S. HRG. 116–137

FISCAL YEAR 2020 BUDGET AND 2021 ADVANCED APPROPRIATIONS REQUESTS FOR THE DEPARTMENT OF VETERANS AFFAIRS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED SIXTEENTH CONGRESS

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C O N T E N T S

MARCH 26, 2019

SENATORS

	Page
Isakson, Hon. Johnny, Chairman, U.S. Senator from Georgia	1
Tester, Hon. Jon, Ranking Member, U.S. Senator from Montana	3
Manchin, Hon. Joe, III, U.S. Senator from West Virginia	21
Cramer, Hon. Kevin, U.S. Senator from North Dakota	23
Blumenthal, Hon. Richard, U.S. Senator from Connecticut	25
Moran, Hon. Jerry, U.S. Senator from Kansas	27
Boozman, Hon. John, U.S. Senator from Arkansas	31
Hirono, Hon. Mazie K., U.S. Senator from Hawaii	33
Blackburn, Hon. Marsha, U.S. Senator from Tennessee	34
Murray, Hon. Patty, Chairman, U.S. Senator from Washington	36
Tillis, Hon. Thom, U.S. Senator from North Carolina	38
Brown, Hon. Sherrod, U.S. Senator from Ohio	40
Sullivan, Hon. Dan, U.S. Senator from Alaska	42

WITNESSES

Wilkie, Hon. Robert L., Secretary, U.S. Department of Veterans Affairs; accompanied by Paul R. Lawrence, Ph.D., Under Secretary for Benefits, Veterans Benefits Administration; Richard A. Stone, M.D., Executive in Charge, Veterans Health Administration; and Jon Rychalski, Assistant Secretary for Management and Chief Financial Officer	6
Prepared statement	8
Response to posthearing questions submitted by:	
Hon. Johnny Isakson	47
Hon. Jon Tester	50
Hon. Sherrod Brown	71
Hon. Richard Blumenthal	143
Hon. Mazie K. Hirono	154
Hon. Joe Manchin III	160
Hon. Kyrsten Sinema	175

APPENDIX

Co-Authors of the *Independent Budget*; prepared statement	177

FISCAL YEAR 2020 BUDGET AND 2021 ADVANCED APPROPRIATIONS REQUESTS FOR THE DEPARTMENT OF VETERANS AFFAIRS

TUESDAY, MARCH 26, 2019

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:09 a.m., in room 418, Russell Senate Office Building, Hon. Johnny Isakson, Chairman of the Committee, presiding.

Present: Senators Isakson, Moran, Boozman, Cassidy, Rounds, Tillis, Sullivan, Blackburn, Cramer, Tester, Murray, Brown, Blumenthal, Hirono, Manchin, and Sinema.

OPENING STATEMENT OF HON. JOHNNY ISAKSON, CHAIRMAN, U.S. SENATOR FROM GEORGIA

Chairman ISAKSON. I call the Senate Veterans' Affairs Committee to order and welcome everybody to the Committee today. Thank you to Secretary Wilkie, in particular, and all the members of the VA staff for being here today. You are going to get a lot of questions, I know, and hopefully give us a lot of good answers. Then, we will hopefully get some good results at the end of the year and be moving in the right direction.

The Committee and the VA had a good year last year. We got a lot of things squared away that had been needed to be addressed for some time. We get some laws passed you all wanted for some time, you said you needed for some time, and we want to—we gave them to you and we are going to look for the results this year. That is what we are going to be reviewing, is making sure we are making progress with results, not just promises, and I think we will be able to do that.

This is an important hearing today. This is our annual review of the budget. The President's budget came out a few days ago. The VA's budget is a significant one, and significantly increased.

We have a unique situation. We get more money than anybody in increases every year, as a percentage, however you want to calculate it. Money is not our problem. Now I know there are some people in this room who say, "Oh, yes, it is. I need this much more. I could do this," but we have been—we have looked out for our veterans. We know we are paying for benefits they have earned and we know we have got to finance them. I am proud the President's budget is up 9.1—is that right?—9.5, and $220 billion. Right? That is a huge budget.

But, what I want to do this morning, in my opening remarks, is really just focus a little bit on this year and then how we came to where we are.

The first thing I want to do is thank the VSOs. I changed the way we do this meeting. Used to be they came in as a second panel. The first panel was the Secretary, the second panel was all the VSOs. That took a lot of time, it diminished the value of each person's testimony, and we have just finished with meetings with all the VSOs—almost all the—well, all the VSOs, over the last 5 weeks anyway.

So, the important thing I asked the VSOs to do was to submit their testimony in writing and submit the questions they want specifically to have answered in writing, and then we get those. They submitted some terrific questions, which prompted great thought on my part and other Members' part as we went over those and reviewed those questions. They will be sent for answers to the Secretary; and, Mr. Secretary, I am going to expect an answer on all of them.

I want to thank the VSOs for the time they put into it, and make sure you know that just because I did not include you in terms of verbal testimony at this meeting, it is not because we did not want to hear from you. I wanted to see that what we heard from you actually got done. So, I asked you to submit it in writing and we will submit that to the VA and then we will follow up on it, rather than having it lost somewhere in the ecosystem once you have set it here and it is gone wherever it goes.

The second thing I want to do today is talk about two meetings we have coming up that I am going to insist on. I promised Members; I try to keep my promises. We have done amazingly well on that, and it is because we have cooperation by all of the Committee, particularly the Ranking Member. But, number 1, Senator Manchin had asked for a discussion on burn pits and toxic exposure, et cetera. We are going to have a meeting on toxic exposure. It will come later in the year, after we have begun to swallow the Blue Water Navy. My understanding is that—is this true, Secretary Wilkie, that the Blue Water Navy court decision is not being challenged? Is that right.

Secretary WILKIE. That would be my recommendation from VA.

Chairman ISAKSON. VA has recommended that, which I appreciate, and I have offered that opinion as well. I think that is what is going to end up happening. If that happens, we are going to be in the process of beginning to swallow a big bite, and chew it, and dissolve it, and get it—I was happy to learn from the Secretary that 51 people have already been treated, that would have been eligible, that benefited—Blue Water Navy benefited anyway. Is that correct?

Secretary WILKIE. Fifty-one thousand.

Chairman ISAKSON. Fifty-one thousand. I appreciate the Secretary and the VA doing such a thorough job as far as Blue Water Navy is concerned, and in anticipation of what this Committee and the other Committee in the House did on Blue Water Navy. Hopefully, that will continue.

The other topic is access standards. The big fellow sitting to my right has made it clear to me that access standards are a big thing

with him. Well, they are a big thing with me too, because if you really think about it, if the recently-published-for-comment rules and standards for access of community care, once those are finished then in Alaska and in Kansas and North Dakota, South Dakota, Georgia, Montana, everywhere, our more rural veterans in more rural areas—how it is working for them to get them the care they need as quickly as we can, get a system that works so doctors want to be a part of it. Get a third-party administrator working to make sure that they have got a good repertoire of doctors available, to be chosen from, to meet the standards. It is just terrific.

So, I am going to focus on access standards at our next meeting, which we have on April 10. Is that right?

Mr. REECE. Yes, sir.

Chairman ISAKSON. We are going to focus on access standards. I want to encourage everybody to be there, because if we do one thing this year, if we can get that working—that is the part of Choice that was hard, that is the part of Choice that had the most problems—if we can get it working right for the VA and veterans, and right for us, then we are going to have taken care of our single biggest problem in terms of operations out there on a daily basis, which are veterans' benefits.

With that said I will end my opening remarks and turn to—I guess I should—have I welcomed the Secretary yet? I will let you have your opening run and then I will welcome the Secretary.

Senator Tester.

OPENING STATEMENT OF HON. JON TESTER, RANKING MEMBER, U.S. SENATOR FROM MONTANA

Senator TESTER. Thank you. Thank you much, Mr. Chairman. I do not want to beat you to the punch, but I want to welcome Secretary Wilkie, Dr. Lawrence, and Dr. Stone——

Chairman ISAKSON. I think you just did.

Senator TESTER [continued]. Mr. Rychalski to the hearing today. I look forward to learning from you today and I want to thank your team, and thank you for what you guys do every day.

The Chairman talked about access standards and access standards will be talked about a lot today. We have talked about privatization. Nobody around this table, and I do not believe any of you want to see that happen. But, it is something I am very concerned about because the big boss talks about it all the time, and in the end we need to make sure that, as the VSOs told us a couple of a week ago during joint House and Senate Veterans' Affairs Committee, they prefer the care that you guys provide.

That is a good thing. I think that is a very good thing. That means you guys are doing some things right, OK? We will talk about a few things you might not be doing so right today, and I will apologize ahead of time, but the truth is that these are folks that have served our country and we need to make sure we live up to the promises, as you well know, Mr. Secretary, the promises we made to them.

Look, over the past few years this Committee has heard from the VA about what it needs to be successful. We have engaged with VSOs, as we did for the last couple of weeks, to see what they wanted in their VA, and I will tell you this Committee listened,

and we acted, leading the way on a number of monumental reforms that, quite frankly, a lot of people did not think we could ever get done, but we did last Congress, on behalf of our Nation's veterans.

This is an important part of our job, providing you, the VA, with the tools that you need to do your job. Equally critically, though, is your job of deciding how the new authorities, and the resources, are executed and utilized, which is where, as I have said already, my concerns tend to lie. In my view, the level of commitment from Congress to address health care vacancies and critical infrastructure needs at the VA needs to be matched by the Department.

I have talked about my parochial interest in Montana—and I am going to talk about it again today—Fort Harrison. By the way, if you run back about 15 years, it was one of the top VA facilities in the country. Fort Harrison today has one primary care physician, a part-time doctor who sees a handful of patients. I have got CBOCs in Montana, as you know, Mr. Secretary, with no primary care doctors, no advanced primary care clinicians, and where that care is only provided through telehealth.

Now I am going to tell you—telehealth is a great innovation and it does some great things with folks that have mental health issues—but it cannot replace all types of health care. So, you get my frustration, that VA primary focus seems to be expanding eligibility and investments in the community care, but I do not want it to be at the expense of capacity-building initiatives.

I am going to say that again. I do not want our investments in community care to be at the expense of capacity-building initiatives.

As you and I have discussed, there is certainly a role for the private sector, especially in a rural State like Montana. I am sure Senator Sullivan would agree in Alaska, and other States, too. But, I think we have got to be careful that we do not take the Department down a dangerous path. And, when it comes to veterans, you can outsource the care but you cannot outsource the responsibility. When they are sent to the community care option without first knowing if that care can be provided in a timely manner and if it is quality care, we are going to pay the price for that later, because, quite frankly, the veteran is going to come back and ask, "Why?"

So, I think we need to hold our VA providers to one set of standards and community care providers to that same set of standards. After all, none of us want a flood of veterans going to community care if it is lower and less—lower quality and less timely. And, we certainly cannot head down a path without a firm grasp on how much it is going to cost the American taxpayer.

For example, we received multiple estimates from the Department on how much it would cost to implement access standards in the month leading up to the budget request. None of those estimates matched the number that finally appeared in the budget request, and as we go forth I would like you to clarify that if you could, why that is.

It is not clear how that estimate came about. It is also not clear whether the technology you need to implement this program, such as the decision support tool, will be ready in time for implementation. I have been receiving conflicting reports about the readiness of this tool. I am frustrated we continue to hear about IT solutions

that may not be executed properly. There is a huge chunk of money in this budget for IT. If it is not spent properly we have wasted taxpayer dollars and we have not delivered the services to our veterans that they have earned.

As you know, the VA has struggled for many years in the field of IT, earning a place on the GAO's high-risk list this year again. I recently had a great meeting with Jim Gfrerer but there is no OIT representation from the Department here today, so I hope that is not a reflection of how this issue is being prioritized. I know the table is short so you have to pick and choose. But, we have seen how flawed IT rollouts impact veterans and the progress the VA is making on replacing an antiquated system that cannot afford to be plagued with shortcuts.

By the way, we are here today with the MISSION program as a direct result of IT failures in Arizona. So, this is a big thing. We need to work. You have got a great team around you, Mr. Secretary. I have said it before and I will say it again. I think you are a great guy. I think you are the right guy for this job, and I am glad you are there. But, we need to find out the details of this budget, and as we move forward I certainly do not want to see VA care dollars transferred to community care because we ran out of money in the community care budget.

With that I would just say thank you all for being here. Thank you, Mr. Chairman, for the opportunity to speak, and I look forward to this hearing.

Chairman ISAKSON. Thank you, Senator Tester. For everybody's benefit here I think I heard, without exception, at our hearings with the VSOs, "We ain't going to privatize" said 100 times. I did not have a single person write me, call me, trip me up, throw me down the steps, or anything else, wanting to privatize the VA, and I have no interest in doing so. So, let us just put that sign behind the bathroom door rather than the front door, and let us talk about making the VA the best VA we can make it and be what our veterans want it to be.

Jon is right. They like their VA and that is why they call it "my VA." They just want it to be a little bit better, which is what we want to make it, a little bit better—better in its accountability and better in its results. So, that is what we will be talking about.

With that said, talking about better, we have the best guy you could ever have, in terms of Secretary of the VA. Robert Wilkie—I did not know Mr. Wilkie until he was nominated, I guess. That is the first time we met. I have heard quite frequently that he has got a good bedside manner. He is really easy to talk to. He just has a resonant voice. He is very easy-going, knows some great jokes. They are all clean. He is just a terrific guy all the way around. But, the good thing about it is he does not just have a good personality and a good demeanor, he likes to get the job done, and he talks in measures that are accountable, that hold himself accountable. I appreciate that.

I think with his type of persona we already are seeing improvements and results with the VA. We have got a long way to go, but they do a lot of things well and we are proud of those things. We want to do the things we do not do well better and take some of our problems that have been hanging on with us for a long time

and get those problems solved. I think Robert Wilkie is the man to do it and I am really pleased to work with him, plus Senator Tester, and the Members of our Committee in the Senate to see to it we finish the job—we will never finish the job—but continue the job of improving the Veterans Administration for the benefit of our vets.

With that said I could go over your military background, the fact that you are a good Southern boy, and all those good things, Robert, but instead I would just like to say we have a great Secretary of the Veterans Administration and I am proud to work with Robert Wilkie, I appreciate what he does, and I am proud to introduce him for as much time as he might consume, except remind him that how much he does consume may consider how much we enjoy what he has to say, so do not take too much of it.

Secretary WILKIE. Well——

Chairman ISAKSON. Introduce your other——

Secretary WILKIE [continuing]. Yes, sir.

STATEMENT OF HON. ROBERT L. WILKIE, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY PAUL R. LAWRENCE, PH.D., UNDER SECRETARY FOR BENEFITS, VETERANS BENEFITS ADMINISTRATION; RICHARD A. STONE, M.D., EXECUTIVE IN CHARGE, VETERANS HEALTH ADMINISTRATION; AND JON RYCHALSKI, ASSISTANT SECRETARY FOR MANAGEMENT AND CHIEF FINANCIAL OFFICER

Secretary WILKIE. Well, first of all, thank you for the courtesy and thank you for the kindness that you have shown me. I am going to take a point of personal privilege and thank you and Senator Tester for all the support that you have given me.

As you know, I came to this position having been the Under Secretary of Defense for Personnel and Readiness. I was raised in the military world. My service, compared to my ancestors, is incredibly modest, but it is service, nonetheless, and I have been privileged to see the military life from many angles. There is no higher honor than to be sitting here before you.

I am pleased to have with me, and I will start on the left side, Jon Rychalski, who is our project guru, our Assistant Secretary for Management and our Chief Financial Officer; Dr. Richard Stone, who is our Executive in Charge of VHA; and our most recent award winner, who has just received an award for being the government's best senior executive, and that is Dr. Paul Lawrence, our Under Secretary for Benefits, and I thank them for coming.

When I last reported to this Committee, Mr. Chairman, in December, I said that the state of VA is better. I believe, from the statements that you have made and from the statements Senator Tester has made that you believe that as well. I count that to the support of this Committee.

Earlier this morning, I addressed the House Doctors Caucus, and I said the changes made in VA were not driven by the Executive branch. The changes made in the VA came from the two authorizing committees. I argue that it is the most transformative period in the history of this Department, going all the way back to Omar Bradley's day, and I do not believe that we are any longer on the cusp of transformation. We are actually in the middle of it.

Before I talk about that I do want to talk about the trajectory that VA is on. In the last month we have had—the last few months—we have had some excellent news. In most of my career in and out of government VA has always been rated 16 of 17 or 17 out of 17 in terms of the best places in government to work. The Partnership for Public Service, for the first time, said we are no longer there. We are in the top third and we are actually moving in a higher direction. So, if we have customer service amongst ourselves we will provide good customer service to those that we are honored to serve.

The *Annals of Internal Medicine* said, as Senator Tester implied, that the medical care that VA gives is good or better than any medical care in any region of the country, and we are proud of that. And last, the *Journal of the American Medical Association* said that our wait times in the four most important categories of medical care or as good or better than any in the private sector. That is an indication as to where we are headed in our Department.

The major driver of transformation is the MISSION Act. As you know, it simplifies and consolidates VA's seven Community Care Programs into a single, streamlined, simple-to-use program. It extends the Choice Program, expands the Caregiver Program, and provides a new urgent care benefit as well as other access improvements. Regulations setting new access standards, ensuring greater choice for veterans, will be completed in June. We have proposed a 30-minute average drive time standard for primary care and mental health care and a 60-minute average drive time standard for specialty care.

We have also proposed appointment wait time standards of 20 days for primary care and mental health care and 28 days for specialty care from the date of request, with certain exceptions, and I want to also begin to address the privatization argument. Obviously, I come from the conservative Republican side of the aisle. The issue that has been raised many times about privatization is just not borne out by our budget, by the directions of this Committee, and I am here to say, as Senator Tester said, that the care in the private sector, 9 times out of 10, is probably not as good as care in VA.

I will give you an example. One of your colleagues gave an interview in one of his State's newspapers, saying that he was disappointed in the wait times for certain services at VA in one of his major metropolitan areas. The wait time was 12 days for VA. In the major metropolitan area it was 78 days. That also is an indication that we are moving in the direction that you have pointed for us and the direction that veterans deserve. Things are not always greener on the other side of the hill.

At the same time, we are trying to move out in making VA a modern 21st century health care administration. No longer will we have an ad hoc supply chain. We are tying in with the Department of Defense and their computerized systems for medical supplies. The days where VA doctors at the DCVA have to run across the parking lot to MedStar to find equipment have to be over if we are going to continue the road of improvement.

The other part of our major transformation is the electronic health record, where we tie in with the DOD the minute that

young American walks into the military entrance processing station, so that we have a complete picture of that veteran's health.

The Chairman mentioned burn pits. For the first time, when this is online, VA doctors will be able to see everything that had happened in that soldier's life, from exposures to toxins overseas, from exposures to toxics in the continental United States, and we will then know better how to serve that veteran.

I have been asked to lead the National Suicide Prevention Task Force. That is one of three areas that VA is moving out on in response to this Committee. For Senator Manchin it is the opioid epidemic, and how we begin to change the way we treat our veterans when it comes to the use of opioids.

Homelessness is another area; and then finally, suicide prevention. In the last year we have hired over 3,900 mental health professionals. We now provide same-day mental health service for veterans in need.

As part of the continued transformation we are also engaging in the creation of a modern H.R. system. Right now there are 140 H.R. offices across VA. We are consolidating those down to 18, and for the first time bringing in H.R. professionals to create a modern human resource capability that will send doctors, nurses, and health care professionals to those parts of the country where they are most needed.

As for the budget, the Chairman is right, a $220 billion budget. That is a 9.5 percent increase over what VA had last year. That is $97 billion in discretionary spending, a $123.2 billion in mandatory spending, and funding for 393 full-time employees, which is an increase in 13,000 for those working at VA.

That means that for the MISSION Act, 19 percent of the funding will go to community care but 81 percent for VA care; $1.6 billion to the electronic health record; $184 million for a modern, integrated financial acquisition management system; and $36 million for us to continue to adopt the Defense Medical Logistics Standard Support system; $8.1 million to continue the improvement in customer service, the prime directive for those in VA; $547 million for women's health; and $1.6 billion for capital investment.

