workforce Succession plans, Facility Staff Ratio Tools, and Resource Management Committees. Resource Management Committees evaluate and manage clinical and administrative staff levels. The committees are also responsible for succession planning to ensure continuous coverage of critical staff areas.

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Question 6: In the interim report on the DC VAMC, it was noted that the facility did not have the proper number of staff working at the hospital in Sterile Processing and Inventory Management.

Question 6a: If such basic functions are chronically understaffed in a hospital, how can VA expect the hospital to function properly and provide veterans with high quality cost effective medical care?

VA Response: VA is making system-wide improvements to address and remediate failures on a number of levels that were outlined in the Inspector General Report. Immediately following the publication of the Office of Inspector General's full report on the DC VAMC in March 2018, VA initiated an immediate hiring and staffing review at every facility to help correct and prevent similar problems, including tasking independent healthcare management experts to begin making unannounced on-site audits at VA facilities, conduct VA-wide staffing reviews, restructure logistics to centralize accountability, and establish new control and oversight for medical center performance, including at VA Central Office.

Question 7: What is the decision making process for filling vacancies at VA hospitals?

VA Response: Each facility identifies their own hiring needs and prioritizes vacancies based on Veteran demand for services, VA and Joint Commission staffing directives, and other criteria such as the availability of care in the community.

Question 7a: Does VA have a minimum staffing requirement for each position at each hospital?

VA Response: No. However, there are minimum staffing levels for clinical areas and if staffing levels do not meet the minimum threshold, VA would be unable to safely provide services. VHA has had long-standing staffing models for primary care, mental health, nursing, pharmacy, laboratory services and other clinical care services. In a complex healthcare environment, there are many options for staffing departments and providing care, including utilizing fee basis care and care in the community. Each facility must retain the flexibility to staff operations as needed in order to operate as efficiently as possible (e.g. telehealth, provider agreements, or consolidation of services). VA continuously monitors staffing levels, workload, and provider productivity to ensure the Veteran is being served.

Question 7b: Why do some VA hospitals not have enough janitors or supply techs or dental techs?

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VA Response: In some locations, VA does face challenges recruiting for entry level and support positions, especially in high cost of living areas. Normal attrition for some of these occupations with large numbers of employees such as custodians and medical support assistants results in an expected, continuous vacancy and recruitment cycle.

Question 8: Given the availability and use of CHOICE, what guidance has VA provided to VA facilities to adjust their staffing so that medical care is cost effectively provided at the VA and through CHOICE?

VA Response: Each facility provides oversight of staffing. Facility leadership has the authority to adjust staffing based on the demand for services from their Veteran population.

Question 9: In areas where there are few providers and few CHOICE providers, what strategies has VA employed to improve access to high demand specialists apart from telemedicine?

VA Response: Facilities contract with community providers to the greatest extent possible and may recruit for Advanced Practice Registered Nurses in lieu of Physicians. Veterans may also be referred to another VA facility that can provide the health care.

Question 10: Given the modest size of veteran populations near many rural VA hospitals and clinics, is it time to permit VA specialists to provide care to non-VA patients, thus providing the demand (VA and Non VA) for the providers that both VA and the community lack locally?

VA Response: VA and non-VA health care systems face the same provider shortages and hiring challenges in rural America. There are opportunities for VA to continue collaborations with providers that serve Veterans and non-Veterans, thereby optimizing the use of scarce health care specialists, particularly in rural areas. To facilitate these collaborations, and provide greater reach into rural communities for the delivery of care, VHA is working with the Health Resources and Services Administration (HRSA) on *Advancing Telehealth through Local Access Stations (ATLAS)*, which will allow VA providers to treat Veterans at community facilities using telehealth, and also enable community providers to treat non-VA patients **and** Veterans using that same equipment. In addition, the MISSION act provides a platform for community providers to treat a greater number of VA patients.

Question 11: How does a VA hospital measure whether it has the human resources, on both the clinical and business side of the hospital, to ensure the provision of quality healthcare?

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VA Response: The accepted industry approach for addressing staffing needs is to compare staffing against workload using benchmarks internal to the organization. VA accomplishes that using its extensive data systems. VHA maintains a comprehensive database of the provider workforce with near real-time reporting (by pay period) of staffing levels, clinical workload, and productivity by specialty and practice setting. This database, referred to as the Provider Productivity and Staffing Cubes, provides detailed information about the staffing levels and clinical workload for each VAMC. VHA uses an industry accepted metric of a work relative value unit (wRVU) to measure provider productivity (clinical work per provider). Provider clinical workload, measured in wRVUs, adjusts for the differences in time, intensity, and complexity of medical services. This provides an analytic tool designed to assist VHA managers and leadership in effectively managing their specialty provider practices towards the ultimate goal of ready access to quality specialty services. VHA tracks specialty care practice and provider level productivity performance for 30+ areas of specialization (e.g. Psychiatrists) and a current provider workforce representing over 35,000 FTE (*FY2017 Physicians (MD, DO), Chiropractors, Optometrists, Podiatrists, Psychologists, Nurse Practitioners, Clinical Nurse Specialists, and Physician Assistants*). This database serves as the foundation to assess VHA's Provider Capacity given specialty specific productivity expectations taking into consideration the practice infrastructure; the practice setting (Medical Center Complexity Group); and support staff ratios. Provider capacity monitoring is included in the Strategic Analytics for Improvement and Learning performance system.