The last item on my list is to continue my pledge to you that we be an open department. We are joined at the hip with this Committee and with the Committee of the House of Representatives. We all have the same mission in mind. Again, I thank you for your courtesy. I thank you for allowing me the honor of serving in this capacity, and I look forward to your questions.

[The prepared statement of Mr. Wilkie follows:]

PREPARED STATEMENT OF HON. ROBERT L. WILKIE, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Good morning, Chairman Isakson, Senator Tester, and distinguished Members of the Committee. Thank you for the opportunity to testify today in support of the President's Fiscal Year (FY) 2020 Budget for the Department of Veterans Affairs (VA), including the FY 2021 Advance Appropriation (AA) request. I am accompanied today by Dr. Richard Stone, Executive in Charge, Veterans Health Administration (VHA), Dr. Paul Lawrence, Under Secretary for Benefits, and Jon Rychalski, Assistant Secretary for Management and Chief Financial Officer.

I begin by thanking Congress and this Committee for your continued strong support and shared commitment to our Nation's Veterans VA. In my estimation, two Federal Government departments must rise above partisan politics—the Depart-

ment of Defense (DOD) and VA. The bipartisan support this Committee provides sustains that proposition. To continue VA's momentum, the FY 2020 budget request fulfills the President's strong commitment to Veterans by providing the resources necessary to improve the care and support our Veterans have earned through sacrifice and service to our country.

FISCAL YEAR (FY) 2020 BUDGET REQUEST

The President's FY 2020 Budget requests $220.2 billion for VA—$97.0 billion in discretionary funding (including medical care collections). The discretionary request is an increase of $6.8 billion, or 7.5 percent, over the enacted FY 2019 budget. It will sustain the progress we have made and provide additional resources to improve patient access and timeliness of medical care services for the approximately 9 million enrolled Veterans eligible for VA health care, while improving benefits delivery for our Veterans and their beneficiaries. The President's FY 2020 budget also requests $123.2 billion in mandatory funding, $12.3 billion or 11.1 percent above 2019.

For the FY 2021 AA, the budget requests $91.8 billion in discretionary funding including medical care collections for Medical Care and $129.5 billion in mandatory advance appropriations for Compensation and Pensions, Readjustment Benefits, and Veterans Insurance and Indemnities benefits programs in the Veterans Benefits Administration (VBA).

For VA Medical Care, VA is requesting $84.1 billion (including collections) in FY 2020, a 9.6 percent increase over the 2019 level, and a $4.6 billion increase over the 2020 AA, primarily for community care and to transition the Choice Program workload to VA's discretionary Medical Community Care account. This Budget will provide funding for treating 7.1 million patients in 2020.

This is a strong budget request that fulfills the President's commitment to Veterans by ensuring that they receive high-quality health care and timely access to benefits and services while concurrently improving productivity and fiscal responsibility. I urge Congress to support and fully fund our FY 2020 and FY 2021 AA budget requests—these resources are critical to enabling the Department to meet the evolving needs of our Veterans and successfully execute my top priorities.

CUSTOMER SERVICE

It is the responsibility of all VA employees to provide an excellent customer service experience (CX) to Veterans, Servicemembers, their families, caregivers, and survivors when we deliver care, benefits, and memorial services. I am privileged to champion this effort.

Our National Cemetery Administration has long been recognized as the organization with the highest customer satisfaction score in the Nation. That's according to the American Customer Satisfaction Index ACSI). And that's across all sectors of industry and government. We need to work to scope that kind of success across all benefits and services.

That's why I incorporated CX into the FY 2018–2024 VA Strategic Plan. Last year, I issued VA's first customer service policy. That policy outlines how VA will achieve excellent customer service along three key pillars: CX Capabilities, CX Governance, and CX Accountability. I am holding all VA executives, managers, supervisors, and employees accountable to foster a climate of customer service excellence. We will be guided by our core VA Values of Integrity, Commitment, Advocacy, Respect, and Excellence (I-CARE). These values define our culture of customer service and help shape our standards of behavior.

Because of VA's leadership in customer experience, our Veterans Experience Office has been designated Lead Agency Partner for the President's Management Agenda (PMA) Cross-Agency Priority (CAP) Goal on Improving Customer Experience across government.

Our goal is to lead the President's work of improving customer experience across Federal agencies and deliver customer service to Veterans we serve that is on par with top private sector companies.

This is not business as usual at VA. We are changing our culture and putting our Veteran customers at the center of our process. To accomplish this goal, we are making investments in Customer Service, and we are making bold moves in training and implementing customer experience best practices.

Veterans Experience Office. The Veterans Experience Office (VEO) is my lead organization for achieving our customer service priority and providing the Department a core customer experience capability. VEO offers four core customer experience capabilities, including real-time customer experience data, tangible customer experience tools, modern technology, and targeted engagement. For FY 2020, VEO is shifting from a full reimbursable authority (RA) funding model to a hybrid of a RA and

budget authority (BA) model. The FY 2020 request of $69.4 million for the VEO ($8.6 million in BA and $60.6 million in RA) is $8.1 million above the FY 2019 enacted budget. The budget increase and the transition to a BA highlights VA's commitment to customer service and the institutionalization of CX capabilities within the Department to improve care, benefits and service to Veterans, their families, caregivers and survivors.

MISSION ACT IMPLEMENTATION

The VA MISSION Act of 2018 (the MISSION Act) will fundamentally transform elements of VA's health care system, fulfilling the President's commitment to help Veterans live a healthy and fulfilling life. It is critical that we deliver a transformed 21st century VA health care system that puts Veterans at the center of everything we do. The FY 2020 budget requests $8.9 billion in the VA Medical Care program for implementation of key provisions of the MISSION Act: $5.5 billion for continued care of the Choice Program population; $2.9 billion for expanded access for care based on average drive time and wait time standards and expanded transplant care; $272 million for the Urgent Care benefit, and $150 million to expand the Program of Comprehensive Assistance for Family Caregivers.

Access to Care. Over the past few years, VA has invested heavily in our direct delivery system, leading to reduced wait times for care in VA facilities that currently meet or exceed the quality and timeliness of care provided by the private sector. And VA is improving access across its more than 1,200 facilities even as Veteran participation in VA health care continues to increase.

From FY 2014 through FY 2018, VA saw an increase of 226,000 unique patients for outpatient appointments (a four percent increase). Since FY 2014, the number of annual appointments for VA care is up by 3.4 million. There were over 58 million appointments in VA facilities in FY 2018—620,000 more than the prior fiscal year. We have significantly reduced the time to complete an urgent referral to a specialist. In FY 2014, it took an average of 19.3 days to complete an urgent referral and in FY 2018 it took 2.1 days, an 89 percent decrease. As of December 2018, that time was down to about 1.6 days.

Still, our patchwork of multiple separate community care programs is a bureaucratic maze that is difficult for Veterans, their families, and VA employees to navigate.

The MISSION Act empowers VA to deliver the quality care and timely service Veterans deserve so we will remain at the center of Veterans' care. Further, the MISSION Act strengthens VA's internal network and infrastructure so VA can provide Veterans more health care access more efficiently.

Transition to the New Community Care Program. We are building an integrated, holistic system of care that combines the best of VA, our Federal partners, academic affiliates, and the private sector.

The Veterans Community Care Program consolidates VA's separate community care programs and will put care in the hands of Veterans and get them the right care at the right time from the right provider. On January 30, 2019, we announced proposed access standards that would determine if Veterans are eligible for community care under the access standard eligibility criterion in the MISSION Act to supplement care they are provided in the VA health care system. The proposed regulation for the program (RIN 2900-AQ46) was published in the *Federal Register* on February 22, 2019, and was open for comments through March 25, 2019.

New Veterans Community Care Program Eligibility Criteria

1. VA does not offer the care or services the Veteran requires;
2. VA does not operate a full-service medical facility in the State in which the Veteran resides;
3. The Veteran was eligible to receive care under the Veterans Choice Program and is eligible to receive care under certain grandfathering provisions;
4. VA is not able to furnish care or services to a Veteran in a manner that complies with VA's designated access standards;
5. The Veteran and the Veteran's referring clinician determine it is in the best medical interest of the Veteran to receive care or services from an eligible entity or provider based on consideration of certain criteria that VA would establish; or
6. The Veteran is seeking care or services from a VA medical service line that VA has determined is not providing care that complies with VA's standards for quality.

Proposed Access Standards. VA's proposed access standards—proposed for implementation in June 2019—best meet the medical needs of Veterans and will complement existing VA facilities with community providers to give Veterans access to health care.

1. FOR PRIMARY CARE, mental health, and non-institutional extended care services VA is proposing a 30-minute average drive time from the Veteran's residence.

2. FOR SPECIALTY CARE, VA is proposing a 60-minute average drive time from the Veteran's residence.

3. VA is proposing APPOINTMENT WAIT-TIME STANDARDS of 20 days for primary care, mental health care, and non-institutional extended care services and 28 days for specialty care from the date of request, unless a later date has been agreed to by the Veteran in consultation with the VA health care provider.

	Primary/Mental Health/ Non-institutional Extended Care	Specialty Care
Appointment Wait Time	Within 20 Days	Within 28 Days
Average Drive Time	Within 30 Min	Within 60 Min

VA remains committed to providing care through VA facilities as the primary means for Veterans to receive health care, and it will remain the focus of VA's efforts. As a complement to VA's facilities eligible Veterans who cannot receive care within the requirements of these proposed access standards would be offered community care. When Veterans are eligible for community care, they may choose to receive care with an eligible community provider, or they may continue to choose to get the care at their VA medical facility.

The proposed access standards are based on analysis of practices and our consultations with Federal agencies—including the DOD, the Department of Health and Human Services, and the Centers for Medicare & Medicaid Services—private sector organizations, and other non-governmental commercial entities. Practices in both the private and public sector formulated our proposed access standards to include appointment wait-time standards and average drive time standards.

VA also published a Notice in the *Federal Register* seeking public comments, and in July 2018, VA held a public meeting to provide an additional opportunity for public comment.

With VA's proposed access standards, the future of VA's health care system will lie in the hands of Veterans—exactly where it should be.

Urgent Care. This budget will also invest $272 million in implementing the new urgent (walk-in care) benefit included in the VA MISSION Act. On January 31, 2019, VA published a proposed rule that would guide the provision of this benefit using the provider network available through national contracts. Under the new urgent care authority, we will be able to offer eligible Veterans convenient care for certain, limited, non-emergent health care needs.

Caregivers. The MISSION Act expands eligibility for VA's Program of Comprehensive Assistance for Family Caregivers (PCAFC) under the Caregiver Support Program, establishes new benefits for designated primary family caregivers of eligible Veterans, and makes other changes affecting program eligibility and VA's evaluation of PCAFC applications. Currently, the Program of Comprehensive Assistance for Family Caregivers is only available to eligible family caregivers of eligible Veterans who incurred or aggravated a serious injury in the line of duty on or after September 11, 2001. Implementation of the MISSION Act will expand eligibility to eligible family caregivers of eligible Veterans from all eras.

Under the law, expansion will begin when VA certifies to Congress that VA has fully implemented a required information technology system. The expansion will occur in two phases beginning with eligible family caregivers of eligible Veterans who incurred or aggravated a serious injury in the line of duty on or before May 7, 1975, with further expansion beginning two years after that.

Over the course of the next year, VA will be establishing systems and regulations necessary to expand this program. Caregivers and Veterans can learn about the full range of available support and programs through the Caregivers website, www.caregiver.va.gov, or by contacting the Caregiver Support Line toll-free at 1–855–260–3274.

The FY 2020 Budget for the Caregivers Support Program is $720 million, $150 million of which is specifically requested to implement the program's expansion because of the MISSION Act.

Telehealth. VA is a leader in providing telehealth services. VA leverages telehealth technologies to enhance the accessibility, capacity, and quality of VA health care for Veterans, their families, and their caregivers anywhere in the country. VA achieved more than one million video telehealth visits in FY 2018, a 19 percent increase in video telehealth visits over the prior year. Telehealth is a critical tool to

ensure Veterans, especially rural Veterans, can access health care when and where they need it. With the support of Congress, VA has an opportunity to continue shaping the future of health care with cutting-edge technology providing convenient, accessible, high-quality care to Veterans. The FY 2020 Budget includes $1.1 billion for telehealth services, a $105 million or 10.5 percent increase over the 2019 current estimate.

Section 151 of the MISSION Act strengthens VA's ability to provide even more telehealth services because it statutorily authorizes VA providers to practice telehealth at any location in any State, regardless of where the provider is licensed. VA's telehealth program enhances customer service by increasing Veterans' access to VA care, while lessening travel burdens.

In FY 2018, more than 782,000 Veterans (or 13 percent of Veterans obtaining care at VA) had one or more telehealth episodes of care, totaling 2.29 million telehealth episodes of care. Of these 782,000 Veterans using telehealth, 45 percent live in rural areas. VA's major expansion for telehealth and telemental health over the next five years, for both urban and rural Veterans, will focus on care in or near the Veteran's home. VA's target is to increase Veterans receiving some care through telehealth from 13 percent to 20 percent using telehealth innovations like the VA Video Connect (VVC) application, which enables private encrypted video telehealth services from almost any mobile device or computer. VVC will be integrated into VA clinicians' routine operations to provide Veterans another option for connecting with their care teams.

Strengthening VA's Workforce. Recruitment and retention are critical to ensuring that VA has the right doctors, nurses, clinicians, specialists and technicians to provide the care that Veterans need. The FY 2020 Budget strengthens VHA's workforce by providing funding for 342,647 FTE, an increase of 13,066 over 2019. VA is also actively implementing MISSION Act authorities that increased VA's ability to recruit and retain the best medical providers by expanding existing loan repayment and clinical scholarship programs; it also established the authority to create several new programs focused on medical school students and recent graduates. VA is also implementing additional initiatives to enhance VA's workforce, such as the expanded utilization of peer specialists and medical scribes.

BUSINESS TRANSFORMATION

Business transformation is essential if we are to move beyond compartmentalization of the past and empower our employees serving Veterans in the field to provide world-class customer service. This means reforming the systems responsible for claims and appeals, GI Bill benefits, human resources, financial and acquisition management, supply chain management, and construction. The Office of Enterprise Integration (OEI) is charged with coordination for these efforts.

Office of Enterprise Integration. The scale and criticality of the initiatives underway at VA require management discipline and strong governance. As part of OEI's coordination role in VA's business transformation efforts, we have implemented a consistent governance process to review progress against anticipated milestones, timelines, and budget. This process supports continuous alignment with objectives and identifies risks and impediments prior to their realization.

For example, our VA Modernization Board recently initiated a leadership integration forum to synchronize deployment schedules across three major enterprise initiatives: adoption of Defense Medical Logistics Standard Support (DMLSS), financial management business transformation, and our new electronic health record. This forum allowed us to assess the feasibility of a concurrent deployment and identify an alternate course of action. By implementing strong governance and oversight, we are increasing accountability and transparency of our most critical initiatives.

Appeals Modernization. The Veterans Appeals Improvement and Modernization Act of 2017 (AMA) was signed into law on August 23, 2017 and took effect on February 19, 2019. The Appeals Modernization Act transforms VA's complex and lengthy appeals process into one that is simple, timely, and fair to Veterans and ultimately gives Veterans choice and control over how to handle their claims and appeals.

The FY 2020 request of $182 million for the Board of Veterans' Appeals (the Board) is $7.3 million above the FY 2019 enacted budget and will sustain the 1,125 FTE who will adjudicate and process legacy appeals while implementing the Appeals Improvement and Modernization Act. The Board continues to demonstrate its commitment to reducing legacy appeals and decided a historic number of appeals—85,288—in FY 2018, the highest number for any fiscal year. The Board is on pace to decide over 90,000 appeals in 2019.

To ensure smooth implementation, the Board launched an aggressive workforce plan to recruit, hire, and train new employees in FY 2018. The Board on-boarded approximately 242 new hires, including 217 attorneys/law clerks and approximately 20 administrative personnel.

The new appeals process features three decision-review lanes:

1. HIGHER-LEVEL REVIEW LANE: A senior-level claims processor at a VA regional office will conduct a new look at a previous decision based on the evidence of record. Reviewers can overturn previous decisions based on a difference of opinion or return a decision for correction. VBA has a 125-day average processing goal for decisions issued in this lane.

2. SUPPLEMENTAL CLAIM LANE: Veterans can submit new and relevant evidence to support their claim, and a claims processor at a VA regional office will assist in developing evidence. VBA has a 125-day average processing goal for decisions issued in this lane.

3. APPEAL LANE: Veterans who choose to appeal a decision directly to the Board of Veterans' Appeals (Board) may request direct review of the evidence the regional office reviewed, submit additional evidence, or have a hearing. The Board has a 365-day average processing time goal for appeals in which the Veteran does not submit evidence or request a hearing.

In addition to focusing on implementation of the Appeals Modernization Act, addressing pending legacy appeals will continue to be a priority for VBA and the Board in FY 2019. VBA's efforts have resulted in appeals actions that have exceeded projections for fiscal year to date 2019. VBA plans to eliminate completely its legacy, non-remand appeals inventory in FY 2020 and significantly reduce its legacy remand inventory in FY 2020.

Finally, VBA is also undertaking a similar, multi-pronged approach to modernize its appeals process through increased resources, technology, process improvements, and increased efficiencies. VBA's compensation and pension appeals program is supported by 2,100 FTEs. VBA added 605 FTEs in FY 2019 to process legacy appeals and decision reviews in the modernized process. As of October 1, 2018, to best maximize its resources an enable efficiencies, VBA centralized these assets to conduct higher-level reviews at two Decision Review Operation Centers (DROC). VBA will convert the current Appeals Resource Center in Washington, DC, into a third DROC using existing assets.

Forever GI Bill. Since the passage of the Harry W. Colmery Veterans Educational Assistance Act of August 16, 2017, VA has implemented 28 of the law's 34 provisions. Twenty-two of the law's 34 provisions require significant changes to VA information technology systems, and VA has 202 temporary employees in the field to support this additional workload.

Sections 107 and 501 of the law change the way VA pays monthly housing stipends for GI Bill recipients, and VA is committed to providing a solution that is reliable, efficient and effective. Pending the deployment of a technology-based solution, Veterans and schools will continue to receive GI Bill benefit payments as normal. By asking schools to hold fall enrollments through the summer and not meeting the implementation date for the IT solutions of Sections 107 and 501, some beneficiaries experienced delayed and incorrect payments.

In accordance with the Forever GI Bill Housing Payment Fulfillment Act of 2018, VA established a Tiger Team tasked to resolve issues with implementing sections 107 and 501 of the Forever GI Bill. This month we awarded a new contract that we believe will provide the right solution for implementing Sections 107 and 501. By December 2019, we will have Sections 107 and 501 fully implemented. By spring 2020, all enrollments will be processed according to the Colmery Act. We will recalculate benefits based on where Veterans take classes, and we will work with schools to make Sections 107 and 501 payments retroactive to the first day of August 2018, the effective date.

The Department is committed to making sure every Post-9/11 GI Bill beneficiary is made whole based on the rates established under the Forever GI Bill, and we are actively working to make that happen. We got the word out to Veterans, beneficiaries, schools, VSOs, and other stakeholders that any Veteran who is in a financial hardship due to a late or delayed GI Bill payment should contact us immediately.

In December 2018, we updated the housing rates like we normally would have in August. Those rates were effective for all payments after January 1, 2019. Additionally, we processed over 450,000 rate corrections, ensuring that any beneficiary who was underpaid from August through December received a check for the difference. We have completed the spring peak enrollment season without any significant challenges. We worked with schools to get enrollments submitted as quickly as possible.

As VA moves forward with implementation, we will continue to regularly update our Veteran students and their institutions of learning on our progress and what to expect. Already, VA has modified its definition of "campus" to better align itself with statutory requirements, and in doing so has lessened the administrative burden on schools to report to VA housing data.