VA assesses the administrative infrastructure with an Administrative Staffing Model, which assesses staffing levels for the Budget Object Code of 1001 "Administrative Personnel" as well as Title 38 Personnel working in Administrative functions. The Administrative Staffing Model adjusts for important Medical Center and patient characteristics such as the complexity or risk of the patient population. The Administrative Staffing model provides a tool for VISNs and facilities to understand variation in staffing levels – both high and low staffing patterns are identified. The goal of this model and framework is to correct administrative staffing levels so as to not create inefficiency with large administrative overhead or critically understaff necessary administrative functions.

Question 12: Should VA identify and publish minimum staffing requirements for each hospital?

VA Response: VA believes that a more integrated approach to staffing is required and that minimum staffing levels would not achieve the goals of improved access to care. There are known approaches to model staffing requirements; however, there is no consensus on a definitive methodology or technique. Recent literature suggests an integrated approach that combines elements of supply and demand with that of benchmarking, which is exactly the approach we have described in our response to

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Question 11. VHA maintains a Provider Workforce Report that includes these integrated elements. The Provider Workforce Report delivers system level staffing norms by geographic location (VISN) and Practice Setting (Medical Center Complexity Group). Staffing levels per population (Core Facility Unique Patients and Specialty Specific patients treated) are included in this report as well as provider productivity levels. Additionally, the composition of the care team (Physicians, Advanced Practice Providers and Support Staff levels) are included. This report can be used to determine comparison staffing levels; however, local facility managers must contextualize these data to their potentially unique characteristics such as patient reliance and the ability to recruit and retain a workforce consistent with its mission and infrastructure.

Question 13: Does VA's request for Mental Health Care include funds for the creation and implementation of the VA/DoD Joint Action Plan to provide access to mental health treatment to transitioning uniformed Servicemembers?

VA Response: VA estimates as much as \$100 million from VA's existing budget will be used to support implementation of Executive Order (EO) 13822 in FY 2018. This includes the Joint Action Plan required by the EO, and realigns funds to support suicide prevention as one VA's core priorities. Not all of the mental health services provided to transitioning Servicemembers and Veterans as a result of the EO will be high-cost services. In FY 2019, VA anticipates covering the cost of care associated with the implementation of the VA/DoD Joint Action Plan from within existing resources. Future program needs and sustainment costs that remain unfunded beyond FY 2019 will be requested at that time.

Question 13a: If not, how does VA plan to fund this expansion?

VA Response: See above.

Question 13b: How does VA plan to implement this Executive Order?

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

Question 13c: Will veterans be enrolled in the VA health care system on a temporary basis? What happens after the one year is over?

VA Response: The EO focuses on the first year following a Servicemember's or Veteran's transition from military service. However, mental health care for eligible former Servicemembers and Veterans through VA is not time-limited so long as the individual remains eligible for such care. The EO did not change or affect VA's underlying authorities to provide mental health care.

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Question 13d: Will they be dis-enrolled?

VA Response: Mental health care for eligible former Servicemembers and Veterans through VA is not time-limited so long as the individual remains eligible for such care.

Question 13e: What would happen to their treatment plans and the relationships they veterans with their VA providers?

VA Response: The Executive Order focuses on the first year following a Servicemember's or Veteran's transition from military service. However, mental health care for eligible former Servicemembers and Veterans through VA is not time-limited so long as the individual remains eligible for such care. The Executive Order did not change or affect VA's underlying authorities to provide mental health care.

Question 14: VA has removed, demoted, or suspended for longer than 14 days approximately 220 employees since the beginning of January 2018. However, nearly a quarter (approximately 23%) of these disciplinary actions were taken against Housekeeping Aides - and when we add in Laundry and Food Service Workers the number rises to almost a third (approximately 30%).

Question 14a: What actions is VA taking to ensure that support personnel such as Housekeeping and Food Service are not disproportionately targeted?