Information Technology Modernization. The FY 2020 budget request of $4.343 billion continues VA's investment in the Office of Information Technology (OIT) modernization effort, enabling VA to streamline efforts to operate more effectively and decrease our spending while increasing the services we provide. The budget allows OIT to deliver available, adaptable, secure, and cost-effective technology services to VA—transforming the Department into an innovative, twenty first century organization—and to act as a steward for all VA's IT assets and resources. OIT delivers the necessary technology and expertise that supports Veterans and their families through effective communication and management of people, technology, business requirements, and financial processes.

The requested $401 million funds for development will be dedicated to mission critical areas, continued divestiture of legacy systems such as the Benefits Delivery Network and the Burial Operations Support System, and initiatives that are directly Veteran-facing. Funds will continue to support Veteran focused initiatives such as Mental Health, MISSION Act and Community Care, and the continued transition from the legacy Financial Management System (FMS) to the new Integrated Financial and Acquisition Management System (iFAMS). The Budget also invests $379 million for information security to protect Veterans' information.

Financial Management Business Transformation (FMBT). As mentioned above, a critical system that will touch the delivery of all health and benefits is our new financial and acquisition management system, iFAMS. In support of the Financial Management Business Transformation (FMBT) program, the FY 2020 budget requests $66 million in IT funds, $107 million in Franchise Fund Service Level Agreement (SLA) funding from the Administrations and other Staff Offices to be paid to the Financial Services Center (FSC), and General Administration funding of $11.9 million.

Through the FMBT program, VA is working to implement an enterprise-wide financial and acquisition management system in partnership with our service provider, CGI Federal Inc. VA will utilize a cloud hosted solution, configured for VA, leveraging CGI's Software as a Service (SaaS) model. VA will gain increased operational efficiency, productivity, reporting capability, and flexibility from a modern Enterprise Resource Planning (ERP) cloud solution. The new cloud solution will also provide additional security, storage, and scalability.

Infrastructure Improvements and Streamlining. I want to thank Congress for providing $2 billion in additional funding for VA infrastructure in 2019. This additional funding for minor construction, seismic corrections, and non-recurring maintenance will enhance our ability to address infrastructure needs. In FY 2020, VA will continue improving its infrastructure while transforming our health care system to an integrated network to serve Veterans. This budget allows for the expansion of health care, burial and benefits services where needed most. The request includes $1.235 billion in Major Construction funding, as well as $399 million in Minor Construction to fund VA's highest priority infrastructure projects. These funding levels are consistent with our requests in recent years.

Major and Minor Construction

This funding supports major medical facility projects including providing the final funding required to complete these projects: New York, NY—Manhattan VAMC Flood Recovery, Bay Pines, FL—Inpatient/Outpatient Improvements, San Juan, PR—Seismic Corrections, Building 1; and Louisville, KY—New Medical Facility. The request also includes continued funding for ongoing major medical projects at San Diego, CA—Spinal Cord Injury and Seismic Corrections, Reno, NV—Correct Seismic Deficiencies and Expand Clinical Services Building, West Los Angeles, CA—Site utilities for Build New Critical Care Center, and Alameda, CA—Outpatient Clinic & National Cemetery.

The 2020 request includes additional funding for the completion of the new cemetery at Western New York Cemetery (Elmira, NY) and the replacement of the cemetery at Bayamon, PR (Morovis), and expansion project at Riverside, CA. The national cemetery expansion and improvement projects at Houston and Dallas, TX and Massachusetts (Bourne, MA) are also provided for. The FY 2020 Budget provides funds for the continued support of major construction program including the seismic initiative that was implemented in 2019 to address VA's highest priority facilities in need of seismic repairs and upgrades.

The request also includes $399 million in minor construction funds that will used to expand health care, burial and benefits services for Veterans. The minor construction request includes funding for 131 newly identified projects as well as existing partially funded projects.

Leasing

VA is also requesting authorization of seven major medical leases in 2020 to ensure access to health care is available in those areas. These leases include new leases totaling $33 million in Colombia, MO and Salt Lake City, UT as well as replacement leases totaling $104 million in Baltimore, MD; Atlanta, GA; Harlingen, TX; Jacksonville, NC; and Prince George's County, MD. VA is requesting funding of $919 million to support ongoing leases and delivery of additional leased facilities during the year.

Repurposing or Disposing Vacant Facilities

To maximize resources for Veterans, VA repurposed or disposed of 175 of the 430 vacant or mostly vacant buildings since June 2017. Due diligence efforts (environmental/historic) for the remaining buildings are substantially complete, allowing them to proceed through the final disposal or reuse process.

SUICIDE PREVENTION

Suicide is a national public health issue that affects all Americans, and the health and well-being of our Nation's Veterans is VA's top priority. Twenty (20) Veterans, active-duty Servicemembers, and non-activated Guard or Reserve members die by suicide on average each day, and of those 20, 14 had not been in our care. That is why we are implementing broad, community-based prevention strategies, driven by data, to connect Veterans outside our system with care and support. The FY 2020 Budget requests $9.4 billion for mental health services, a $426 million increase over 2019. The Budget specifically invests $222 million for suicide prevention programming, a $15.6 million increase over the 2019 enacted level. The request funds over 15.8 million mental health outpatient visits, an increase of nearly 78,000 visits over the 2019 estimate. This builds on VA's current efforts. VA has hired more than 3,900 new mental health providers yielding a net increase in VA mental health staff of over 1,000 providers since July 2017. Nationally, in the first quarter of 2019, 90 percent of new patients completed an appointment in a mental health clinic within 30 days of scheduling an appointment, and 96.8 percent of established patients completed a mental health appointment within 30 days of the day they requested.

Preventing Veteran suicide requires closer collaboration between VA, DOD, and the Department of Homeland Security (DHS). On January 9, 2018, President Trump signed an Executive Order (13822) titled, "Supporting Our Veterans During Their Transition from Uniformed Service to Civilian Life." This Executive Order directs DOD, VA, and DHS to develop a Joint Action Plan that describes concrete actions to provide access to mental health treatment and suicide prevention resources for transitioning uniformed Servicemembers in the year following their discharge, separation, or retirement. On March 5, 2019, President Trump signed the National Roadmap to Empower Veterans and End Suicide Executive Order (13861), which creates a Veteran Wellness, Empowerment, and Suicide Prevention Task Force that is tasked with developing, within 1 year, a road map to empower Veterans to pursue an improved quality of life, prevent suicide, prioritize related research activities, and strengthen collaboration across the public and private sectors. This is an all-hands-on-deck approach to empower Veteran well-being with the goal of ending Veteran suicide.

For Servicemembers and Veterans alike, our collaboration with DOD and DHS is already increasing access to mental health and suicide prevention resources, due in large part to improved integration within VA, especially between the VBA and VHA. VBA and VHA have worked in collaboration with DOD and DHS to engage Servicemembers earlier and more consistently than we have ever done in the past. This engagement includes support to members of the National Guard, Reserves, and Coast Guard.

VA's suicide prevention efforts are guided by our National Strategy for Preventing Veteran Suicide, a long-term plan published in the summer of 2018 that provides a framework for identifying priorities, organizing efforts, and focusing national attention and community resources to prevent suicide among Veterans. It also focuses on adopting a broad public health approach to prevention, with an emphasis on comprehensive, community-based engagement.

However, VA cannot do this alone, and suicide is not solely a mental health issue. As a national problem, Veteran suicide can only be reduced and mitigated through a nationwide community-level approach that begins to solve the problems Veterans

face, such as loss of belonging, meaningful employment, and engagement with family, friends, and community.

The National Strategy for Preventing Veteran Suicide provides a blueprint for how the Nation can help to tackle the critical issue of Veteran suicide and outlines strategic directions and goals that involve implementation of programming across the public health spectrum, including, but not limited to:

- Integrating and coordinating Veteran Suicide Prevention across multiple sectors and settings;
- Developing public-private partnerships and enhancing collaborations across Federal agencies;
- Implementing research informed communication efforts to prevent Veteran suicide by changing attitudes knowledge and behaviors;
- Promoting efforts to reduce access to lethal means;
- Implementation of clinical and professional practices for assessing and treating Veterans identified as being at risk for suicidal behaviors; and
- Improvement of the timeliness and usefulness of national surveillance systems relevant to preventing Veteran suicide.

Every day, more than 400 Suicide Prevention Coordinators (SPC) and their teams—located at every VA medical center—connect Veterans with care and educate the community about suicide prevention programs and resources. Through innovative screening and assessment programs such as REACH VET (Recovery Engagement and Coordination for Health—Veterans Enhanced Treatment), VA identifies Veterans who may be at risk for suicide and who may benefit from enhanced care, which can include follow-ups for missed appointments, safety planning, and care plans.

VHA has also expanded its Veterans Crisis Line to three call centers and increased the number of Veterans served by the Readjustment Counseling Service (RCS), which provides services through the 300 Vet Centers, 80 Mobile Vet Centers (MVC), 20 Vet Center Outstations, over 960 Community Access Points and the Vet Center Call Center (877-WAR-VETS). In the last two fiscal years, clients benefiting from RCS services increased by 14 percent, and Vet Center visits for Veterans, Servicemembers, and families increased by 7 percent.

We are committed to advancing our outreach, prevention, and treatment efforts to further restore the trust of our Veterans and continue to improve access to care and support inside and outside VA.

ELECTRONIC HEALTH RECORD MODERNIZATION (EHRM)

We made a historic decision to modernize our electronic health record (EHR) system to provide our Nation's Veterans with seamless care as they transition from military service to Veteran status. On May 17, 2018, we awarded a ten-year contract to Cerner Government Services, Inc., to acquire the same EHR solution being deployed by DOD that allows patient data to reside in a single hosting site using a single common system to enable sharing of health information, improve care delivery and coordination, and provide clinicians with data and tools that support patient safety. The FY 2020 Budget includes $1.6 billion to continue to support VA's EHRM effort to create and implement a single longitudinal clinical health record from active duty to Veteran status, and to ensure interoperability with DOD.

The request provides necessary resources for post Go-Live activities completion of Office of Electronic Health Record Modernization's (OEHRM) three Initial Operating Capability (IOC) sites and full deployment of the remaining sites in Veterans Integrated Service Network (VISN) 20, the Pacific Northwest region. Additionally, it funds the concurrent deployment of waves comprised of sites in VISN 21 and VISN 22, the Southwest region. The solution will be deployed at VA medical centers, as well as associated clinics, Veteran centers, mobile units, and other ancillary facilities.

We are working closely with DOD to synchronize efforts as we deploy and test the new health record. We are engaging front-line staff and clinicians to identify efficiencies, hone governance, refine configurations, and standardize processes for future locations. We are committed to a timeline that balances risks, patient safety, and user adoption while also working with DOD in providing a more comprehensive, agile, and coordinated management authority to execute requirements and mitigate potential challenges and obstacles.

Throughout this effort, VA will continue to engage front-line staff and clinicians, as it is a fundamental aspect in ensuring we meet the program's goals. We have begun work with the leadership teams in place in the Pacific Northwest. OEHRM has established clinical councils from the field that will develop National workflows and serve as change agents at the local level.

SUPPLY CHAIN TRANSFORMATION

VA has embarked on a supply chain transformation program designed to build a lean, efficient supply chain that provides timely access to meaningful data focused on patient and financial outcomes. We are pursuing a holistic modernization effort which will address people, training, processes, data and automated systems. To achieve greater efficiencies by partnering with other Government agencies, VA will strengthen its long-standing relationships with DOD by leveraging expertise to modernize VA's supply chain operations, while allowing the VA to remain fully committed to providing quality health care and applying resources where they are most needed. The FY 2020 budget includes $36.8 million in IT funding to support this effort.

As we deploy an integrated health record, we are also collaborating with DOD on an enterprise-wide adoption of the Defense Medical Logistics Standard Support (DMLSS) to replace VA's existing logistics and supply chain solution. VA's current system faces numerous challenges and is not equipped to address the complexity of decisionmaking and integration required across functions, such as acquisition, logistics and construction. The DMLSS solution will ensure that the right products are delivered to the right places at the right time, while providing the best value to the government and taxpayers.

We are piloting our Supply Chain Modernization program initially at the Captain James A. Lovell Federal Health Care Center (FHCC) and VA initial EHR sites in Spokane and Seattle to analyze VA enterprise-wide application. On March 7th, 2019, we initiated the pilot kickoff at the FHCC for VA's business transformation and supply chain efforts. This decision leverages a proven system that DOD has developed, tested, and implemented. In the future, DMLSS and its technical upgrade LogiCole will better enable whole-of-government sourcing and better facilitate VA's use of DOD Medical Surgical Prime Vendor and other DOD sources, as appropriate, as the source for VA medical materiel.

VETERANS HOMELESSNESS

The FY 2020 Presidents Budget (PB) continues the Administration's support of VA's Homelessness Programs, with $1.8 billion in funding, which maintains the 2019 level of funding, including $380 million for Supportive Services for Veterans Families (SSVF).

Over the past five years, VA and its Federal partners have made a concerted effort to collaborate at the Federal level to ensure strategic use of resources to end Veteran homelessness. Coordinated entry systems are the actualization of this coordinated effort at the local level. Coordinated entry is seen, and will continue to be seen, as the systematic approach that is needed at the community level to ensure that resources are being utilized in the most effective way possible and that every Veteran in that community is offered the resources he or she needs to end their homelessness. All homeless Veterans in a given community are impacted by the coordinated entry system given that its framework is designed to promote community-wide commitment to the goal of ending homelessness and utilizing community-wide resources (including VA resources) in the most efficient way possible for those Veterans who are in most need. This includes the prioritization of resources for those Veterans experiencing chronic, literal street homelessness. The number of Veterans experiencing homelessness in the United States has declined by nearly half since 2010. On a single night in January 2018, fewer than 40,000 Veterans were experiencing homelessness—5.4 percent fewer than in 2017.

Since 2010, over 700,000 Veterans and their family members have been permanently housed or prevented from becoming homeless. As of December 19, 2018, 69 areas—66 communities and three states—have met the benchmarks and criteria established by the United States Interagency Council on Homelessness, VA, and the Department of Housing and Urban Development to publicly announced an effective end to Veteran homelessness.

Efforts to end Veteran homelessness have greatly expanded the services available to permanently house homeless Veterans and VA offers a wide array of interventions designed to find homeless Veterans, engage them in services, find pathways to permanent housing, and prevent homelessness from occurring.

OPIOID SAFETY & REDUCTION EFFORTS

In October 2017, the President declared the opioid crisis in our country a public health emergency. Opioid safety and reduction efforts are a Department priority, and we have responded with new strategies to rapidly combat this national issue as it affects Veterans. Success requires collaboration among VA leadership and all

levels of VA staff—from medical centers to headquarters—Congress, and community partners to ensure we are working with Veterans to achieve positive, life-changing results. The fact that opioid safety, pain care transformation, and treatment of opioid use disorder all contribute to reduction of suicide risk makes these efforts particularly important. The FY 2020 Budget includes $397 million, a $15 million increase over 2019, to reduce over-reliance on opioid analgesics for pain management and to provide safe and effective use of opioid therapy when clinically indicated.

VA's Opioid Safety Initiative has greatly reduced reliance on opioid medication for pain management, in part by reducing opioid prescribing by more than 50 percent over the past four years. Most of this progress is attributable to reductions in prescribing long-term opioid therapy by not starting Veterans with chronic, non-cancer pain on opioid therapy and, instead utilizing multimodal strategies that manage Veteran pain more effectively long-term such as acupuncture, behavioral therapy, chiropractic care, yoga, and non-opioid medications.

We are committed to providing Veteran-centric, holistic care for the management of pain and for promoting well-being. We are seeing excellent results as sites across the country deploy this "Whole Health" approach. Non-medication treatments work as well and are often better than opioids at controlling non-cancer pain. We want to assure Congress—and Veterans on opioid therapy—that Veterans' medication will not be -decreased or stopped without their knowledge, engagement, and a thoughtful discussion of accessible alternatives. Our goal is to make sure every Veteran has the best function, quality of life, and pain control.

WOMEN'S HEALTH

VA has made significant progress serving women Veterans in recent years. We now provide full services to women Veterans, including comprehensive primary care, gynecology care, maternity care, specialty care, and mental health services. The FY 2020 Budget requests $547 million for gender specific women Veterans' health care, a $42 million increase over 2019.

The number of women Veterans using VHA services has tripled since 2000, growing from nearly 160,000 to over 500,000 today. To accommodate the rapid growth, VHA has expanded services and sites of care across the country. VA now has at least two Women's Heath Primary Care Provider (WH-PCP) at all of VA's health care systems. In addition, 91 percent of community-based outpatient clinics (CBOCs) have a WH-PCP in place. VHA now has gynecologists on site at 133 sites and mammography on site at 65 locations. For severely injured Veterans, we also now offer in vitro fertilization services through care in the community and reimbursement of adoption costs.

VHA is in the process of training additional providers so every woman Veteran has an opportunity to receive primary care from a WH-PCP. Since 2008, 5,800 providers have been trained in women's health. In fiscal year 2018, 968 Primary Care and Emergency Care Providers were trained in local and national trainings. VA has also developed a mobile women's health training for rural VA sites to better serve rural women Veterans, who make up 26 percent of women Veterans. This budget will also continue to support a fulltime Women Veterans Program Manager at every VHA health care system who is tasked with advocating for the health care needs of women Veterans.

VA is at the forefront of information technology for women's health and is redesigning its electronic medical record to track breast and reproductive health care. Quality measures show that women Veterans who receive care from VA are more likely to receive breast cancer and cervical cancer screening than women in private sector health care. VA also tracks quality by gender and, unlike some other health care systems, has been able to reduce and eliminate gender disparities in important aspects of health screening, prevention, and chronic disease management. We are also factoring care for women Veterans into the design of new VA facilities and using new technologies, including social media, to reach women Veterans and their families. We are proud of our care for women Veterans and are working to increase the trust and knowledge of VA services of women Veterans, so they choose VA for benefits and services.

NATIONAL CEMETERY ADMINISTRATION (NCA)

The President's FY 2020 budget positions NCA to meet Veterans' emerging burial and memorial needs through the continued implementation of its key priorities: Preserving the Legacy: Ensuring "No Veteran Ever Dies;" Providing Access and Choosing VA; and Partnering to Serve Veterans. The FY 2020 Budget includes $329 million for NCA's operations and maintenance account, an increase of $13.2 million (4.2 percent) over the FY 2019 level. This request will fund the 2,008 Full-Time Equiva-

lent (FTE) employees needed to meet NCA's increasing workload and expansion of services, while maintaining our reputation as a world-class service provider. In FY 2020, NCA will inter an estimated 137,000 Veterans and eligible family members and care for over 3.9 million gravesites. NCA will continue to memorialize Veterans by providing 383,570 headstones and markers, distributing 634,000 Presidential Memorial Certificates, and expanding the Veterans Legacy Program to communities across the country to increase awareness of Veteran service and sacrifice.

VA is committed to investing in NCA's infrastructure, particularly to keep existing national cemeteries open and to construct new cemeteries consistent with burial policies approved by Congress. NCA is amid the largest expansion of the cemetery system since the Civil War. By 2022, NCA will establish 18 new national cemeteries across the country, including rural and urban locations. The FY 2020 request also includes $172 million in major construction funds for three gravesite expansion projects (Houston and Dallas, TX and Bourne, MA) and additional funding for the replacement cemetery in Bayamon, PR, the gravesite expansion project in Riverside, CA, and the new national cemetery in Western NY. The Budget also includes $45 million for the Veteran Cemetery Grant Program to continue important partnerships with States and tribal organizations. Upon completion of these expansion projects, and the opening of new national, State and tribal cemeteries, nearly 95 percent of the total Veteran population—about 20 million Veterans—will have access to a burial option in a national or grant-funded Veterans cemetery within 75 miles of their homes.