VA Response: Distinct termination rates were tabulated for the custodial, laundry, and food service occupations. Terminations include resignations and retirements in lieu of termination, but exclude other losses to military, transfers, or expired appointments. These occupations have seen small increases in the last two fiscal years. Averaging across these occupations, there was a small increase between FY 2016 and FY 2017 of .89% (less than a one percent increase). These occupations have historically experienced higher termination rates compared to other occupations. The increase in termination rates for these occupations was compared to occupations that experienced similar terminations rates in FY17 (between 2 percent and 5 percent; e.g. laboring, information receptionist, office automation/clerical assistant). The increase in termination rates for custodial, laundry, and food service occupations were actually lower than the increase seen in other high termination rate occupations (.72 percent increase vs. .86 percent increase between FY 2016 and FY 2017). Based on the analysis conducted, termination rates for these occupations are comparable to other similar occupations, and the enactment of the Accountability Act has not unfavorably targeted these occupations.

Occupation	Measure	FY 2015	FY 2016	FY 2017	FY 2018 thru 6/30/18
3566 Custodial Worker	Onboard Average	11,206.8	11,455.1	11,660.4	
	Total Loss Rate	15.67%	16.09%	16.80%	
	Distinct Termination Numerator	410	430	540	465

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	Distinct Termination Rate	3.66%	3.75%	4.63%	
7304 Laundry Worker	Onboard Average	693.1	710.1	707.3	
	Total Loss Rate	11.98%	13.38%	16.26%	
	Distinct Termination Numerator	20	25	28	12
	Distinct Termination Rate	2.89%	3.52%	3.96%	
7408 Food Service Worker	Onboard Average	4,818.8	4,858.3	4,914.3	
	Total Loss Rate	15.25%	14.96%	14.49%	
	Distinct Termination Numerator	168	171	222	198
	Distinct Termination Rate	3.49%	3.52%	4.52%	
Custodial Worker, Laundry Worker, & Food Service Worker	Onboard Average	16,718.8	17,023.5	17,282.1	
	Total Loss Rate	15.39%	15.65%	16.11%	
	Distinct Termination Numerator	598	626	789	675
	Distinct Termination Rate	3.58%	3.68%	4.57%	
Other High Termination Occupations	Onboard Average	4,261.1	4,379.6	4,700.5	
	Total Loss Rate	13.87%	15.18%	14.89%	
	Distinct Termination Numerator	99	76	125	79
	Distinct Termination Rate	2.32%	1.74%	2.66%	
All VHA Occupations	Onboard Average	305,657.0	317,558.9	325,800.1	
	Total Loss Rate	9.33%	9.39%	9.16%	
	Distinct Termination Numerator	2,464	2,371	2,856	2,353
	Distinct Termination Rate	0.81%	0.75%	0.88%	
All VHA Occupations excluding Custodial, Laundry & Food Service Worker	Onboard Average	288,938.3	300,535.4	308,518.1	
	Total Loss Rate	8.98%	9.04%	8.77%	
	Distinct Termination Numerator	1,866	1,745	2,066	1,678
	Distinct Termination Rate	0.65%	0.58%	0.67%	

Question 15: In the VA Secretary's testimony and in the FY19 budget submissions it mentions that VA has implemented an initiative to detect and prevent fraud, waste, and abuse (STOP FWA). In December 2017 OIG estimated that the Office of Community Care (OCC) made \$39 million in overpayments to TPAs.

Question 15a: Has VA recovered this amount?

VA Response: This amount has not yet been recovered as VA is currently working closely with the VA OIG, VA OGC, and all relevant government stakeholders to determine a process to ensure that overpayments identified as part of this audit and all other subsequent audits/reviews that have been performed on Choice payments will be recovered.

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Question 15b: If not, what concrete steps has VA taken to date to recover this \$39 million?

VA Response: As noted above, VA is working closely with many government stakeholders to ensure that Choice payments are reviewed and overpayments are recovered. In addition, VA has taken steps to implement internal processes to improve the accuracy of Choice payments through pre-payment reviews. VHA's Office of Community Care has implemented a pre-payment analytic tool that identifies and prevents potential duplicate payments from being made and, since July 2017, approximately \$35 million in potential overpayments have been prevented. VA's Financial Services Center also processes Choice claims and has implemented pre-payment automated controls to detect and prevent potential overpayments from occurring prior to payment.

Question 16: In 2014, GAO recommended VA identify and implement an IT system to better support the Caregiver Program. In 2017, VA alleges that this recommendation cannot be closed because the project "lacks the funding needed for a contract extension to complete the work."

Question 16a: Does VA's FY19 request include funding to cover the identification and implementation of an IT system that can comprehensively monitor and support Caregiver Program participants and workload?

VA Response: The identification and implementation of an IT system to comprehensively monitor and support the Program of Comprehensive Assistance for Family Caregivers is projected to be in place through the utilization of FY 2017 and FY 2018 development funds. At that point, FY 2019 sustainment funding is planned to allow the updated system to continue operating smoothly. However, any legislative change expanding eligibility for the Program of Comprehensive Assistance for Family Caregivers would result in additional funding needs for the IT system.