ACCOUNTABILITY

The FY 2020 Budget requests direct appropriations for the Office of Accountability and Whistleblower Protection (OAWP) for the first time since it was established. The total request for OAWP in FY 2020 is $22.2 million, which is $4.5 million, or 25 percent higher than the 2019 funding level. This funding level demonstrates VA's commitment to improving the performance and accountability of our senior executives through thorough, timely, and unbiased investigations of all allegations and concerns. This funding level will also enable OAWP to continue to provide protection of valued whistleblowers against retaliation for their disclosures under the whistleblower protections provisions of 38 U.S.C. § 714. In FY 2018, OAWP assessed 2,241 submissions, conducted 133 OAWP investigations, and monitored over 1,000 referred investigations. These efforts are part of VA's effort to build public trust and confidence in the entire VA system and are critical to our transformation.

The FY 2020 budget also requests $207 million, a $15 million increase over 2019, and 1,000 FTE for the Office of Inspector General (OIG) to fulfill statutory oversight requirements and sustain the investments made in people, facilities, and technology during the last three years. The 2020 budget supports FTE targets envisioned under a multi-year effort to grow the OIG to a size that is more appropriate for overseeing the Department's steadily rising spending on new complex systems and initiatives. The 2020 budget request will also provide sufficient resources for the OIG to continue to timely and effectively address the increased number of reviews and reports mandated through statute.

CONCLUSION

Thank you for the opportunity to appear before you today to address our FY 2020 budget and FY 2021 AA budget request. VA has shown demonstrable improvement over the last several months. The resources requested in this budget will ensure VA remains on track to meet Congressional intent to implement the MISSION Act and continue to optimize care within VHA.

Mr. Chairman, I look forward to working with you and this Committee. I am eager to continue building on the successes we have had so far and to continue to fulfill the President's promise to provide care to Veterans when and where they need it. There is significant work ahead of us and we look forward to building on our reform agenda and delivering an integrated VA that is agile and adaptive and delivers on our promises to America's Veterans.

Thank you.

Chairman ISAKSON. Thank you very much, Mr. Secretary. We appreciate it and I appreciate your acknowledgment of what I had said earlier about the amount of money we were talking about. We are not here complaining about what we have to spend it on. We are looking for answers to spend it better and to see our veterans get better services, and we will work it out better all along. We

have got a good budget to work with. We are not begging for more. We are looking for results.

Which brings me to my first question that I will ask. The private sector today, in health care, the whole answer to most—whatever the question is, the answer is outcomes. They are trying to measure outcomes for everything, from reimbursement, to being a network, to anything else.

When you refer to the improvements that you referred to, how do you measure your outcomes in the VA? Do you take them from the senior person in charge or do you take them from evaluations or do you take them randomly? How do you gauge your outcomes for the services you provide to our veterans?

Secretary WILKIE. A combination, Mr. Chairman. I really look to the veterans first. I have been very aggressive in the 8 months that I have been in this chair, in reaching out to veterans in terms of surveys, in terms of interviews. What I have seen is that our customer satisfaction rates are moving in an upward direction, where we have, I think, an 89 percent customer satisfaction rate amongst veterans.

In terms of other metrics, opioids is the outstanding example. How are we changing the way that we approach this national tragedy? We approach it in changing the way that we treat our veterans, by providing things that would have been anathema to somebody like my father, 30 or 40 years ago, with alternative medicines, tai chi, acupuncture, yoga. We are on the cutting edge both of alternative treatments to our veterans, we are on the cutting edge of telehealth, as Senator Tester said, and we are on the cutting edge in terms of tackling the national epidemic of suicide and homelessness.

So, the answer is: it is a combination of things, but for me the most important is listening to what our veterans say.

Chairman ISAKSON. On that answer let me say this. In your—in the budget, in the recommendations you have, it includes funding for retiring two IT systems that currently exist within the VA. You and I have talked about this before, but it seems like the VA is a place where you collect software and systems, where people have bought things over the years, and they have piled up. They do not talk to each other, they do not work together, and we are not getting good bang for our buck.

You obviously are trying to clean that up, and I would like for you to talk about those two recommendations in terms of retiring those programs and the overall picture in terms of VA's IT system, getting it improved and getting it better.

Secretary WILKIE. Well, I told you 8 months ago that the overall condition of VA's IT system was bad. As a result of that, this Committee is looking at, as Senator Tester said, a massive increase in our budget, $4.2 billion, I believe. But, that money, in the past, has been spent on redundant systems, going down the same road that led to the failure in the Forever GI Bill as well as other systems.

What we are doing, and you, I believe, will have the CIO up here for testimony in the next few weeks, is we are beginning to migrate our legacy systems out and bring the VA in line with the rest of America, through the cloud. We now have 8,000 employees who are dedicated simply to that transition. We will ask for a bit of pa-

tience on some of these, but the migration to the cloud is the wave of the future and it is the way that we will maintain, I think, the trajectory that VA has undergone in terms of its overall customer service.

But, you are absolutely right. The reason the Forever GI Bill crashed and burned, the directions from this Committee were placed on a 40-year-old IT system. It was bound to fail, which is one of the reasons why I stopped us going down that same old road and pivoted just so we can make sure that our veterans got their checks.

Chairman ISAKSON. Well, let me say one thing. I am not going to ask you another question, but I am going to make a statement, and I will make an admission, too.

The State of Georgia brought me in when they lost their superintendent of schools in the middle of an election cycle, to take over the Board of Education in Georgia, and the Department of Education, going through Y2K. Now I had a pretty good company in terms of dealing with technology and stuff like that, and I learned that you can buy every trick in the book when the salespeople come in and start talking to you, because they have got an advantage. They know what they are talking about and you do not know, and you do not understand it. If you are as old as I am, you really do not understand digits and clouds and all the other stuff.

I want to find that damn cloud one of these days too. I want to see where that thing is. Everybody always says that is the solution. Well, I think it may be the problem. I just cannot find it anywhere.

Anyway, my point is this. So many times when we go to clean up a system of technology and information, we end up buying more stuff to clean up the mess, and we have a bigger mess when it is over than we had before, plus we have not solved the main problem, which is the workability and the interoperability of the IT systems we had. So, let me just encourage you to make sure we have got the right people, who know what they are talking about, making the decisions or the recommendations to you on the final decision, those that understand technology and what it can and cannot do, and do not buy every bid and promise that comes through the front door, because that gets expensive and it can cause you lots of problems.

The VA is so big, the number of employees is so large, the budget is so big, you are talking about any little problem in the VA is a big cost, particularly if it is the IT system. So, I encourage you to continue what you are doing and I appreciate what you are doing on that.

Mr. Tester.

Senator TESTER. I will yield to Senator Manchin.

Chairman ISAKSON. Senator Manchin.

HON. JOE MANCHIN III,
U.S. SENATOR FROM WEST VIRGINIA

Senator MANCHIN. Thank you, Mr. Chairman, and, Secretary, thank you for being here. I have not met a veteran yet in my State—and we have a high percentage of veterans—who want the VA to be privatized. I have not heard that from any of you all and I do not think you do either.

But, here is the troubling thing that we have. Your request is a 44 percent decrease in funding levels for construction programs. That was in the budget that you all submitted. I know that we are investing heavily in Community Care. We are leaving our current VA facilities. Let me give you a few examples.

In a rural State such as mine, in West Virginia, our rural mobile unit in Clarksburg is totally inoperable, totally inoperable. Our medical centers have not had any update nor increase in residential rehab centers since the '50s and '60s. Most of our facilities require basic maintenance, deferred maintenance as we call it, for roofs, HVAC, all of the above.

I am worried that even though our intent in the verbal agreement that we have, that we do not want to privatize because of starving some of the things, people are going to say, "Well, I would rather not go to VA because it does not have proper services. They do not have updated equipment."

It leads me right into another question, is that there are over 40,000 vacancies at any time, in any moment, in the VA. This morning there were 138 positions posted on USA Jobs, in my State—138. I have got pulmonologists, cardiologists in Huntington, psychology in Beckley, practitioners in Martinsburg. We are hurting all over the board.

So, even though the intent might not be there it looks like the signs we are moving in that direction because of demand from our veterans. If our veterans are not getting the care they are going to say, "I just need better care. I am not getting it." And, if a facility is not worth even going to because it is not in good enough shape—so you can see the concern, Mr. Secretary, of what we have and what we have to answer to. They are still totally, overwhelmingly supportive of the VA.

Secretary WILKIE. Well, let me take your comments seriatim. First, I would be lying to you if I told you that we are anywhere near turning the corner on capital investment. My estimate is that we need $60 billion over the next 5 years to come up to speed. That is an incredible number.

Let me tell you what else we are dealing with. More than half of the buildings that I am responsible for age in range from over 50 years to 100 years. This Committee has provided the way forward. We are now engaged—and I believe it was Senator Moran's idea—with market assessments of our national infrastructure and our human resource needs that will then inform, when they are done, what this Committee told us to create, and that is the Asset Infrastructure Review Commission, to bring our facilities up to speed where the veterans are.

Again, this is a monumental problem. My first job is to do as much as I can to ensure that the basic health needs of the veterans are taken care of, and, unfortunately, there are cost/benefit analyses that have to be made. I cannot come to you and say, "Give me $60 billion to repair all of those facilities."

As for the human resource side, you are absolutely right, but let me tell you where we have been and where we are headed. My first week in office I had two senior leaders give me two different numbers as to how many employees we had. Now that is outrageous. And, I asked a military question—where is your manning docu-

ment? A manning document in the military is one where you have your requirements and you have the people to match them. We never had one.

Finally, we now have a modern H.R. team in place that has come on in the last few months, at my direction. I have consolidated, or am in the process of consolidating 140 individual H.R. offices into 18, so that we have an even distribution of resources across the enterprise.

We have asked for the resources to hire 13,000 people. As Senator Tester knows, my emphasis, as the head of VA, has been for rural America, rural America and native America, those two sections of the country that provide the highest per capita number of men and women in uniform, and for the native populations, the population that provides the highest number of holders of the Medals of Honor and combat decorations.

So, it is a complex problem, as I said. I would be lying to you if I think we are anywhere near turning the corner, but I understand it.

Senator MANCHIN. Let me just say—and I am sorry, my time is up, but I just want to make this comment. I speak to veterans all over my State and anywhere I can, and I tell them, "I do not believe that we intend to build brand-new VA facilities." Then, they say, "Can't you at least take care of what we have?" That is the biggest concern they might have, and I would hope that you all would understand it. They are scared to death that they are being set up, that this thing is going to go private because the demand will switch. Demand will switch if the facilities are not adequate enough to give them the service they need.

Secretary WILKIE. Mr. Chairman, let me—let me ask your indulgence. That means we have to be much more creative. Senator Tillis is here, and he has one of the fastest-growing veteran populations in the country. In Fayetteville, my hometown, which sits underneath Fort Bragg, two massive VA facilities. The new one is leased. The VA center director does not have to worry about HVAC, does not have to worry about the lawn. He concentrates on taking care of veterans.

We have to be more creative in terms of two things: one, how we manage our infrastructure, which the MISSION Act tells us to do better; and two, giving more incentives—and I want to come to this Committee and talk about it—something like a veterans' Peace Corps, to get medical professionals out into areas like rural West Virginia, western North Carolina, and provide the means to serve those veterans in communities that are hard to reach, yet provide the highest percentage of service of anyone in the country.

Senator MANCHIN. Thank you. Sorry, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Manchin.

Senator Cramer.

HON. KEVIN CRAMER, U.S. SENATOR FROM NORTH DAKOTA

Senator CRAMER. Thank you, Mr. Chairman, and thank you, Mr. Secretary, for being here. Thank you for our previous discussion and to all of those who are with you.

I will ask my questions specifically to you and you can defer them to others if it is more appropriate. You mentioned—you

talked a fair bit in your testimony about alternatives to pain management, alternatives certainly to opioids, and you talked about some things like acupuncture and other types of care. You did not mention hyperbaric oxygen chamber treatment, particularly for pain. We have found it to be quite effective, I think, in other types of treatments, particularly Post Traumatic Stress, brain injuries, things common to veterans, athletes, and others. I just wonder why and what do you think the potential is for that?

Secretary WILKIE. Well, it certainly was not for lack of appreciation of the treatment. I pledge to you that I will be out in Fargo to look at the headquarters of one of America's largest hyperbaric chambers.

No, we have to be more creative, particularly as treatments become more complex for more complex injuries, particularly the injuries of the brain. I think we are not even at the Sputnik stage when it comes to exploring the brain and how it responds to trauma, how it recovers. Dr. Stone is probably the better expert when it comes to the actual medical conditions that that treatment addresses.

Dr. STONE. Certainly, as a practitioner who has spent much of my career doing wound management, hyperbaric oxygen is something we have worked with for a long time. Using hyperbaric oxygen to actually heal the brain or to do some of the work that you have been discussing is work that has been studied for at least a decade, in both the DOD as well as in VA.

What we know is that hyperbaric oxygen chambers have a dramatic effect in improvement of individuals with both PTSD as well as brain injuries. What we do not understand is what the addition of oxygen to the presence in that chamber does. There have been multiple studies done by all three uniformed services as well as by the VA, demonstrating that, and we look forward to further research on it. Brain rest remains one of the mainstays at this time, and certainly going into a chamber where there is silence has great value. Whether the addition of oxygen under pressure remains in debate.

Senator CRAMER. That would be interesting to see, because my understanding is that the presence of more oxygen could have the alternative impact, because, of course, it is stimulative, I would guess.

Dr. STONE. Senator, I agree with you, and as a practitioner who has done wound management in the presence of trying to penetrate oxygen into wounds, that is exactly correct.

Senator CRAMER. Well, we would love to help you with that experimentation in Fargo, so we can talk further about that later.

The other thing I wanted to mention, because you have mentioned it both in your testimony and in your answer to Senator Manchin, you talked about 13,000 more people. You are in the people business. It requires practitioners to do the work that you do, and they do it very well. And, by the way, they do it really well in Fargo. We are very pleased and proud of the service they provide our veterans.

But, it is getting harder to find good people and to attract them, to keep them, and particularly, in an economy like North Dakota has, as you are aware, it is even really elevated there. The chal-

lenge is amplified, I think, in an economy and in a region like ours, and, probably like other rural States.

That said, can you elaborate a little bit on specific programs, whether it is loan repayments—what are some of the tools that you have available, or that we could, you know, help you with, to attract and maintain and keep good people?

Secretary WILKIE. Well, I will say the Chairman and the Ranking Member inserted into the MISSION Act the first monumental step in addressing the needs of rural veterans by giving us the authority—extra authorities on relocation pay, reimbursement, the ability to pay off medical school loans up to $200,000. Those are absolutely needed.

My goal, though, is to try to even—to try to create even a more robust relationship with our universities and also with the armed services. General Bradley's goal is to have at least half of the doctors and nurses coming off of active duty coming into VA. General Mattis and I spoke a great deal about that. We are now telling doctors that when they decide to leave active service, come to VA to continue your service to those who have worn the uniform. I want to go back to the future on that, but this Committee has given us a start, particularly when it comes to rural America.

Senator CRAMER. Thank you, and thank you, Mr. Chairman.

Chairman ISAKSON. [Off microphone]—for all of his games. It must work some—he is a pretty good quarterback. I just heard that. I do not know if that is true or not. It sounds good.

Mr. MORAN. No. Mr. Blumenthal. I am sorry, and then it is—OK.

HON. RICHARD BLUMENTHAL,
U.S. SENATOR FROM CONNECTICUT

Senator BLUMENTHAL. Thanks, Mr. Chairman. I hesitate to interrupt Senator Moran, but I will.

Senator MORAN. I am anxious to hear what you have to say.

Senator BLUMENTHAL. Thanks, Mr. Chairman. Thank you, Senator Moran. Thank you, Secretary Wilkie, and your team for being here today. I want to congratulate and thank you on your announced decision that you would not be appealing the ruling of the court in the Blue Water Navy case.

Secretary WILKIE. That is my recommendation. I do not know what other departments will do.

Senator BLUMENTHAL. Well, I think your recommendation will be key; it is instrumental. I would, perhaps, with all due respect, Mr. Chairman, express on my behalf, and I hope on behalf of the Committee on Veterans' Affairs, that that recommendation be adopted and endorsed heartily to bring fairness and justice to our Blue Water Navy veterans. It would culminate a crusade that has been bipartisan, involving almost everyone on this Committee. It has been a team effort and I am grateful to you for making that recommendation.

I also want to submit, for your consideration, the Agent Orange Exposure Fairness Act, which would extend the basic principles of that court decision, and suggest also that there are other toxic chemicals and poisons on today's battlefield that are worth the research and attention that the VA should give them in deciding what kinds of benefits and disability compensation our veterans de-

serve. The potential for poisons on the battlefield is one of the great challenges of our time, one of the areas of unknown consequences to our heroes in uniform, and as the father of two veterans who have fought in recent wars and a friend of many, I hope that we can carry forward the spirit of that court decision and of your support for it.

I want to move to the Veterans Affairs' health care system, especially, in particular, the VA facility in West Haven. I think you are familiar with my letters to you on this topic. I understand that sterilization processes there essentially have been stalled so that the operating facilities are at one-third of capacity. To put it very bluntly, two-thirds of the veterans who need surgery at the West Haven facility are either sent elsewhere or their surgeries are delayed or possibly denied. That is because the sterilization capacity is limited.

The surgical facilities were closed for about 3 months because of flooding. They are back open now, but the tools and equipment used in those surgeries cannot be properly sterilized. A mobile trailer is planned for a year from now. That is way too long. A permanent facility, 5 years from now—much too long. I would like to know what the plans are, Mr. Secretary, for expediting the availability of that surgical capacity, in other words, the sterilization process facility.

Secretary WILKIE. I know how important West Haven is. Dr. Stone is supervising that.

I do want to step back, though, and say I agree with you, and some of your earlier statements about burn pits. We do not want to go through what we went through with Agent Orange. I certainly saw that in my family. I worked for Senator Tillis on the Burn Pit Registry legislation that he and Senator Klobuchar introduced and had passed a few years ago. So, it is important to me. Now I will let Dr. Stone talk about West Haven.

Senator BLUMENTHAL. Thank you.

Dr. STONE. Senator, we appreciate your role and your activism in this, in the recovery of West Haven.

Clearly this goes back to the fact that this is an older facility. We have got a steam line running underneath the sterilization area, and as we have worked to recover that facility let me reassure you that the surgery being performed in that facility today is safe and sterilization is a safe process.

Senator BLUMENTHAL. I do not doubt that it is safe, and I want to emphasize that the docs, physicians, staff are doing their best. They have one hand tied behind their back. In no way are they compromising the safety or effectiveness of the surgeries they do. They are to be commended. But, I think the VA here is failing them by failing to expedite the sterilization processes which limits their capacity.

Dr. STONE. My understanding is that the mobile trailers that would bring the ionized water and the sterilization materials in will be installed by June of this year, and that the major hold-up was because of utility issues on that area as well as the building of the trailer. The actual funding of a new sterilization facility will take 3 to 5 years. That said, my expectation is that as soon as that

mobile unit is installed this June we will begin to recover the surgery that needs to be done at that facility.

Senator BLUMENTHAL. Will it go to 100 percent?

Dr. STONE. That is my intention, absolutely.

Senator BLUMENTHAL. Can you make that commitment?

Dr. STONE. I have—absolutely.

Senator BLUMENTHAL. Thank you.

Secretary WILKIE. I will make it.

Senator BLUMENTHAL. Thank you, Mr. Secretary, and I would like to continue our conversation—my time has expired and I thank the Chairman—about the possibility of expediting a more permanent facility, but I appreciate your commitment today.

Chairman ISAKSON. Thank you.

Senator Moran.

STATEMENT OF HON. JERRY MORAN,
U.S. SENATOR FROM KANSAS

Senator MORAN. Chairman, thank you. Thank you and Senator Tester for conducting this hearing. Mr. Secretary, thank you for being here. I join both the Ranking Member and the Chairman in expressing my gratitude for your continued service to those in uniform and I appreciate the job that you are doing at the Department of Veterans Affairs.

I will have a chance, in Senator Boozman's Appropriations Subcommittee here in a few days to have more conversations about the spending and the budget recommendations. I have a couple of things that I think are timely that I want to ask you today, while I have this chance.

First of all, I would like to highlight for you, in 2014, we authorized legislation. We are now working with Senator Brown of Ohio in furthering this legislation. The National Academy of Medicine was required to do a toxic exposure analysis to determine if there is any medical and scientific evidence related to, or whether there needs to be further study on this topic of the relationship between affliction, problems, now challenges effecting generations of the service man or woman now face as a result of that toxic exposure. We look forward to continuing to find the answer to that question.

There may be a whole other generation. It saddens me because I cannot imagine anyone served their country thinking they may harm their children or their grandchildren by their service, but that very well may be the case and we are working to get the medical and scientific evidence to demonstrate that.

I also want to highlight a piece of legislation that Senator Tester led, and I joined him in introducing related to mental health and suicide prevention, and I look forward to getting input from all my colleagues, with Senator Tester's leadership on it.

Secretary WILKIE. That is the Guard and Reserve issues.

Senator MORAN. Actually, there are two of them. That is one of them and in addition to that the Commander John Scott Hannon Veterans Mental Health and Suicide Prevention Act, John Scott Hannon being a veteran who lived in the State of Montana.

For my two questions on the timeliness of this hearing, staff of this Committee, the House Committee, and the staff of our individual Senators on the Committees met with your staff in regard

to the Veterans Hearing Aid Access and Assistance Act. For as poorly as Senator Tester and I get along this is another one that he and I sponsored. It was passed into law in December 2016.

And, the takeaway from that meeting—first of all I should indicate that that legislation in 2016, the law mandates that the Department of Veterans Affairs determine the criteria for hearing aid specialists, then with the goal of integrating them into the care of veterans that the VA serves.

But, the unfortunate circumstance is that since 2016, we can find no evidence of the VA taking any steps to implement that mandate, and the meetings that I think I would describe the takeaway as little interest in meeting that mandate. I highlight, and the reason it is timely is that we asked for a response from VA officials by today's hearing, knowing that you would be here, yet we have received none to date. Perhaps—Dr. Stone appears to be interested in talking about this conversation.

Dr. STONE. Senator, thank you. I appreciate it. I was unaware of the letter. If we have not responded you have my apologies. We will correct that today.

Senator MORAN. I had intended to send a letter. We did not send a letter. It was a conversation with officials at the VA, saying, "OK, the Secretary is going to be here on Tuesday. Could you please get back to us by then? Otherwise, we need to raise this topic with the Secretary."

Dr. STONE. You happened to be looking at a hearing-compromised veteran from my combat service, so I am deeply appreciative of what the VA has brought to me and my family, as we have sought care for my hearing loss due to combat. So, I am well aware of the issues that you bring up. Let me say to you that we, last year, performed over 1 million visits for hearing-compromised veterans, with our audiologists and our technicians. We have continued to grow that. We refer out about 38,000 visits a year and we appreciate the legislation on hearing aid specialists.

But, the question is do we need to move into the specialist area? Clearly you and I may have a different understanding of the role of the specialist. Today I have enough audiologists and enough technicians in order to provide that vast, vast majority of the care that is needed, including less than a 10-day waiting period in order for veterans to come in for care or for their appliances. In addition, we have an under-two-week waiting period in order to take outside prescriptions and fill them on behalf of the veterans.

Senator MORAN. Let me suggest this, Dr. Stone, that maybe with Senator Tester and I's staff we could have this conversation. In the zero seconds I have left, Mr. Secretary, I am in Emporia, KS, on Saturday, 4 days from now. Emporia has a CBOC. The CBOC has 2 days of service and rarely has a physician. It has a mid-level practitioner. The Department, the Eastern Division in Kansas, has announced the closure of that CBOC. One would expect me to be angry about the closure of that CBOC. I am hopeful that with the closure of the CBOC and conversations with the VA that the MISSION Act now provides additional opportunities for care for veterans, because we go from a 2-day CBOC with virtually—with often no physician and one mid-level, to an opportunity for a mul-

titude of community resources being available to those veterans in that area.

I am going to meet with—your folks in Kansas are joining me in Emporia on Saturday. What message would you like for me to deliver about the opportunities that MISSION or the VA now can provide?

Secretary WILKIE. The MISSION Act is about veteran-centric care. It is not about protecting the institution or guarding the status quo. It is about giving that veteran the option to be the guardian of his own or her own future. For rural America, offering the widest aperture possible on access to medical care is meeting the intention of this Committee. As long as we keep the veteran's health at the center of everything that we do then the system will work.

Senator MORAN. I will convey that to those veterans who join me on Saturday.

Mr. Chairman, thank you.

Chairman ISAKSON. In keeping with our bipartisan Committee commitment I am going to excuse myself for just a minute and turn it over to Senator Tester to continue the hearing, and it is also his turn to ask questions. I will be back in a second. Senator Tester?

Senator TESTER [presiding]. Thank you, Mr. Chairman. I assume that means I can just expand the time that I use.

Chairman ISAKSON. It means you have to behave.

Senator TESTER. Oh, I have to behave. Damn it.

Thank you all for being here once again. I hesitate to talk history with somebody who probably knows history far better than I do, especially military history; nonetheless, this is pretty elementary.

In the 1930s, this country did not want to go to war. President Roosevelt turned our car factories into airplane manufacturing and prepared for war, and then came the bombing of Pearl Harbor and we were ready for war. Pretty simple. Pretty ingenious.

Everybody on this Committee, I believe, has said no privatization, and all the VSOs have said no privatization. The President has said something different. You have said no privatization and your staff has also said that.

The questions are asked here today, and I have talked about our vacancies in Montana. Manchin talked about his vacancies, his facilities, that needed improvement. Blumenthal talked about West Haven surgical that was at one-third capacity. Even Senator Moran, even though is not mad about it, is talking about a CBOC that is going to be closed because of the lack of staffing. Everything that I am hearing and everything I am seeing says something different.

Then, I look at the budget and the budget—and you had said earlier that you needed $60 billion in capital investments—and the budget request for major and minor construction was decreased by 43 percent for major construction and 50 percent for minor construction. We are talking about the needs that are out there. By the way, we can go down the list in Montana. It is pretty reflective.

I was at the meeting 6 days ago when you guys said you cannot get the money out the door; nonetheless, you talked about $60 billion in capital expenditures and reducing those accounts by 40 and 50 percent.

Putting all that together, how can we justify that?

Mr. RYCHALSKI. Senator Tester, I can probably shed some light on that. First let me say that as Department CFO I feel dirty not asking for more money, to be honest. But, the fact——

Senator TESTER. The issue is not that you are just asking for more money. I do not care if you ask for more money, but if you have got $60 billion in needs over the next 5 years, and we are reducing those same accounts that will meet those capital expenditures, something does not jive. That is all.

Mr. RYCHALSKI. Let me explain. I was being a little bit facetious.

The fact of the matter is we do have a requirement. There is no question. We have older facilities and we do have a substantial facility requirement. As you know, we had a substantial plus-up in 2018 and 2019. The fact of the matter is that we sort of, very quickly, executed our shovel-ready projects and they are in the works. We are at a point now, when you sort of divide the amount of money we have in the works by the number of facilities, we have about 19 to 20 projects per facility going, and they have limited capacity in a lot of areas, of moving clinics around, moving people around. We are now hearing from a number of facilities, they have actually some shovel-ready projects that they just cannot execute because it is too disruptive.

We are going to end up carrying some of that money forward, from 2019 into 2020, and we are going to carry about $1 billion of the plus-up in NRM. We are also going to carry some minor construction money for——

Senator TESTER. Gotcha. So, I am going to do some quick math for you, not that you do not know this already. If you divide 60 by 5, it is $12 billion a year. And, if that need is out there and we cannot execute the amount of money we have got so far, how do we not privatize the VA?

Secretary WILKIE. Well, we do not privatize the VA because we still have the largest health care system in the country——

Senator TESTER. Got it.

Secretary WILKIE [continuing]. 170 hospitals.

Senator TESTER. Yep.

Secretary WILKIE. Our veterans are voting with their feet.

Let me just say, this is not a libertarian VA. If it were, I would be giving myself a card that says "veteran" and I go out in the private sector and get anything I want.

Senator TESTER. I hear you.

Secretary WILKIE. That is not happening. Again, I fall back, not on anecdote but on the stats. Our veterans are happy. They are going where people speak their language and their culture. I support that and this Committee supports that.

Senator TESTER. Mr. Secretary, I agree with you, but I go back to the example of history. If we are short on manpower, if our facilities are short and substandard, if we are not making the HVAC additions that we need to, eventually those veterans that are going to the VA, they are going to say, "Nope. Not anymore."

Secretary WILKIE. Well, you gave me—this Committee gave me the answer, and that is the market assessments——

Senator TESTER. Yes.

Secretary WILKIE [continuing]. And then the Asset Infrastructure Review Committee, which does exactly what you said, and I think I am going to come to you and ask to accelerate the beginning of that commission.

Senator TESTER. Of the AIR Act?

Secretary WILKIE. Yes, so that it moves more rapidly than the timeline that this Committee has given it.

Senator TESTER. Really quickly, I do not have a problem with that. Can you give me an idea on how quick—because it is set to go into effect in 2021 or 2022? OK.

Secretary WILKIE. I would like to do that earlier because our market assessments are already underway.

Senator TESTER. I would love to visit with you about that, moving forward. OK.

Now we have Senator Boozman.

STATEMENT OF HON. JOHN BOOZMAN,
U.S. SENATOR FROM ARKANSAS

Senator BOOZMAN. Thank you very much, and we do appreciate you and Senator Isakson. We can be very proud that the 2019 appropriations, because of your two's leadership in the Committee, was significantly increased, and I think again we are going to see that going into the next fiscal year. We appreciate your leadership, Secretary Wilkie, and your team, especially in grappling with the Forever GI Bill and getting that under control. I know that was a hard thing to do. Also your work with veteran suicide. I think that we are coming up with a method now that is going to have significant results, so we really do appreciate that and appreciate that in your leadership style, again with your team.

One thing I would like to understand, I was in Arkansas last week in a lot of our smaller communities that will be impacted by the MISSION Act. I guess what I would like to understand is there is a little bit of confusion as to what is going to happen in June. So, we will have the rules and regulations in place, going forward. For the veteran in Mountain Home, AR, who is being told he is ineligible for Choice because of the nearby location of the CBOC, even though it does not provide the medical service he needs, what is going to happen to him in June, if anything? Will he be able to talk to VA on June 6 to get authorized for care from a private hospital, or what is the process?

Dr. STONE. The process is that the veteran will continue to talk to his provider or his scheduler in order to really authorize care and make the best decision on behalf of the veteran. Frankly, June 6 should also be a non-event for the veteran. Today we authorize—well, today we will do over 300,000 visits in our direct care system. We will authorize about 50,000 visits in the community care system. That is all done on a manual basis by our providers and schedulers.

On June 6, it is our hope to have something called a decision support tool that will automate that process. Should we fail with the decision support tool it will look just exactly like it does today. Now, there will be an enhanced number of veterans eligible to make a decision of whether they want to go out for care or not, but the system will look very similar to what it does today, as far as

a veteran sitting in front of a provider or a scheduler or on the phone, making a decision on whether they stay or they go out for care.

Senator BOOZMAN. So, for those that are eligible on June 6 for—theoretically for enhanced care, in the sense that, you know, they are going to fall into the new parameters, if they call will they be told "do this and this," or will it be "We are phasing this in. Call back?"

Dr. STONE. Senator, this will be—they will be told what they need to do for care. There should be no increase in wait times. There should be no increase in wait for care.

Now our problem is that in most areas of America the commercial health care system is not as responsive as we are. Please remember, of those 300,000 visits we are going to conduct today over 22 percent are same-day visits. In the commercial space it is not as responsive. As the Secretary has said previously, in an urban area in the Southeast, it was found that the wait time for the commercial space was dramatically higher than ours.

Senator BOOZMAN. I would like to talk—and again, mine was more in the context of the travel time versus the wait time, but we will talk about that.

The veteran suicide, the collaboration with these groups that seem to be doing a good job, the Secretary and I were in a meeting earlier this morning and one of the Congressmen talked about a program that they had a 70 percent reduction in suicide as a result of. Can you talk about the efforts of the collaboration so that we can get these public-private partnerships going that seem to work well? Again, we need to make sure the metrics are there and all of those things.

Secretary WILKIE. Yes, sir. So, the budget calls for $222 million for suicide prevention programs. I have just been named as the chair of the National Task Force on Suicide Prevention. You know the terrible statistics—20 veterans a day take their lives, 14 of those are outside of our VA.

I think the most important part of the task force, other than a whole health approach to suicide prevention, is the opening of the window for monies to flow into the States and localities, to help us find those veterans.

Example—I was in Alaska with Senator Sullivan. More than half of the veterans in Alaska are not in the VA system. I asked the Alaska Federation of Natives to double the number of VA tribal representatives that they have, to go out into the hinterland of Alaska and help us find those veterans who are not in our system. It sounds simple. Sometimes simple solutions are the better solutions. The States and localities know better than we do, in many of these instances, where veterans are and where they are in need.

A couple of things. I am not going to give you a metric saying that we are going to achieve zero suicides. The majority of veterans who take their own lives are Vietnam era, my father's generation. Some of these Americans have problems that began building when Lyndon Johnson was President. We are not going to be able to cure all of that, but we can—and if the Chair will indulge me—as the former Under Secretary of Defense for Personnel, General Mattis and I both began a system of education throughout an individual's

military career that focused on mental health wellness and taught a soldier, sailor, airman, Marine, to look for the signs of danger, so that for the first time in our military history we actually have people coming out of the service who at least have had some educational grounding throughout their term of service in what to look for, when to ask for help, not only for themselves but for others.

The deepening of the relationship between VA and DOD is absolutely essential, so we never again have those numbers that we have now, that began to build in Southeast Asia 50 years ago.

Senator TESTER. Thank you.

Senator Hirono.

HON. MAZIE K. HIRONO, U.S. SENATOR FROM HAWAII

Senator HIRONO. Thank you, Mr. Chairman. Mr. Secretary, thank you for recommending that the Blue Water decision not be appealed. At this point, appealing that decision is not what we should be using our resources for, so use your persuasive powers to make sure that that happens.

There was an article recently—oh, by the way, I understand that the Chairman is going to have a hearing later on your proposed access standards. That is good because a lot of us have expressed concerns about how those standards were developed and the fact that we heard from many VSOs that they were not consulted during that process. So, that will be happening in April, I understand.

A few weeks ago, Mr. Secretary, the *New York Times* published a story with the heading, "Treated like a piece of meat: Female veterans endure harassment at the VA." Have you read that article?

Secretary WILKIE. I have.

Senator HIRONO. So, it paints a pretty dire picture of the kind of experiences and harassment that the women veterans who go to the VA endure. What is the VA going to do to make sure women veterans are respected by the VA staff and other patients? I realize that there needs to be some kind of a cultural change, but I do not know. Posting signs, whatever you need to do so that this is not the horrendous experience of women veterans, as described in this article.

I want to know whether the VA is conducting any research into the best practices or models of care that increase women veterans' utilization of and satisfaction of VA services. Your testimony mentions that 91 percent of VA's community-based outpatient clinics have a women's health primary care provider. So, when can we expect that number to be 100 percent, because you are almost there? Can you respond to those two?

Secretary WILKIE. Well, that is certainly the goal, and in our—Senator, in our previous relationships, from my former capacity as the Under Secretary of Defense, you and I discussed that the first thing that I had to do as the Under Secretary was promulgate the first DOD regulations on sexual harassment and equal opportunity, which we did. So, that tells you my commitment.

You hit on it. It is a cultural change. I do not believe that what was in the *New York Times* story is apparent in all of our VA facilities. I am not going to be able to tell you with a straight face that I can change the attitudes of every person who works in the VA,

but we are changing the culture. We are putting in women's health centers in all of our VA hospitals.

One of my goals is to make sure that there is an actual privacy barrier, separate entrances, that in the case of this *New York Times* story, those things will probably less likely to occur just by changing the way we bring our women veterans into the system.

I can say that we now—we had 500,000 appointments last year for women veterans. That is a sea change. I will also say that the culture that you talked about is now beginning to change within DOD. I think the longer that that goes on, the less likely you will see an end product such as you described in VA. But, I think we are on the right path.

Senator HIRONO. One would think that when you make those cultural changes that you may not need to expend resources on separate kinds of facilities, but obviously that is something that the women veterans very clearly want at this point.

I want to get to the lack of progress that I have heard on various VA health care projects. For example, the Advanced Leeward Outpatient Healthcare Access, the ALOHA project, in Hawaii, on Oahu, was scheduled for a lease award early calendar year 2018, but has been delayed a number of times and a lease has still not been awarded.

The project was scheduled to be completed originally by fiscal year 2020, and I know that these kinds of outpatient clinics are really helpful because they are usually closer to where the veterans live, and in Hawaii the Tripler Hospital is very crowded, you can hardly get any parking, and it is a pain in the okole, as we say in Hawaii.

So, you know, can you commit to seeing that the ALOHA project is completed on time with no further additional delays?

Secretary WILKIE. Senator, as you know I spent a great deal of time in Hawaii last year. I talked with the Governor about this lease. I will get you more information. My understanding was that there were contractual problems with those responsible for improving the facility. That was what I discussed back in December in Honolulu, but I will get you more information on that.

Senator HIRONO. Thank you, because I would like to see this and other CBOCs come through.

Thank you, Mr. Chairman.

Chairman ISAKSON [presiding]. Thank you, Senator Hirono.

Senator Blackburn.

HON. MARSHA BLACKBURN, U.S. SENATOR FROM TENNESSEE

Senator BLACKBURN. Thank you, Mr. Chairman, and I want to thank you all for being here. Secretary Wilkie, I thank you for the time you have spent with me prior to this, to talk about the needs that some of our veterans in Tennessee have, and to look at how we fulfill that promise of providing for them and for their health care.

I want to start with the EHRs (electronic health records) and your deployment, the modernization that you are doing there. As we have talked, many of our folks would like very much to be able to, under the MISSION Act, seek that care at home, because they

are a good distance away from a facility. And, as we have talked before, interoperability is an imperative in making this work.

I want to know where you are, what control measures you have that have been implemented to ensure that you are going to meet your milestones as you go through this deployment, as that begins to take place.

Secretary WILKIE. Senator, we will go live in March of next year in the Pacific Northwest to reach our initial operating sites. That is on schedule. There are issues that we need to work our way through. These are old facilities. We need to rebuild our communication closets, and that is going to go on this summer. We also need to work our way through all of the internet of medical devices and make sure that they are appropriately——

Senator BLACKBURN. OK. Let me ask you this. As you are doing that, are you working on a plan so that when someone enlists, day one, they begin a cloud-based, encrypted record that will follow them the rest of their life.

Secretary WILKIE. Yes. That is the goal. I use my father as an example. The days of somebody carrying around an 800-page paper record are gone.

Senator BLACKBURN. Right. But, I think it would be instructive and helpful to us if you could provide us with your timeline of when you are going to achieve this.

Now, in the Health Committee today, they are doing a hearing on the EHRs, and we know that whatever you do that you have to have a strategy so that this is going to be interoperable with commercial best practices. So, you have that in place.

Secretary WILKIE. Yes, we do, and obviously you mentioned the goal is to begin building that record the minute that young American walks into a military entrance processing station, and then there is a handoff. I expect—and I do not know when there will be new changes in leadership at the Department of Defense, that I will continue the relationship that I had with General Mattis. I expect to come to this Committee with the announcement of a joint program office, which will be the first—I believe the first joint program office between two departments, so that we combine the resources of both departments to build this record.

Senator BLACKBURN. OK.

Secretary WILKIE. It will be interoperable. I did—I would have never approved it if it could not be interoperable with the private sector.

Senator BLACKBURN. OK. Telehealth. I was recently in Gallatin, TN, to open a veterans clinic there, which is one of the whole-of-life clinics. The day after that I was over at the Nashville VA for the new mental health center. We were walking through that. I think that those are important components to have, because the telehealth helps to bring those services to them, especially in behavioral health.