Question 16b: When does VA expect to close GAO's recommendation?

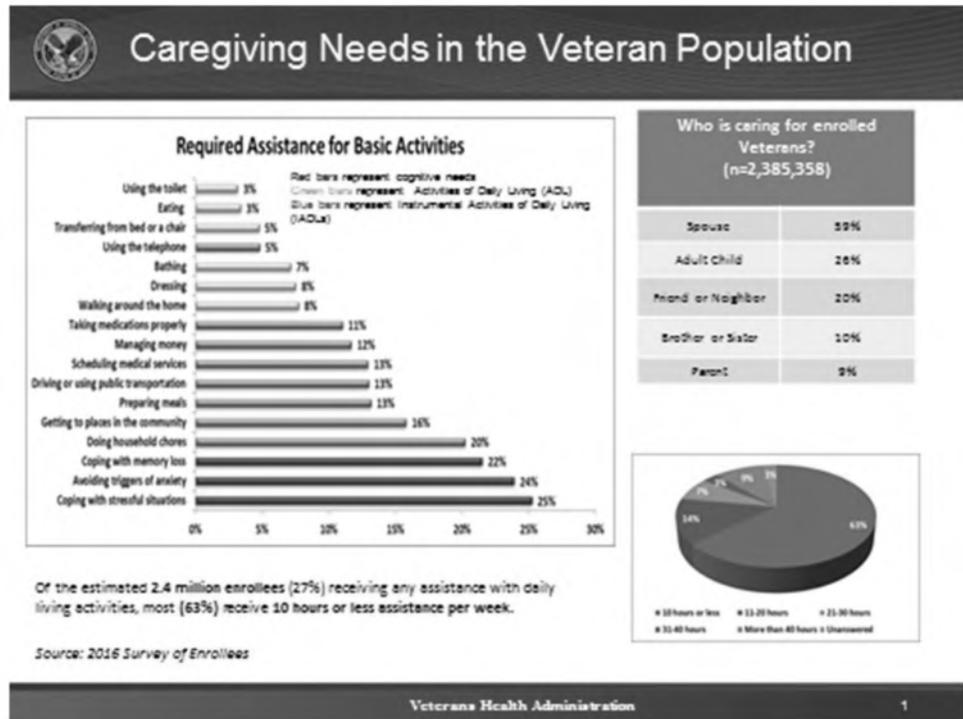
VA Response: The deployment of Care T v1.0 is expected in the fall of 2018. VA will defer to GAO on when the recommendation will be closed thereafter.

Question 17: Has VA received findings from Survey of Veteran Enrollees' Health and Use of Health Care Survey from 2016? If so, please discuss how these findings will impact the Caregiver Program. If not, when does VA expect to receive the findings?

VA Response: The slide below provides an overview of Veterans who require assistance from a family member, friend, or neighbor, within the Veteran population who

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are enrolled in VHA, from the 2016 Survey of Veteran Enrollees' Health and Use of Health Care Survey. Findings provide valuable information concerning the types of activities Veterans identify as being in most need of assistance. It is noteworthy that the top three activities represent assistance with cognitive needs. These findings will assist VA in developing new trainings and programs for family caregivers. They will also be used as data points as discussions about expansion of the Program of Comprehensive Assistance for Family Caregivers continue.



Question 18: VA has submitted a legislative proposal to raise the cap on minor construction projects from \$10 million to \$20 million to increase VA's flexibility in undertaking projects to improve medical facilities. However, local medical facility officials' history of mismanaging minor construction projects, as documented in VA IG reports, raises concerns about their ability to take on even larger projects. For example, in 2017 the IG reported that plans for a \$9.7 million parking garage were reduced from 425 spaces to 25 spaces before the project was cancelled.

Question 18a: What assurance can VA give this Committee that it has made improvements to its minor construction program so as to avoid delays, cost increases and possible anti-deficiency violations?

VA Response: The proposed increase in the construction threshold as referenced will provide flexibility as well as improved execution and management of VHA Minor Construction Projects. The increased threshold will eliminate the need to phase project

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requirements over multiple projects and multiple contract awards over many years to achieve the desired end-state delivery of the requirement. It will enable VHA to deliver these projects faster for delivery of healthcare services to our Nation's Veterans and at a lesser total cost to taxpayers. In order to better manage the execution of these high value/high complexity projects as well as all VHA Non-Recurring Maintenance (NRM) and Minor Construction projects, VHA has already instituted a quarterly review of all active NRM and Minor Construction projects on current FY operating plans, to provide oversight and monitor the acquisition schedule and obligation of contract awards. Annual operating plans for the NRM and Minor Construction Programs are also developed and communicated to the field early. This helps facilitate an earlier completion of the requirements development, acquisition process, and contract award.