I want to know how you are—what is your strategy and your timeline on moving more facilities so they are functioning with telehealth and have that whole-of-life approach to the clinic. We have got a lot of clinics, people cannot get to health care, long waiting lists, and this helps to speed the process.

Dr. STONE. You are exactly correct. About three-quarters of a million veterans consumed telehealth visits last year. That is about 13 percent of the veterans that are enrolled with us. This year's budget will move that to 20 percent. We believe that in order to keep veterans in their homes, especially at-risk veterans, instead of hospitalization, expanding telehealth services is absolutely essential. So, we will move to 20 percent under this budget.

Secretary WILKIE. I would say this Committee has given us authority that no other health care system in the country has, and it allows our doctors to practice across State lines. This is the front line of our attack on the problems of mental health, as you mentioned, with behavioral health. It provides our veterans with the opportunity to stay at home, stay in a comforting surrounding, and stay with people who look after them, their friends, their families, without forcing them to go into a larger facility.

Senator BLACKBURN. I appreciate that. I know my time has expired. I just want to say listening to you all, as you talk about the budget and you talk about urgent needs, things should never have gotten into this shape—never—and it comes from mismanagement. My hope is, as you set these timelines for implementing technologies that are going to enable greater access, that you also are utilizing technology to make certain that there is not the gross mismanagement that has taken place in times past.

Chairman ISAKSON. Senator Murray.

HON. PATTY MURRAY, U.S. SENATOR FROM WASHINGTON

Senator MURRAY. Thank you very much, Mr. Chairman, and thank you, Secretary Wilkie, and your team for being here. Let me start with the fact, Caregivers. I am sure you are shocked I am going there. But, the October 1 deadline that the Caregivers' IT system was to be certified to begin the expansion process is quickly approaching, and the VA still has a lot of work to do before then. We have now heard rumors in the press and in briefings that the VA might not make that deadline. I do really appreciate your personal understanding of the challenges caregivers face. I know you can appreciate how much our prior era caregivers and veterans need this support.

For the record, will you meet the October 1 deadline to certify the IT system and begin expanding eligibility for the caregivers program?

Secretary WILKIE. If I do not I will be back up here, but let me take a step back. The reason that I made the decision not to remove anyone from the Caregiver program was because of not only your work and your insistence but because this process has been mismanaged in the past. So, that was the right thing to do, and that is why I made that decision, based on your recommendation.

The date is October 1. The statute says that I have to certify that the system is working. If I do not certify that no one will be removed. We will continue to manually process the checks. Right now there are 24,000 stipends that go out. It is manually done. But, as long as those checks get to our veterans that is fine with me.

We do have a new commercial office shell technology, and if you have not been briefed I will get you someone to brief it——

Senator MURRAY. OK.

Secretary WILKIE [continuing]. That we brought on board February 22. That is the template that we will be using, hopefully, to be ready on October 1.

The other side of this is that we have increased the budget, primarily because of your work, to about $720 million. I expect that to go up in the next few years. But, we are also using that money to hire professionals to staff out our Caregiver program.

Senator MURRAY. OK.

Dr. STONE. Senator, if I might add, this is a manual program today and there are over 24,000 families receiving benefits. Their checks are manually written every day. As we move to this commercial office shell software system, what we will need to do is to migrate all of the data over and then assure that we can then, on an automated basis, write the checks every month before we are ready to expand. And, although we have made a decision on a software system, the migration of that data we have not recommended a certification date yet on the software system and the expansion.

Secretary WILKIE. I am not going to do it unless it is right.

Senator MURRAY. OK. I appreciate that. At first glance, your request for Caregivers looks strong and appears comprehensive. However, several components of the program are in need of resources. You mentioned staffing, the IT system, the planned expansion of support services provided to caregivers. All of those will need an increase during expansion. And, your budget requests $150 million for expansion of the Caregiver program, leaving $555 million for the needs of the existing program. As I have made clear in previous settings, I want to be sure this request is not individually underfunding expansion or the needs of the existing program.

I wanted to ask you, how will this funding, especially for the expansion, be allocated, and to which areas of need?

Dr. STONE. The basic management structure of this program was done at individual medical centers, resulting in dramatically different criteria for inclusion and removal from the program. The first thing you will see is a stand-up of a regionalized management system to look at who is eligible and who will be removed. No one will be removed until we can assure you that we are doing this in a clear manner that is transparent to America's veterans and to the American people.

As we stand up that regionalized process, that will occur under the chief medical officer of each VISN. We will move from the individual caregiver being the gatekeeper of this program to a regionalized board process, and then institute an appeal process at the VA central office.

So, the entire management structure, in order to do this to the Secretary's standards and the standards that you expect, needs to be stood up and put together. We have introduced this concept to the VISN leadership last week and have begun talking to the chief medical officers about the hiring and stand-up of this system.

Now——

Secretary WILKIE. Let me—the last thing I will say, Senator—I have used your time—we are retraining our clinical staff across the country with the most modern techniques and information on how to deal with families and caregivers. I would say that I think VA

is really the only health care system in the country that has concentrated on this. As the son of a Vietnam soldier it is vital to me.

Senator MURRAY. OK. I appreciate it, and I know this is something you personally care about, too.

As you know, I am going to stay absolutely on top of this. We want to implement it. We want to implement it correctly. We do not want to deny people this care that they have been waiting for, this help and this support. I appreciate your response today, but I will stay in close touch. Thank you very much.

I do have other questions, Mr. Chairman, that I will submit for the record.

Chairman ISAKSON. Thank you, Senator Murray.

Senator Tillis.

HON. THOM TILLIS, U.S. SENATOR FROM NORTH CAROLINA

Senator TILLIS. Thank you, Mr. Chair. Gentlemen, welcome. Secretary Wilkie, it is great to see you.

First off, I want to thank you all for, in your budget request, funds to expand the CBOC down in Jacksonville. How do you see that—well, first off, for people who would suggest that there is a trend in the VA, or Members of Congress to privatize, it seems like budget requests for the expansion of the CBOC, the opening of 1 million square feet in three different health care centers in North Carolina, with a different model, that you mentioned earlier when I was here, seems to suggest that you believe the brick-and-mortar VA presence is a very, very important part of the future.

So, I would not—I would like you to maybe touch on that. But, tell me how that CBOC expansion in Jacksonville, in combination with the PACT teams, are going to help improve care there, and then how do you leverage the PACT model for the rest of the veterans across the country?

Secretary WILKIE. Well, Senator, let me talk about business processes that have led us to that stage. As I mentioned earlier, we are in the process of doing market assessments across the country to lead into the Asset Infrastructure Review Commission. The demographic changes that I see for veterans are changes that mirror those in the rest of the country. By 2027, North Carolina will have the fourth-highest number of veterans in the country. It will begin to nip at the heels of California.

Senator TILLIS. And, it will be the eighth-largest State.

Secretary WILKIE. Yes. For those—like Senator Brown just came in—Ohio remains in the top 10. Because of the large populations in those States—and Georgia is in the top 10, as far as we can see in the future—we have to be more creative. We have to not only combine the brick-and-mortar facilities that we have, we have to manage them more efficiently, but we also have to create an environment where our teams can reach rural areas of our States and be more creative when it comes to things like telehealth. But, we are moving our resources to where the veterans are, and I think Dr. Stone has your PACT answer.

Dr. STONE. The PACTs will continue to expand across the Nation as we hire. In Montana alone we have 38 primary care providers. We have got offers out to 8 additional primary care providers that will come in and expand that rural area.

The Secretary is exactly correct, that we are seeing growth in north Florida, we are seeing growth in south Georgia, we are seeing growth in your State, sir, and we will continue to expand this.

Now let me talk about brick-and-mortar. Veterans are not different than the rest of Americans. Our parents' generation stayed in the same house on a generational basis. We do not and our children do not. They move. We must be able to move from place to place in order to follow where the veterans go. Therefore, lease authorities are incredibly important to us, and enhanced lease authorities that would allow us not just to provide housing, but to also be able to provide ambulatory medical facilities that we can move every 5 to 10 years as to follow where America's veterans are.

Much of the non-recurring maintenance that you hear about and the cost of our infrastructure is for our inpatient facilities. Our inpatient facilities, in many cases, are aged and need substantial improvements, but our ambulatory facilities, more than 1,000 of them, need to be able to be mobile when the veteran moves each decade.

Senator TILLIS. Thank you. I want to talk a little bit about access standards and the MISSION Act. I think I could infer, at least, from some comments from some of my colleagues that it is almost like we are giving some of our veterans too much choice. In some States I think you have 100 percent access to Choice if you want it, which there may be a variety of reasons why you need that. My colleague just came in from Alaska. He has got a very diverse population over a geography that almost spans the United States, from tip to toe, so I can see why you have to have a different solution for different States.

But, what would happen, what would be the negative consequence if Congress succeeded in rolling back the access standards that you are putting in place now, in combination with the MISSION Act?

Secretary WILKIE. Well, Senator, it would no longer be a veteran-centric, patient-centric approach to health care. That was the clear mandate of the MISSION Act, not institutional prerogative, but the health care of a veteran.

So, let me beg the Chair's indulgence and describe what this is not, as I mentioned earlier. This is not a libertarian VA. This is not giving Dr. Stone or me a card and saying, "Thank you very much. Go out and find whatever doctor you want to take care of you for the rest of your life." What this says is that if we cannot provide a service then you have the option to seek that service in the private sector.

I will give you an example. If there is no rheumatologist, and there probably is, in Fayetteville, and you meet the criteria for that service, then we tell you that you have the option to go to Duke or to Chapel Hill or to Cape Fear Valley, in my hometown, to get that service. It is based on the needs of the veteran, and veterans come first. If we cannot do what the veteran needs then we will provide him the opportunity to seek that.

Senator TILLIS. I think it is very important, Mr. Chair, just to close out my questions, that is why I think a broader understanding of what you are trying to accomplish with the patient aligned care teams. It is not like you are giving them a card and

sending them on their way. I mean, you are going to spend a lot of time making sure that the outcomes are going in the right direction, that they are getting their appointments filled when they need to, and you will always have that brick-and-mortar presence, if necessary. I, for one, think the access standards need to continue to move forward and the work that you are layering on top of it is going to provide a better standard of care for the veterans. I thank you for your work.

Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Tillis.

Senator Brown.

HON. SHERROD BROWN, U.S. SENATOR FROM OHIO

Senator BROWN. Thank you, Mr. Chairman. Secretary Wilkie, thanks for your letter back to me regarding the VA History Center at the VA in Dayton, OH. We are excited to get the next phase of this project up and running. My staff and I look forward to a briefing on how this project is progressing. We will be in touch with you about that.

I will be brief. I have a number of questions. Senators Tester and Boozman and I have been working for years to push VA to track and report an overpayment in veteran debt. I have had constituents who have reported a change in status or a dependency to VA and VA did not take action, leading to an overpayment in debt. We were able to get some provisions through last year, as you know. Last week we introduced our updated bill to clearly outline the reporting process for veterans and their families to foster better interagency coordination, reduce overpayments.

I would like your commitment that VA will continue to work with the three of us.

Secretary WILKIE. Yes, sir.

Senator BROWN. Thank you.

Over the past month—this is a bit of a follow-up to Senator Moran's comments and question about toxic exposure. Over the years you and I have discussed this issue, whether it is Agent Orange or burn pits. It took this country far too long to come to terms with Agent Orange, so each veteran did not have to apply individually and go through that pain. I appreciate the decision not to appeal on the Blue Water Navy. That is really important.

Secretary WILKIE. That is my recommendation, Senator. I do not know what other departments are doing.

Senator BROWN. That is your recommendation. OK.

My question is this, I would like to know when VA intends to make a decision regarding the National Academy's recommendations on Agent Orange bladder cancer, hyperthyroidism, hypertension, and Parkinson's-like syndromes.

Dr. STONE. Yeah. We are working our way through that right now and it would be my hope within the next 90 days that we will have some decisions made.

Senator BROWN. OK. Then, you make the decision and it quickly is ratified by Secretary Wilkie. Is that how it works?

Dr. STONE. Sir, I would not presume when the Secretary would——

Senator BROWN. He is sitting right next to you. You might ask him.

Dr. STONE. Yeah.

Senator BROWN. OK. Thank you.

Secretary, thank you for that. You said that Congress put real expectations on an outdated IT system for the Forever GI Bill. Respectfully, sir, VA's IT and programmatic offices should be able to flag these issues for leadership, and leadership should respond accordingly and update Congress.

Secretary WILKIE. If I said that I probably misspoke. I should have said that the VA systems were not capable of handling the changes that Congress mandated.

Senator BROWN. But, they will be.

Secretary WILKIE. They will be, yes.

Senator BROWN. VA went through similar issues with IT for caregivers expansion. Why did that take 6 to 7 months as well?

Secretary WILKIE. That I cannot tell you, based on my tenure here. What I—my short tenure. What I can tell you is that, once again, because we were not ready to implement the programs required to support our caregivers I made a command decision, based on my discussions with Senator Murray, to make sure that no one was removed from the program, that the checks, the stipends that went out to 24,000 caregiver families were done manually, but they were done, and I do expect to come to this Congress by the deadline on October 1, hopefully certifying that the commercial, off-the-shelf technology that we purchased to support caregivers is in place.

But, I will say I am not going to certify anything that does not work. We have been down that road before and that led to the problems with the Forever GI Bill. That led to the problems with caregivers. So, you have my commitment that nothing moves unless we are convinced that it helps veterans.

Senator BROWN. Thank you, and I want to reiterate what the Chairman said about the legacy IT systems, getting them to work together, to work for all of our veterans. That is so important.

One more comment and one last question. The comment is—well, the question is when can we expect nominees for Deputy Secretary and Under Secretary for Health? When is that going to happen?

Secretary WILKIE. Hopefully soon. We have made the recommendations, and I hope there will be an announcement from the White House shortly. I will thank the Committee for approving the nominees for the Office of Whistleblower Protection and CIO.

I do want to say one thing, though. There is an added layer of approval for the Under Secretary for Health. The law, unlike for any other position in Federal Government, requires the convening of a commission to meet, deal with candidates, deliberate, and then pass a recommendation on to me. That was the reason for the delay in the 8 months that I was here, because the commission had to be convened.

Senator BROWN. My last comment. I heard your—thank you, Mr. Chairman, for your forbearance—I heard your Senator, your junior Senator from North Carolina, his laying out Choice and privatization, and I know how he stands on that. I have been disappointed that you are not quite as opposed to privatization as I thought you were during the nomination process. I just ask you—I am not ask-

ing a question, particularly, but just ask you to listen to the veteran service organizations and what they think about this President's philosophical commitment to privatization that I hope the VA does not follow.

Secretary WILKIE. I will say, Senator, with your permission, Mr. Chairman, I think I have been very clear about where I stand and where I think the Department is heading. I think the legislation was right on target when it said that the veteran is at the center of everything that we do. I also think that the veteran is voting with his feet, or her feet. Our customer satisfaction rates are at an all-time high. I look at that as the gauge as to how well we are doing.

I also believe, and I am not one to use a lot of anecdotes but I can say, as someone who has spent an entire life in and amongst the military, that our veterans, no matter what age they are, will go primarily to someplace where people speak the language and understand the culture, because there is nothing else like it in the United States. And, I stand by what I have done in the last 8 months.

Senator BROWN. I understand and appreciate that, but I also understand that the way that Congress appropriates or withholds money can have a whole lot to do with people voting with their feet, so I hope you will keep that in mind.

Thank you, Mr. Chairman.

Chairman ISAKSON. Senator Sullivan.

HON. DAN SULLIVAN, U.S. SENATOR FROM ALASKA

Senator SULLIVAN. Thank you, Mr. Chairman, and, Mr. Secretary and your team, thank you for being here. I also am interested in the nominees, you know, for Under Secretary, very important, so we need to get those out the door. I also want to mention to my Democratic colleagues they also need not to delay the nominees once they are on the floor. There has been very, very unprecedented obstruction of very basic nominees for their confirmation. So, we get them out the door and we will have guys like Senator Brown move them quickly as opposed to delaying them, because that is not helping at all. It was not a nice try. It is actually a really serious issue, so they need to help. They cannot just say, "Give us nominees" and then delay them for 10 months. It is ridiculous, and that is what has been happening.

Let me mention—first of all, congratulations on these national awards. I think that what you are talking about for your team, it should be commended. Sometimes you guys come here, you get the wrath of the Congress, and we rarely recognize when there has been improvement. I am going to recognize it and I appreciate it. So, keep up the good work on these things.

You may have also noticed the Alaska VA health care system was also awarded, with the most improved inpatient experience for the entire country in 2018. I want to thank all of you for that.

Secretary WILKIE. Dr. Ballard is one of the best.

Senator SULLIVAN. Dr. Ballard does a great job. But, it is help from the top. You know, the VA out in the Mat-Su Valley, a huge veteran population, finally has not just one, not just two, but three doctors. It only took 5 years but now we have some doctors. Thank

you for that, and, Mr. Secretary, I also want to thank you—it is not exactly in your purview but you may have seen my Alaska Native Vietnam Veterans Equity Allotment Act was recently signed into law, and when the President cited the broader bill it was in he highlighted this very important bill for Alaska that helped our Vietnam veterans overcome a huge injustice——

Secretary WILKIE. May I——

Senator SULLIVAN [continuing]. And the fact that the President highlighted that in his signing ceremony made me very happy.

Secretary WILKIE. I will add to that, Senator. I mentioned that the caregiver legislation closes one of the last loops of the Vietnam era. Sadly it has been 44 years since the fall of Saigon. I think the Alaska allotment issue was one that sadly took almost as long, and I think that also closes a loop, particularly for a State that has the highest per capita number of veterans in the country.

Senator SULLIVAN. Well, I appreciate that, Mr. Secretary, and you weighing in on that, former Secretary Zinke weighing in on that. Again, previous administration, remarkably they were opposed to it, so you guys at the Cabinet level weighing in really helped make it happen. Thank you for that.

I wanted to talk about what the Veterans Benefits Administration is working on—and I know it is a big issue for you—identifying off-the-VA-grid veterans who have yet to make contact with the VBA and its services. I know you are looking at possibly doing a case study in Alaska. You know; you have been out there. So, thank you. I look forward to your visit and Dr. Stone's visit here soon again.

Can you just talk a little bit about that, whether it is the pilot program in Alaska. We do have enormous challenges on this issue, but also how you are working it in other rural communities throughout the country.

Mr. LAWRENCE. Certainly. You may recall that at confirmation time when I visited with you, you spoke about your reference to engage your constituents. So, after I was confirmed I did not forget that conversation. I set in motion to try to figure out how we might actually do that, our presence augmented by our relationship with the county and State VSOs, as well as tribal and communities to better understand how that network should be set up so that if you cannot touch us you can touch somebody who can touch us.

That is what we are trying to do, and we are using Alaska by engaging those groups to figure out exactly how the workings of that take place and what we can do in terms of the ways we communicate and the effectiveness by way we are able to do that. So, we are trying to use that in understanding how do we mobilize all the resources that are in the veteran community, VSOs included, to figure out how we do those touches and engage folks effectively.

Senator SULLIVAN. How about the pilot program you are looking at in Alaska?

Mr. LAWRENCE. It is just—I am happy to come brief you on some of the details. We are just getting started, in terms of how that all works.

Senator SULLIVAN. OK. Well, I appreciate you guys focusing on that.

Mr. Secretary, I know you have been asked earlier by Senator Boozman and others on how you are feeling with regard to the MISSION Act launch date. You know, Alaska has been carved out, its own region, Region 5. There have been some concerns that we are behind the power curve there a little bit relative to the rest of the country. Can you just give me a quick update on that and how you are feeling about that launch?

Dr. STONE. Actually, because of the uniqueness of the geography and the dispersion of the population I worry about it a lot. We are on schedule, though, for getting out the contract. So, when I say that the bid should be out, I think it is this fall.

Senator SULLIVAN. What can we do to ameliorate your concerns and worries? I share them.

Dr. STONE. I think just a continuing dialog with your staff and yourself. I am looking forward to my visit up there where we can dialog and really walk our way through it. But, it is a unique area with geographical challenges, and you are exactly correct, in our previous conversations. It should be handled locally.

Secretary WILKIE. And, I will add, if you go down the list—and I have said this to folks in Alaska, the Federation of Natives, and I have said it on Alaska television—if you go down the list and look what we are prototyping in VA, my philosophy on electronic health, on logistics, on VBA, and here with MISSION is: if we can make it work in Alaska it will work anywhere, because of the unique challenges that Alaska presents by its massive size, but also because of the impact that veterans have on the population of the State. It is a unique situation.

Senator SULLIVAN. Thank you. Well, we look forward to you getting back up there, Mr. Secretary, and Dr. Stone, your visit as well. Thank you.

Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Sullivan.

Senator Moran had one additional question, so if you do not mind, Mr. Secretary, and I will have one very short statement after his question.

Senator MORAN. Unfortunately, the Chairman almost tells the truth. I have two. One developed while I was waiting to ask the one.

Chairman ISAKSON. We better hurry.

Senator MORAN. Yes, sir.

I wanted to go back to the hearing aid specialists, just for a moment, and this really is to you, Mr. Secretary. I understood what Dr. Stone said, that the VA may have reached the conclusion it does not believe that additional professionals in this arena are necessary. But, I want to highlight a complaint I have had with the Department of Veterans Affairs for as long as I—which is now 23 years that I have been on a Committee on Veterans' Affairs, is can we get the Department to abide by the Congressional law, the mandate that you have, and the issue of whether or not the specialists are necessary at the VA, that is a different issue than abiding by the law that requires you to determine what the qualifications would be for that profession at the VA.

I do not want to diminish this issue. It is important to many people and it is important to many people who are hearing specialists

who want to provide those services, who want to serve our veterans. It is important to veterans that they have the care necessary. Knowing you, Mr. Secretary, I want to highlight the importance of the folks who work for you not making an independent decision whether or not they get to abide by the law, the mandate that Congress gave them to act in any particular way.

Secretary WILKIE. Yes, sir. I did not know that that was occurring. That is my honest answer, and you know my background so they will be told to abide by Congressional will.

Senator MORAN. I think it is true when you were confirmed—it is true as I recall it—every confirmation hearing for Secretary at the VA that my question has been, "Will you make certain that the people who work for you work with Congress, provide the information that we need, answer our letters," and, of course, a given is abide by the law. I just want to highlight for you the importance of that.

We raised the issue of toxic exposure and I told you about a study that was completed by the National Academy of Medicine in November 2018. That law that created that study requires you, Mr. Secretary, to determine, based upon that report, within 90 days, if—there is a trigger in that law. It requires you to make a determination about now how to proceed. I just learned that March the 22nd, which is just a day ago, you have sent a letter to the Committee. You are now—you were not in compliance, I do not know, at the 90 days, but you are in compliance by responding, and I appreciate that. You now have a responsibility that I want to work with you to make certain that there is action taken. Again, we are talking about the generational consequences. The National Academy determined there is no medical research that determines the relationship between toxic exposure and the next generation of the veteran.

There is a great opportunity, and a necessary opportunity, for you and the Department of Defense to proceed in determining that relationship, but also getting the facts in place so that we can determine who those veterans are, and you are a perfect person with your relationship and history at the Department of Defense to accomplish this goal.

I will digest your March 22 letter in a more timely fashion, but this is something I wanted to highlight for you. Thank you.

Thank you, Chairman.

Chairman ISAKSON. You are welcome. Senator Sullivan was inspired to ask one more question, and I want to grant him that privilege.

Senator SULLIVAN. Thank you, Mr. Chairman, and it will just be one.

Mr. Secretary, this goes to the issue of infrastructure improvements, streamlining expansion, where you see the populations that are growing in certain areas of the country and States, populations that are declining. And again, in your—I know that broadly the VA has repurposed or disposed of 175 of 430 vacant or mostly vacant buildings since June 2017. I think that makes a lot of sense. But, you have also talked to me about, you know, areas. If the VA is looking at expansion with regard to leases or even facilities, I know you were struck by some of what was going on in Alaska in that

way, given that you mentioned not only more vets per capita, the size, but also I think we are one of the few States that does not have a full-service VA hospital, not even one.

Can you just give me an update on what you are thinking with the VA's prioritization of leases that are in the budget request? We have—in Fairbanks, we are looking at the possibility of a new campus and also outside of JBER, you may remember that kind of big parking lot area that we were talking about after our tour.

Secretary WILKIE. The simplest answer is that we are going where the veterans are, and this is only the first step. The legislation requires market assessments to be done throughout the country. We are in the process of doing that. That develops a knowledge base on population trends, the services available in those areas to inform an Asset Infrastructure Review Commission. I mentioned earlier that I expect to come to this Committee to ask for an accelerated date for the beginning of the deliberations on the Asset Infrastructure Review Commission, because we have to go where the veterans are.

I also mentioned earlier that what you said is only the beginning of many different processes. More than half of our buildings, 57 percent, are between the age of 50 and 130 years old. Because of that, the leasing option and co-locating—and I am not going to say that we are in the process of doing, but I saw a number of facilities in Alaska that present us with an opportunity to be more creative about co-locating with entities outside of the Federal structure.

Senator SULLIVAN. Thank you. Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Sullivan.

Let me conclude the meeting by thanking the Secretary and his staff and each of the department heads for their being here today and for your thorough answers. I appreciate what you all are doing for our vets. We all have the vets at heart, the vets in mind, and the vets in soul, and we are going to see to it they are taken care of as best as possible.

I want to thank the VSOs for not being offended by my request for them not to testify, but rather to submit questions and statements. Mr. Fuentes is sitting in the back of the room and just taking copious notes, and I am sure he is going to make sure that I keep every promise I have made, just like they are going to keep every promise that they make. But, I want the VSOs to be sure to remember that. I have asked you to submit the question you want answered.

Mr. Secretary, I not going to give you a deadline because that does not do any good, I do not think, but I want to give you the encouragement to, as quickly as possible, answer those questions and copy the Committee staff with the answers to those questions.

Secretary WILKIE. Yes, sir.

Chairman ISAKSON. They are very good and they are very thoughtful, particularly on the priorities of the budget and what some of the statements, and your statements have meant, and what actually, when they materialize, will mean. So, it is very important.

If this works well I think we will get better responses because we consume so much time when we have too many witnesses that we do not get to points that we really need to get to, as dem-

onstrated by Mr. Sullivan and Mr. Moran, who had instant thoughts toward the end. They were both very good and appreciative.

I want to thank you for being here, thank all of our veterans for the service they provide to all of us. I wish all of you a very nice day and a very happy week, and I look forward to seeing you soon. Please recognize the record will stay open for 5 days on submissions to the Committee for this hearing, and the Secretary will respond as quickly as possible to the questions. If you will get those questions to the Committee they will make sure that it gets to the Secretary, and that we have a copy to trail.

Thank you very much.

Secretary WILKIE. Thank you, sir.

[Whereupon, at 12:04 p.m., the Committee was adjourned.]

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOHNNY ISAKSON TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. At its March 11 budget briefing, VA officials stated that the FY 2020 budget request was predicated on a carryover of approximately $3 billion from FY 2019 appropriations, but offered no details or further explanation.

Question 1a. Exactly, how much "carryover" is assumed in the FY 2020 budget request and how did VA determine less than halfway through FY 2019 that such a large amount of funding could not be used to meet veterans health care needs?

Response. Please see details of the Budget-assumed carryover into FY 2020 for the Veterans Health Administration's (VHA) accounts and programs in the table below:

Account	Projected Unobligated Start of Year ($000)	CJ Page
Base Carryover:		
Medical Services	$1,000,000	VHA-34
Medical Community Care	$300,000	VHA-34
Medical Support & Compliance	$50,000	VHA-34
Medical Facilities	$150,000	VHA-34
Total Base Carryover	$1,500,000	
Medical Facilities Infrastructure:		
P.L. 115-141 sec 255	$402,801	VHA-34
P.L. 115-244 sec 248	$624,305	VHA-34
Total Infrastructure Carryover	$1,027,106	
Mandatory		
The Veterans Access, Choice, and Accountability Act of 2014 (VACAA) sec 801	$34,887	VHA-34
Veterans Choice Fund	$781,500	VHA-35
Total Mandatory Carryover	$816,387	
Grand Total VHA Medical Care Carryover	$3,343,493	

Carryover estimates for the four main accounts in the base were informed by actual carryover levels in recent years. In addition, VA carried more than $1.34 billion in the Medical Services appropriations from 2018 into 2019. This, combined with Congress's enactment of a generous 2019 advance appropriation, yielded the large estimated carryover into 2020.

Regarding the no-year Infrastructure funding in the Medical Facilities account, Congress directed VA to fully fund the total costs to complete an identified list of maintenance projects. The carryover reflects the timing of these projects' phased execution. Mandatory carryover estimates reflect remaining Section 801 funds for unawarded leases and future graduate medical education program growth, as well as the planned wind-down costs associated with the sunset of the Veterans Choice Program.

Question 1b. What are the specific dollar amounts being carried over and from what specific accounts, and into what accounts and for what purposes will this carryover funding be used in FY 2020?

Response. Carryover in the four main accounts will be used to meet Veteran demand for care, both in the direct care system and the community. The carryover no-year Infrastructure funding will support continuation of the specifically identified projects. Carryover in the Veterans Choice Fund will be used for the leases and the Graduate Medical Education (GME) program as well as wind-down costs associated with the sunset of the Veterans Choice Program.

Question 2. As discussed above, VA officials indicated that there would be zero new dollars necessary for the Medical Community Care account as a result of the new wait time access standards proposed because VA assumes it will be able to meet those standards 100 percent of the time within VA facilities. VA indicated it will do this through workload recapture, greater efficiency, and a 30 percent increase in the total number of VA primary care providers.

Question 2a. What new initiatives will VA undertake and what are the specific increases in productivity that each will achieve?

Response. The Office of Veterans Access to Care is partnering with several VHA program offices to lead an initiative called Increasing Capacity, Efficiency, and Productivity (ICEP).

The main goals of ICEP are the following:

- Ensure accuracy of labor mapping, person class code, and Primary Care Management Module data;
- Ensure sustainment plan for maintaining continued accuracy for the data in sub-bullet one;
- Balance supply and demand by using present resources and full care teams more efficiently by maximizing individual providers capacity for direct patient care; and
- Partner with workforce development to hire additional staff where applicable.

Overall, the focus of ICEP Phase 1 for Primary Care is to review the expected versus actual bookable time in direct patient care. This includes face-to-face (F2F) appointments, video appointments, telephone care, and secure messaging. Sites that need improvement can expect up to a 10 percent increase in productivity together in these four appointment modalities. For Primary Care, some sites are seeing an appropriate increase in panel sizes that meets national benchmarks. A similar review is being done for Mental Health and Specialty Care, with increases of up to 10 percent in productivity expected at some sites.

Additionally, VA is enhancing Same Day Primary Care and Mental Health services and leveraging virtual care modalities to provide Veterans convenience while increasing access.

Question 2b. What are VA's detailed plans and projections for increasing primary care providers by 30 percent, and how will these new providers be in place at the beginning of FY 2020?

Response. There is a national shortage of Primary Care (PC) providers, thus VA competes with the private sector to recruit this limited resource. VA facilities will increase their efforts to aggressively recruit for PC providers through the following incentives:

- Tier exception for increased salary in hard-to-recruit areas;
- Utilization of Relocation, Recruitment, and Retention bonuses; and
- Expand opportunities for telework via telehealth.

VHA is challenging facilities to follow the support staffing guidelines for core Nursing and Administrative staff as well as extended team members including Clinical Pharmacists, Social Workers, Psychologists, and Dieticians. This enables PC providers to focus on their important patient care activities and work at the top of their licenses.

Facilities are also increasing efforts to work with their University affiliates to provide a meaningful outpatient experience in their VA continuity clinics in an effort to recruit our trainees.

Question 3. What factors did VA consider in reaching its decision to cut research spending for the emerging field of genomics research in FY 2020 by 2 percent at a time when medical research inflation is estimated to be 2.8 percent?

Response. The FY 2020 Congressional Justification does not reflect a reduction in funding for genomics research from FY 2019 to FY 2020. Requested funding for the Million Veteran Program (MVP) increased from $83.9 million in FY 2019 to $85 million in FY 2020 (Volume II, Page 361), an increase of 1.3 percent.

The FY 2019 appropriation enacted a onetime addition of $27 million for collaboration with Department of Energy (DOE) on a big data science initiative and high capability computing (this funding is enacted with a 5-year period of funding expiring in 2023).

The total request for research in FY 2019 is $752 million. For FY 2020, VA requested an increase of $10 million to support the growth of all other initiatives, from $752 million to $762 million. That $10 million growth represents an overall program growth of 2 percent.

Question 4. In the full budget documents made available on March 18, the Veterans Benefits Administration budget request seeks appropriations to support the exact same level of FTE for FY 2020 as it does in FY 2019. However, the Direct Labor estimate for the Disability Compensation program shows a decrease of 51 FTE in FY 2020. This small decrease in claims processors occurs at a time that the VA budget is projecting that number of pending claims for disability compensation will rise to over 450,000 by the end of FY 2020, almost a 50 percent increase in just the past three years.

Question 4a. Why is VA requesting fewer claims processing staff in FY 2020 when its own data shows that the number of pending claims is rising dramatically?

Response. VA's FY 2020 budget request reflects a small decrease (51) in Compensation Direct Labor full-time employees (FTE). While the bulk of Compensation Direct Labor FTE are Veterans Service Representatives and Rating Veterans Service Representatives, direct labor FTE also include a significant number or Claims Assistants, quality review staff, and coaches not directly related to rating-related claims production. The decrease in Compensation Direct Labor FTE will not impact the FTE directly responsible for processing rating-related claims. Despite this small decrease in direct labor FTE, VBA expects that rating-related production for compensation claims in FY 2019 will be sustained in FY 2020. The reported year-end inventory increase for all claims results from an expected substantial increase in receipts. In FY 2020, VA will continue its commitment to look for innovative ways to improve claims processing through people, processes, and technology to mitigate the projected growth in inventory.

Question 5. VA budget documents state that the Vocational Rehabilitation and Employment (VRE) program will meet and sustain the congressionally-mandated goal of 1:125 counselor-to-client ratio. However, the latest data in the VA budget document also shows that from 2016 to 2018, the number of VRE participants fell from 173,606 to 164,355, more than a five percent decrease. During that same period, VRE's caseload also dropped from 137,097 to 125,513, an 8.4 percent decline. It would appear that VRE is able to meet the 1:125 goal by serving fewer veterans.

Question 5a. Given how important and beneficial the VRE program is to disabled veterans—providing many of them with the ability to increase their economic independence—why are fewer veterans taking advantage of this program?

Response. In 2018, Vocational Rehabilitation and Employment (VR&E) program participants achieved over 15,000 positive outcomes while participants decreased by 5 percent. VR&E Service attributes the decrease to a combination of the following factors:

- Applicants found eligible for the VR&E program are not reporting to their initial orientation and, therefore, not entering a plan of services; and
- The number of Veterans successfully exiting the program have increased each year (positive outcomes).

With the number of new plans remaining stagnant and despite the steady mix of eligible and entitled applicants, more Veterans are exiting the program than entering. However, VR&E continues to work on plans to hire additional Vocational Rehabilitation Counselors (VRC) to reach a Veteran-to-Counselor ratio of 125 to 1 or below, implement a new case management system, and use other technological solutions to keep Veterans engaged throughout the lifecycle of their program participation (remote entitlement, VA Video Connect (tele-counseling), appointment reminders, etc.). These changes are expected to increase the number of participants.

Question 5b. Has VRE instituted any new policies or practices that have deterred disabled veterans from seeking VRE services and what actions is VRE taking to increase awareness about the availability and benefits of VRE services?

Response. No, VA's VR&E program has not instituted any new policies or practices that would deter Servicemembers or Veterans with service-connected disabilities from seeking VR&E benefits and services. To the contrary, over the past several years, VR&E has taken several actions to meet Servicemembers and Veterans where they are and in the manner they wish to be met. These actions, coupled with

legislative changes, were expected to increase participation in the VR&E program. These actions include the following:

1. In accordance with Public Law 114–223, Section 254, Veteran-to-Counselor ratio should not exceed 125 to 1. VA's VR&E Program began the process of reducing the average Veteran-to-Counselor ratio to 125 to 1 or below through the hiring of 169 VRCs. This will help improve service to Veterans with service-connected disabilities and employment barriers, as well as help provide them with expanded services to improve their ability to transition to the civilian workforce.
2. The placement of 145 VRCs on 71 military installations across the Nation provides outreach and rehabilitation services to Servicemembers and their families prior to discharge from active duty service.
3. The placement of 87 VRCs on 104 college campuses across the Nation provides outreach and rehabilitation services to Servicemembers, Veterans, and their dependents.
4. On September 29, 2018, the Department of Veterans Affairs Expiring Authorities Act of 2018, Public Law 115–251, Section 126, made the authority to provide automatic entitlement to VR&E benefits and services to Servicemembers who are awaiting discharge due to a severe illness or injury incurred during active duty service.
5. VR&E expanded its Tele-counseling policy to allow its use during all aspects of the rehabilitation process. This practice allows VR&E VRCs to meet virtually with a VR&E participant via an application that can be used on a computer or smart device. This practice saves travel time for the participant and allows for greater access to the program.

VR&E continues to increase awareness and share information on VR&E benefits and services. VR&E reviews and updates all VR&E fact sheets and Web sites each year as needed as well as promotes, monthly, all the marketing material that is available on line. VR&E promotes the online marketing materials in a variety of ways, including by email, social media, outreach events, and conference calls with VR&E's field staff. They have developed an overview whiteboard video which was distributed to the field offices. The video provides an overview of VR&E's benefits and the types of assistance available and is a tool for the VRCs to promote the VR&E program. VR&E has also provided numerous trainings on how to promote early intervention into VR&E to active duty members on the military installations. Last, VR&E is changing the performance standards for the VRCs on military installations to focus more on ensuring Servicemembers are entering the VR&E program.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JON TESTER TO U.S. DEPARTMENT OF VETERANS AFFAIRS

During the hearing, Dr. Stone indicated that the impact of construction projects on health care operations was a consideration that factored into how much construction funding VA can execute each fiscal year. In other words, he indicated facilities cannot do all the construction projects they want in a given year because they would disrupt care delivery.

Question 1. Please provide a list of the top ten projects from a patient safety perspective that are in need of construction work but are hampered by the competing priority of not wanting to take the space out of use due to the impact on care delivery.

Response. A list of projects is not available as it is site-specific and more of a coordination issue that creates a maximum volume of construction that a single facility can handle. For any given renovation to take place in space that is providing care, something must be done with that service during construction, to which there are a set number of options available.

The first option is to relocate to "swing space" on campus (vacant space specifically set aside for this purpose). Issues with this approach are that it simply may not be available as most facilities do not have the square footage to spare for this purpose. Also, this space may need to be renovated itself prior to use, increasing cost of the original construction project and swing space is usually in a less than ideal location, adding inconvenience to the patients.

The second option is to bring in temporary space in the form of modular buildings or trailers; this is, however, dependent on land being available on campus in a suitable location. This type of space is also not always ideal for health care and will add cost as the expenses of renting this space is required to be included in the total project cost of construction.

Another option is to contract out care during construction, which adds significant costs and creates an issue with staff needing assigned to other areas. There is also a loss of synergy with other services offered at the VA facility.

The last option is to simply reduce the capacity of the department under construction. For instance, when renovating an Inpatient Medical Ward, the facility can choose to temporarily reduce the number of available operating beds and phase the project over several years.

Question 2. Please provide details regarding the VA's use of swing space, temporary medical units, trailers, etc. as a strategy to ensure medical care continues to be delivered uninterrupted while construction projects move forward at VA medical facilities.

Question 2a. Please describe the cost to use these types of temporary space options and explain the considerations VA takes into account when determining whether to use the temporary space units, etc. at a particular facility and/or project.