VHA is also updating its project prioritization and tracking data, to help facilitate earlier detection of schedule and cost issues, when they arise on approved construction projects. Additionally, VHA will be instituting a project execution risk mitigation process for the more complex projects, to help assure that the overall project execution plan is sound, and complies with the NRM or Minor Construction program policy. And lastly, VHA will utilize appropriate acquisition strategies to assure timely contract awards such as use of Indefinite Delivery/Indefinite Quantity contracts for technical services and Multiple Award Task Order Contracts for construction services, expanded use of Two-Step Design-Build Contracts on appropriate projects. VA also plans to conduct market research, to help identify the best possible firms for technical services and construction services.

Questions from Congresswoman Julia Brownley

Question 1: When can we expect a rule from VA for veterans with reproductive injuries looking to pursue adoption? We authorized the VA to facilitate this service in September 2016.

VA Response: VA covers In Vitro Fertilization (IVF) for certain eligible Veterans and their non-Veteran spouse. VA has nearly finished the needed regulations for adoption reimbursements.

Question 2: Does the VA still believe that its authority to provide IVF and adoption services only lasts until September 2018?

VA Response: Yes, VA believes this authority only lasts until September 30, 2018.

Question 3: How many veterans and spouses are currently undergoing fertility treatment paid for by the VA?

VA Response: As of February 22, 2018, 168 Veterans and their spouses have been referred for IVF treatment.

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Question 4: Under current law, if a VA-appointed fiduciary misuses or steals a veteran's benefits, the VA has the power to remove the fiduciary. However, the VA can only reissue the lost benefits to the veteran if their fiduciary manages VA benefits for at least nine other veterans. The VA budget calls for this to be fixed. Does VA believe it can implement this change on its own, or do we need to pass legislation such as the Protect Veterans from Financial Fraud Act first?

VA Response: Under current 38 United States Code (U.S.C.) § 6107, VA has authority to reissue misused benefits when VA is negligent in administering aspects of the fiduciary program or, without regard to negligence, when the fiduciary is an entity that provides fiduciary services for one or more beneficiaries or an individual who provides fiduciary services for 10 or more beneficiaries. Without a finding of VA negligence, VA cannot reissue lost benefits to all victims of misuse unless Congress amends current 38 U.S.C. § 6107(b). Congress enacted 38 U.S.C. § 6107; therefore, any changes that will allow VA to reissue misuse benefits to all will require an act of Congress. With such an amendment to 38 U.S.C. § 6107, VA can reissue misused benefits to all victims of misuse. VA does not need any additional legislation to extend its reissuance authority to allow the reissuance of benefits to a beneficiary in cases of misuse by individual fiduciaries, who manage benefits for ten or more beneficiaries, without regard to VA negligence in appointing or overseeing such fiduciaries. Currently, VA has procedures in place for the reissuance of benefits to victims of fiduciary misuse, without regard to VA negligence, when the fiduciary is not an individual, or when the fiduciary is an individual who manages benefits for ten or more beneficiaries. With an amendment to 38 U.S.C. § 6107 to reflect that VA will pay the beneficiary or the beneficiary's successor fiduciary an amount equal to the amount of the misused benefits in any case in which a fiduciary misuses a beneficiary's VA benefits without regard to a finding of VA negligence, VA will extend these reissuance procedures to all victims of misuse. The amendment will allow VA to promptly reissue benefits that have been misused, thereby avoiding any financial hardship to beneficiaries caused by the misuse or delays in obtaining restitution or a VA negligence determination. VA will continue to seek to make the Government whole by establishing the fiduciary's debt to the United States in the amount of the misused benefits, or through coordination with VA's Office of Inspector General and other Federal and state agencies to pursue court-ordered restitution or other actions that those agencies deem appropriate.

Question 5: Are you still on track for a December 2018 release of the report mandated under the Female Veteran Suicide Prevention Act, breaking out which VA mental health programs and services work best for female veterans?

VA Response: VA is on track to release the report by December 2018. VA is implementing the requirements of 38 U.S.C. § 1709B, as amended by Public Law 114-188, the Female Veteran Suicide Prevention Act, including participating in a third party evaluation of VA mental health and suicide prevention programs. VA has contracted

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with an independent evaluator to conduct an evaluation of the VA mental health and suicide prevention programs to determine the effectiveness, cost effectiveness and Veteran satisfaction with VA mental health and suicide prevention programs. It is our plan to use the results of this evaluation to improve the mental health care and services VA provides to Veterans.

Questions from Congresswoman Ann McLane Kuster

Question 1: Secretary Shulkin, I am disappointed to see that the only construction project of high priority is the CBOC for Portsmouth, NH. Given the number of problems at the facility, can you explain why only renovations to primary care is listed at #137?

VA Response: The Department's Strategic Capital Investment Process (SCIP) determines long range capital needs and serves as the basis to inform VA's capital budget request. It ensures the highest priority projects across VA's entire portfolio are requested and that the projects address critical need and address performance gaps. Project priority, which is used as the basis for VA's capital request, is based on how well a project meets established VA goals such as improving safety and security, meeting utilization needs, rightsizing space and correcting facility deficiencies across VA's asset portfolio. The Manchester VAMC, the parent station to the Portsmouth Community Based Outpatient Clinic (CBOC), submitted three projects through the 2019 SCIP cycle for funding consideration: 1) a lease renewal and expansion for the Portsmouth CBOC (Primary Care/Mental Health, SCIP ranked #37) was approved and expected to be funded in 2019; 2) an NRM project, to replace the air handling units in the Community Living Center (Bldg 15, SCIP ranked #270), which was approved and included in the 2019 request; and 3) a minor construction project to Expand and Renovate Building 1 for Primary Care (ranked #181), which did not score high enough to be considered for funding in 2019 because it scored poorly on 9 of the 11 enterprise-wide sub-criteria. This project is eligible to re-compete in the 2020 SCIP cycle for funding consideration.

Question 2: I noticed that the vast majority of potential future projects at the facility are listed as non-recurring maintenance (NRM) projects. Can you explain why these projects are not provided as part for FY2019 projects? If Congress appropriates an additional \$4 billion for NRM for FY18 and FY19, can you provide a commitment to me that these projects will be prioritized?

VA Response: The SCIP process helps VA to identify the capital projects needed over a 10-year planning horizon to address infrastructure issues and service gaps across the entire portfolio. A major tenet for projects being submitted in the first year (the budget year) of the planning cycle, is that they must be able to obligate funding in the budget year. For the 2019 SCIP cycle, VHA's 10-year enterprise planning process included approximately 2,911 NRM projects. Of this total number, 422 NRM projects requested funding in FY 2019. VA recognizes the urgency in completing pending NRM projects

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across the country, to help ensure our facilities suitable for providing state-of-the-art care and services for our Nation's Veterans. Should the NRM program receive an additional \$4 billion, the funding would be distributed to NRM projects based on their priority score, as determined by the Department's enterprise-wide needs and their ability to obligate funding.

Question 2a: I am concerned that your budget requests to use half of the \$4 billion for community care projects instead of NRM. It seems that maintenance is an acute problem. Can you explain why you think it is appropriate to change those priorities?

VA Response: Recognizing the substantial needs of VA's aging infrastructure, our FY 2019 request (including major and minor construction and non-recurring maintenance) is \$3.3 billion. Delivery of Veteran Healthcare Services has many competing priorities and we believe that we are striking a reasonable balance among competing priorities.

Question 3: I am additionally concerned that the VA is not accounting for its construction needs with this budget. Does VA believe that their construction budget accounts for needs across the VA? If not, how does VA propose to ensure facilities like Manchester will be able to operate without needed improvements?

VA Response: The FY 2019 \$3.3B capital request is a significant increase over the 2018 request of \$2.7B, which VA will use to help modernize VA's infrastructure system. The FY 2019 request will help VA fix and upgrade facilities, and address projected safety, security, seismic, access and capacity needs.

Question 4: There is concern that your budget requests have ballooning costs for the Community Care program when VA facilities continue to experience deteriorating conditions and often lack facilities that could reduce costs, such as ambulatory surgical centers. Has the Secretary considered prioritizing ambulatory surgical centers to help mitigate wait-times issues across the system, issues experienced with veterans in my state, especially those that go to Manchester?

VA Response: In FY 2017 the Veterans Health Administration Surgery programs consisted of 134 VHA Surgical Programs, of which 110 were Inpatient VHA Surgery Programs and 24 were VHA Ambulatory Surgery Centers. These programs performed 424,290 surgical procedures, of which 76 percent of the surgical procedures were performed on an outpatient (ambulatory or same day basis) 73.1 percent of non-emergent surgical procedures were performed within 30 days of the clinically indicated date and 91.7 percent of non-emergent surgical procedures were performed within 60 days of the clinically indicated date with a median wait time of 16 days.

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Question from Congressman Beto O'Rourke

Question 1: How many outstanding primary care providers are there nationwide at the VA? The VA staff provided us with the number 270 during the hearing; however, both the Congressman and the Secretary agreed this number is low. Please also provide a breakdown of the positions/jobs for which the vacancies exist within primary care.

VA Response: As of July 7, 2018, there were 587 primary care physician vacancies in VHA. VHA is unable to provide a breakdown of all primary care provider vacancies by position. VHA does not have a code, or a series title, indicating that the employee is a primary care physician, in the system. It would require a manual data pull, and even at that time it would be difficult to determine, as a physician may not be full time primary care.

Questions from Congresswoman Kathleen Rice

Question 1: On Monday evening, a document that was posted to VA's website included an amendment to the agency's current 59-year-old motto, a line from President Lincoln's Second Inaugural Address in 1865—"To care for him who shall have borne the battle and for his widow, and his orphan"—changed to read, "To fulfill President Lincoln's promise to care for those 'who shall have borne the battle' and for their families, caregivers, and survivors." According to the Washington Post, this document was removed the next day because VA spokesman Curt Cashour reportedly said that the more inclusive mission statement "is not VA's position."

Question 1a: Who made the final decision to remove this document from the VA website?

VA Response: Former Secretary Shulkin made the decision to remove the document.

Question 1b: Do you believe the motto should be updated to be more inclusive and include women veterans?

VA Response: The Department proudly offers the care and benefits that have been to earned and are deserved by both our Nation's men and women Veterans. The use of "him" is to assume gender neutrality in this historical usage and context. VA is proud of Lincoln's words as a historic tribute to all Veterans, including women Veterans, whose service and sacrifice inspire us all.

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Question 1c: Have you, or anyone else at VA to your knowledge, discussed the issue of changing the motto with anyone in the White House (that is, the Executive Office of the President)?

VA Response: The Department is unaware of any such discussions between former Secretary Shulkin and the White House.

Question 2: Women veterans represent a rapidly growing demographic within VA, and deserve the same level of respect afforded to their fellow male veterans for the tremendous sacrifices they make for our nation. Yet, the VA still fails to fully recognize and support women veterans in its continued use of an exclusionary motto. As Allison Jaslow, the executive director of Iraq and Afghanistan Veterans of America (IAVA), pointed out in her letter sent to you this past October, this motto enshrined at VA's headquarters has also enshrined a culture that too often renders women veterans invisible at the agency, even to this day. The Washington Post reports that Ms. Jaslow has not received a response from your office to this letter. When can she expect a response?

VA Response: The Department's response to Ms. Jaslow was signed January 26, 2018.

Questions from Congressman Gregorio Sablan

Question 1: The Northern Marianas remains the only state or territory without a VA clinic or Vet Center. I understand and appreciate that discussions are underway now to begin Vet Center outreach services in the Marianas, with the goal of establishing a fully-staffed Vet Center that would be able to provide the readjustment counseling, outreach and referral services, and other assistance that veterans in my district presently lack.

Question 1a: Provide the status of plans to stand up a Vet Center, whether a needs assessment will be conducted in the near future, and the timeline for beginning services?

VA Response: VISN 21 and more specifically the VA Pacific Islands Healthcare System operates a partnered VA Clinic on Saipan which includes a .40 Full Time Equivalent Employee (FTEE) Primary Care Physician, 1.0 FTEE Administrative Support Position, and soon a 1.0 FTEE newly recruited licensed social worker. The Veteran population of the Northern Mariana Islands (NMI) is estimated at 650 Veterans (FY 2017), with around 300 Veterans utilizing the VA clinic per year. Based on the number of Veterans, and commensurate with VA primary care panel size evaluation, a .30 primary care provider FTEE would normally be the recommended provider staffing level. Current demand for services has not yet warranted increasing service provision levels. This demand model process begins with focused outreach efforts to determine

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community needs, and then if appropriate, the establishment of regularly scheduled services through a Vet Center Community Access Point (CAP) (using donated space and through the provision of services up to several times a week). As demand warrants, the CAP service delivery hours may increase or decrease. If demand rises, the CAP can become a Vet Center Outstation (permanently assigning at least one counselor) with the approval of the Under Secretary for Health. If demand continues to rise at the Outstation, the creation of a full Vet Center (average 6 employees) can be approved by the VA Secretary. Vet Center staff currently travel to engage with Veterans in the NMI on a quarterly basis through a Vet Center CAP and are exploring tele-mental health options.

Question 2: The lack of VA staff and facilities keeps veterans and their families from accessing important VA services and programs. For example, the Program of Comprehensive Assistance to Family Caregivers is not available to veterans in the Northern Marianas.

Question 2a: What can the VA do under current authorities to resolve the staffing and resource constraints preventing veterans in the Northern Marianas from participating in the Program of Comprehensive Assistance to Family Caregivers and other programs?

VA Response: There are multiple aspects of the Program of Comprehensive Assistance for Family Caregivers that cannot currently be provided to Veterans living in the Commonwealth of the Northern Mariana Islands (CNMI). It's important to note that the Program of Comprehensive Assistance for Family Caregivers is a clinical intervention and program. Under the program, VA staff is required to conduct initial eligibility assessments and ongoing monitoring. In addition, VA is required to provide specific services, including mental health services and respite. Therefore, infrastructure would need to support ongoing delivery of these services.

Question 3: I understand that a candidate for the Licensed Clinical Social Worker position in Saipan has accepted the position and is going through the credentialing process.

Question 3a: What services will the Licensed Clinical Social Worker be providing to Northern Marianas veterans?

VA Response: We are pleased about the recruitment of a licensed VA social worker, now involved in the VA credentialing process, who will be supporting the Saipan VA clinic. The social worker will be working collaboratively with the VA primary care provider and other consultative providers such as mental health to address and facilitate Veterans' needs as part of their prescribed care plans. VA social workers are expert in matching required resources and solutions for Veterans and their families in support of

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care and treatment plans. They are also familiar with many community and non-profit organizations and resources.

Question 3b: The Licensed Clinical Social Worker will be based on Saipan. However, there are veterans living in Rota and Tinian that may need also services. Will the Licensed Clinical Social Worker have the resources to travel to Rota and Tinian to provide services to veterans living in those islands?

VA Response: We are pleased to bring the following information to your attention about efforts to enhance and expand care to CNMI Veterans:

- VA staff visited the CNMI (Tinian, Saipan & Rota) March 5-10, 2018.
- The purpose of the visit was to conduct a needs assessment and gap analysis to determine readiness to provide care in non-VA settings initially through telehealth technology. Project ATLAS is a VA Office of Rural Health and Office of Connected Care funded project that utilizes emerging technologies to provide telehealth care to Veterans in their communities. This program seeks to develop partnership sites within the community, allowing rural and underserved Veterans to receive virtual primary and mental health care within their community.
- VA Pacific Islands Health Care System has successfully implemented comprehensive Telehealth primary care and mental health services in Guam and hopes to build on these successes throughout the Marianas.
- The project ATLAS team has already been in contact with leadership at the Commonwealth Health Center (Saipan), Tinian Health Center, and the Rota Health Center.
- The project ATLAS team has recently conducted successful telehealth test calls with the Rota and Tinian Health Centers.
- Assuming a successful partnership, we hope to be able to provide mental health and primary care services initially, with the addition of other specialty services in the near future.

Question 3c: Will the Licensed Clinical Social Worker be able to provide the services needed to make the Family Caregiver program available to Northern Marianas veterans?

- i. **If yes: How long before the program is up and running?**
- ii. **If no: What other staff is needed, and can VA community providers, under the oversight/supervision of VA staff in Saipan, Guam or Honolulu, fill the gap?**

VA Response: There are multiple aspects of the Program of Comprehensive Assistance for Family Caregivers that cannot currently be provided to Veterans living in

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the CNMI. It's important to note that the Program of Comprehensive Assistance for Family Caregivers is a clinical intervention and program. Under the program, VA staff is required to conduct initial eligibility assessments and ongoing monitoring. In addition, VA is required to provide specific services including mental health services and respite. Therefore, infrastructure would need to support ongoing delivery of these services.

A licensed VA social worker, now involved in the VA credentialing process, will be supporting the Saipan VA clinic. The social worker will be working collaboratively with the VA primary care provider and other consultative providers, such as mental health, to address and facilitate Veterans' needs as part of their prescribed care plans. VA social workers are expert in matching required resources and solutions for Veterans and their families in support of care and treatment plans. They are familiar with many community and non-profit organizations and resources, as well, and work to help Veterans achieve their highest level possible in areas including the activities of daily living.

Question from Congressman Scott Peters

Question 1: Does this budget provide enough resources to pay VA caseworkers who are required to help find housing and social services for veterans eligible for HUD-VASH vouchers?

VA Response: The proposed FY 2019 budget for the Department of Housing and Urban Development – VA Supportive Housing (HUD-VASH) shows a sustained level from FY 2018 Specific Purpose funding in the amount of \$408,300,000 for case management/staffing. This will support the staffing for the FY 2008-2017 voucher allocations, but if there are additional vouchers allocated in FY 2019, then additional case management funding may be needed. Currently, there are approximately 3,750 VA staff working in the HUD-VASH program, as well as 30 contracts awarded with more than 280 staff under them, all supporting case management services for more than 85,000 vouchers. In FY 2018, there will be approximately 5,500 new HUD-VASH vouchers allocated to help meet the needs of homeless Veterans, focusing on the chronically and most vulnerable homeless. It is anticipated that there will be approximately 150 additional staff added to the HUD-VASH program to support these vouchers. There are approximately 1,000 project based vouchers that will become active during FY 2018 or FY 2019, and there will be additional staff needed at some VAMCs to support these vouchers.