Response. As detailed in the response to question 1, VA has the option to use swing space as well as temporary medical units and trailers to provide care while construction occurs within the space where clinical services are normally offered. When the need for use of these options arise, any financial costs occurred (rental costs, renovating swing space, etc.) must be included within the total project cost of construction and be accounted for as an impact cost to construction. This further limits the funds available for actual construction when impact costs are used as it is accounted for within the same budget and program limits as the construction itself.

The monetary cost for swing space involves any renovation necessary to make the space usable as well as the cost to physically relocate the staff and equipment needed to provide care. For temporary units or trailers, there is a cost for making the required utilities available as well as the recurring costs to rent the unit. The issues needing consideration beyond the financial cost are the difficult-to-measure impacts on patients, such as the space being less than ideal for health care or in a location on campus that is inconvenient to locate or travel to.

Question 2b. At what level of the organization are temporary space decisions made within the organization (facility, VISN, VACO) and is there a dollar threshold on the cost of temporary space options that determines decisionmaking authority?

Response. The decision to use temporary space is made at the facility level with Veterans Integrated Services Network (VISN) and VA Central Office (VACO) support offering guidance and recommendations. As the temporary space being required is a result of a specific project, the costs associated with them are deemed to be an impact to that project and all expenses count toward the total cost of that construction. These costs are therefore limited by the program limit of the construction type (currently $20 million for Non-Recurring Maintenance renovations and Minor Construction projects).

Question 3. In Senate Report 115–130, which accompanied S. 1557 in the 115th Congress, the Committee on Appropriations included language stating "the Committee directs VHA to form a corporate planning function patterned after high performing commercial healthcare delivery systems. Such function must include representation from VHA clinical leadership, and leaders from VHA offices that control, oversee, or manage facility investments, transition, facility operations, and organizational change, as well as the appropriate VA offices that are dedicated to the planning and procurement of capital infrastructure, whether built or leased by VA." Senate Report 115–269, which accompanied S. 3024 contained similar language.

What is the status of the formation of the corporate planning function and the other requirements of this section of the report language?

Response. VHA actions to meet the corporate planning function requirement are the following:

- Strategy: Market Area Health System Optimization Workgroup (MAHSOW) produced an eight-step methodology for VISNs and VA medical centers to drive market area health system optimizations, which will inform VISN action plans, national realignment strategy, capital investments, and removal of legislative barriers;
- Corporate planning function: MAHSOW, which includes representation from all appropriate VA and VHA offices, managed by VHA Office of Policy and Planning, which is responsible for corporate planning activities related to a high-performing integrated health network; and
- Vision: "To deliver a high-performing provider network to better serve Veterans. This network consists of all VA health care assets in VISNs, federally-affiliated providers in the Department of Defense (DOD), federally Qualified Health Centers (FQHC), Academic Affiliates, and other community providers and health systems

with a track record of providing high quality health care and understanding the needs of Veterans."

- Goals:

1. Veterans choose VA for easy access, greater choices, and clear information to make informed decisions;
2. Veterans receive timely and integrated care and support that emphasizes their well-being and independence throughout their life journey;
3. Veterans trust VA to be consistently accountable and transparent; and
4. VA will modernize systems and focus resources more efficiently to be competitive and to provide world-class capabilities to Veterans and employees.

Question 4. What resources does the budget provide specifically for the support of VistA over the next decade to ensure a safe patient experience?

Response. VA's Office of Electronic Health Record Modernization (OEHRM) is working the overall pivot strategy in cooperation with the Office of Information and Technology (OIT) to ensure continuous care for our Veterans as we transition from the various VistA-based legacy systems to the new Cerner Millennium EHR platform. VistA and Millennium will operate in parallel for a period of time, with efficiencies and corresponding strategies/plans for the sunsetting and/or transitioning of legacy systems. It currently costs VA approximately $426 million to sustain VistA in FY 2019. As part of the final pivot strategy development, OEHRM will include projected sustainment costs for VistA over the 10-year Cerner implementation, as well as sustainment cost for the Cerner Millennium solution following the initial 10-year contract period. Currently there is no VistA sustainment cost reduction directly tied to the electronic health record (EHR) rollout. VistA will be in operation until all VA medical centers have migrated to Millennium, at which time the redundant VistA modules will be decommissioned. VistA modules that are not replaced by the Cerner solution will be maintained until replacement solutions are developed/deployed.

Funding Type	FY 2019
HPS	
FTE's	106
Burdened Rate	$153,967
FTE Pay	$16,320,502
DME	$—
O&M	$22,292,477
Total	38,612,979
EPMD	
FTE's	275
Burdened Rate	$153,967
FTE Pay	$42,340,925
DME	$21,028,161
O&M	$34,082,695
Total	97,451,781
ITOPS	
FTE's	419
Burdened Rate	$153,967
FTE Pay	$64,512,173
DME	$—
O&M	$224,758,359
Total	289,270,532
Grand Total	
FTE's	800
Burdened Rate	$155,507
FTE Pay	$123,173,600
DME	$21,028,161
O&M	$281,133,531
Total	425,335,292

FY 2019

Sub-Project [BF Line]	$ FY19 Amount
Ancillary and Surgery Requirements Updates	$7,957,121
CPRS Enhancements Phase 2	$4,000,000
Fileman 24 Interface	$1,427,752
Methadone Dispensing Tracking Phase 2	$2,800,000
National Clozapine Coordination Phase 3	$3,000,000
Pharmacy Re-Engineering -PRE Inbound ePrescribing Version 3	$1,843,288
Total	$21,028,161

FY 2019

Sub-Project [BF Line]	$ FY19 Amount
Medication Permissions and Dispensing Updates	$1,691,000
Methadone Dispensing Tracking	$2,044,377
National Clozapine Coordination Phase 3	$3,712,000
Pharmacy Re-Engineering—PRE Inbound ePrescribing	$1,905,612
Pharmacy Re-Engineering—PRE Inbound ePrescribing	$1,123,353
Pharmacy Re-Engineering—PRE Medication Order Check Health care Application (MOCHA)	$1,325,000
Pharmacy Re-Engineering—PRE Medication Order Check Health care Application (MOCHA) Phase 2	$2,154,527
Pharmacy Re-Engineering—PRE Pharmacy Product System National (PPS-N)	$1,230,000
Pharmacy Safety Updates Phase 2	$3,146,007
Standards and Terminology Services (STS)	$3,711,000
Veterans Data Integration and Federation VDIF	$3,205,350
VistA Computerized Patient Record System (CPRS)	$400,000
VistA Integration Adapter (VIA)	$1,059,999
VistA Scheduling Enhancements Phase 2	$3,892,000
VistA Security Remediation	$3,482,470
Total	$34,082,695

FY 2019

Sub-Project [BF Line]	$ FY19 Amount
Enterprise Application Maintenance	$6,559,226
Occupational Health Record-Keeping System (OHRS)	$310,353
Primary Care Management Module Rehost—PCMMR	$9,949
VistA Imaging	$3,771,868
VistA Maintenance	$11,641,081
Total	$22,292,477

FY 2019

Sub-Project [BF Line]	$ FY19 Amount
Dental Record Mgr (DRM)	$1,606,305
Event Capture	$1,276,919
Fee Basis	$24,681,528
Insurance Buffer Card (IBC)	$7,653,055
Intersystems Cache	$87,843,032
Maintenance of VistA and VistA Imaging (MSV III)	$39,211,999
Mental Health SW Maint	$4,319,051
Release of Information (ROI)	$3,144,017
VistA Maintenance	$39,211,999
Central VistA Imaging Exchange	$320,700
Vista Integration Adapter	$387,139
Veterans Health Information Systems and Technology Architecture (VistA) VistAWeb	$196,571
Vista Blood Establishment Computer Software	$2,616,978
Vitria/VistA Interface Engines	$4,889,466
Vista Maintenance Project	$1,441
VistA—e-Pharmacy Claims software/ VistA—Electronic Claims Management Engine	$51,284

FY 2019—Continued

Sub-Project [BF Line]	$ FY19 Amount
VistA—Functional Independence Measurement	$70,558
VistA—Home Based Primary Care	$20,007
IAA with DOI—(GS35F0701M) Financial Interface Tech Support Contract	$923,760
R1/2/3 DISA DECC	$5,963,000
R4 RDC	$14,650
VistA Migration contractor	$319,200
Backup Tapes for VistA imaging	$35,700
Total	$224,758,359

FY Annual Labor Rates

VA On-Board			VA New Hires*					
Fiscal Year	VA	% Increase	GS–09	GS–11	GS–12	GS–13	GS–14	GS–15
2018	$152,443	1.00%	$82,852	$100,242	$120,147	$142,870	$168,830	$198,588
2019	$153,967	1.00%	$83,680	$101,244	$121,349	$144,299	$170,518	$200,574
2020	$155,507	1.00%	$84,517	$102,257	$122,562	$145,742	$172,223	$202,580
2021	$157,062	1.00%	$85,362	$103,279	$123,788	$147,199	$173,945	$204,605
2022	$158,633	1.00%	$86,216	$104,312	$125,026	$148,671	$175,685	$206,651
2023	$160,219	1.00%	$87,078	$105,355	$126,276	$150,158	$177,442	$208,718
2024	$161,821	1.00%	$87,949	$106,409	$127,539	$151,659	$179,216	$210,805
2025	$163,440	1.00%	$88,828	$107,473	$128,814	$153,176	$181,008	$212,913

Source:
VA On-Board
Budget Database / Forms / Budget and Contract Administration Forms / Labor Rates
* OPM salary data based on Grade / Step-5; Washington Locality Pay; 30% to cover benefits; added
VA amount updated and based on actual Station 116 salary expense / on-board FTE
Future years are an increase of 1% per year, which is an estimate only for projections

Question 4a. Please provide amounts for both development and sustainment.

Response. It currently costs VA approximately $426 million to sustain VistA in FY 2019. VistA will be operated until all VA medical centers have migrated to Millennium, at which time the redundant VistA modules will be decommissioned. VistA modules that are not replaced by the Cerner solution will be maintained until replacement solutions are developed/deployed.

Question 5. According to VA officials, a report on the recommendations for a joint governance structure between the VA and the Department of Defense (DOD) was submitted to the Department on February 28th.

Question 5a. When will that report be made available to this Committee?

Response. On March 1, 2019, the Federal Electronic Health Record Modernization Working Group (FEHRM WG) presented the draft Plan of Action and Milestones (POA&M) to leadership from DOD and VA. The report will be made available to the Committee once the internal process is complete.

Question 5b. What process was utilized, and who participated, in the creation of this report?

Response. In response to the September 2018 DOD/VA Joint Commitment Statement, DOD and VA chartered the FEHRM WG, consisting of governance and subject matter experts, and key DOD/VA leaders, to make recommendations for a joint governance structure. The FEHRM WG meets on a weekly basis to provide progress updates and discuss key decisions to advance the analysis.

Question 5c. If a decision has been made as to what joint governance structure VA and DOD will be utilizing, please provide details as to who made this decision and what criteria was used.

Response. Executive leaders within the FEHRM WG preliminarily approved the POA&M draft. The FEHRM WG applied the following evaluation criteria for each course of action in the POA&M: rapid decisionmaking, agile decisionmaking, EHR deployment risk, and change management risk. FEHRM is working to jointly select a lead and deputy with concurrence from both Departments. The lead will act as a neutral arbiter ensuring timely decisionmaking regarding the requisite architecture and operations to support the core technology.

Question 6. When will VA be providing a full accounting of how many veterans were affected by late and inaccurate GI Bill payments last fall?

Response. VA underpaid approximately 322,000 beneficiaries an average of $202 for the fall of 2018 terms.

Question 6a. Provide details as to what extent these veterans were affected and when they will be made whole.

Response. On December 8, 2018, VA installed the 2018 uncapped monthly housing allowance rates. Until the information technology (IT) solution is in place, VA will pay students the current year's uncapped rate. Beneficiaries who were underpaid from the fall 2018 term received a separate payment for any difference owed to them. Veterans who were overpaid were not held liable for any debts. On December 1, 2019, all VA processing systems will be updated functionality to process claims in accordance with sections 107 and 501. For section 501, the rate tables will be expanded to house both the capped and uncapped rates. The IT solution will also allow training facilities to accurately report all locations where their students are attending the majority of their classes, so VA can process housing payments in accordance with section 107.

Question 7. This budget states that the Office of Electronic Health Record Modernization (OEHRM) plans to reach a goal of hiring 170 out of 230 FTE by the end of 2019

Question 7a. When does OEHRM anticipate completing the hiring process of all 230 permanent FTE?

Response. OEHRM's approved organizational chart has a total of 274 FTEs as of January 10, 2019. OEHRM anticipates that all permanent FTE will be onboarded by third quarter FY 2020.

Question 7b. How many of these hires are anticipated to be previously detailed or matrixed personnel who have been permanently reassigned to OEHRM? And from what departments were these FTE reassigned?

Response. OEHRM expects to permanently reassign 41 FTEs previously detailed or matrixed personnel to OEHRM from VHA, OIT, Office of Management, and Office of Finance.

Question 8. There are several programs/projects that have received a cut in funding for both Development and Operations and Maintenance in this budget. Please provide justification, including what specific IT functions or projects will not be funded, for the decreases in the following programs:

- Digital Health Platform
- Purchased Care
- Education Benefits
- Human Resources
- Data Integration and Management

VA Response.

• *Digital Health Platform (DHP)*—There are several key factors affecting the FY 2020 Budget request for this Congressional Project. As project development comes to an end, the priorities shift to sustainment, which can sometimes be accomplished at a much lower cost. Additionally, with the acquisition of the Cerner Millennium product, it is anticipated that some associated work will be funded via OEHRM.

In the FY 2020 President's Budget request, VA assumed that FY 2020 funding would decrease due to the following reasons:

(1) The Cerner migration.

(2) Contractor support carryover into FY 2020 (one-year's savings).

Of note: In FY 2019, the DHP program has $25M in requirements and a current Budget Operating Plan (BOP) of $17.558M, giving the program a $5.009M Unfunded Requirement (UFR). Ancillary, Surgery, and VistA Security Remediation are major pieces of the reduced FY 2020 budget request.

• Ancillary is still in the award phase of its initial contract and plans to have support carryover in FY 2020 resulting in a reduced request (one-time savings).

• VistA Security Remediation was broken into three parts: VistA Security Remediation, Enterprise Encryption Key Management System (EEKMS), and VistA Security Scanning. The program manager is discussing the possibility of IT Operations (ITOPS) supporting EEKMS and Office of Electronic Health Record Modernization (OEHRM) will fund Eagle6 (VistA Security Scanning).

The efficacy of one critical technology demonstrated by the DHP was the Application Programming Interface (API). Using the DHP as a baseline technology demonstration platform for APIs, VA has delivered a developer portal, a Benefits Intake API, a Facilities API and a Veterans Health API. VA's Veterans Health API is part of VA's commitment to health IT modernization, and contributes to VA's electronic health record modernization program since much of the data exchanged between

Cerner and the VA health data stores will be through APIs, rather than complicated custom-built interfaces.

• *Purchased Care*—The Congressional Project includes the Medical Care Collections Fund (MCCF) sub-project that has been ongoing for years, which has improved the efficiency and effectiveness of the system. As such efficiencies are realized, the project does not require as much development funding to move forward.

• *Education Benefits*—The funding decrease within the Congressional Project "Education Benefits" from FY 2019 to FY 2020 is based on the plan to execute the largest portions of required work in FY 2018 and FY 2019, therefore there was a larger request in 2019. In addition to this, the FY 2020 request reflects the realignment of a sub-project (eFolder enhancements) and its funding into another Congressional Project (Benefits Systems), which more appropriately aligns to where the work is being performed. Therefore, the FY 2020 request for Education Benefits was reduced in comparison to FY 2019.

• *Human Resources*—The Congressional Project Human Resources includes the following Human Resources (HR) Smart Phase 4 and Talent Management System (TMS) Upgrade sub-projects:

  • TMS Upgrade—TMS has closed its Development efforts in 2018 and has transitioned to sustainment funding supported by the Franchise Fund.

  • HR Smart Phase 4—During the 2020 budget cycle, it was determined that development work would conclude in August 2019, therefore additional funding was not requested for 2020 and beyond. The current system is maintained in the VA Enterprise Cloud (VAEC).

• *Data Integration and Management*—The FY 2020 budget request for this Congressional Project actually increased due to the new sub-project Enterprise Cloud Solutions in the amount of $50 million in operations and maintenance, which is a high priority modernization effort.

Question 9. At recent congressional staff briefings, VA officials have stated that there are 11 different IT projects underway related to VA MISSION Act implementation. The Secretary's March 4, 2019, letter to Appropriations Committee and Subcommittee leadership—which requests authority to transfer $95.94 million to the IT Systems account to support the development of these projects in fiscal year 2019—identifies 9 of those 11 projects. What are the other two projects not listed below?

• Decision Support Tool
• HealthShare Referral Manager
• Provider Profile Management System
• Enterprise Program Reporting System
• Integrated Billing and Accounts Receivable
• Community Care Reimbursement System
• Automated solution to query state prescription drug monitoring program websites
• Caregiver Application Tracker database
• Customer Relationship Management Platform

Response. The other two projects are the following:

• Consult Toolbox; and
• Enrollment and Eligibility.

Question 10. Please provide descriptions of the "integrated billing and accounts receivable" project, the "customer relationship management platform," and the two other projects not listed above, as the letter to the Appropriations Committee did not provide adequate detail on these projects.

Response. The Integrated Billing (*IB*) and Accounts Receivable (AR) (*IB*/AR) module project includes system enhancements to Vista packages to implement long-term administration of Urgent Care (UC) Copays and provides modifications to billing systems to enhance collections capabilities, retrieve the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (MISSION) Copay status, and ensure proper processing and reporting regarding billing.

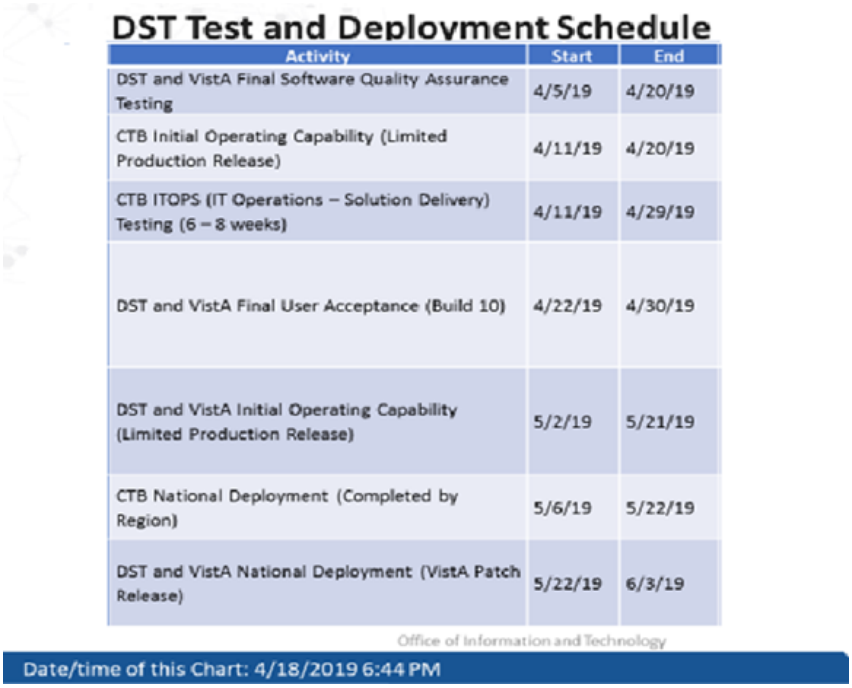
The Customer Relationship Management (CRM) module creates a backend platform to support stakeholder engagement. This facilitates innovation sourcing and engagement at scale leveraging technology instead of manual human effort. Implementing the CRM software in VA contact centers allows VA to collect and preserve the context of interactions and automate processes to enhance performance. The CRM platform functionality provides VA employees a consolidated interface and means of answering, tracking and reporting calls from Veterans, Beneficiaries, and applicable Veteran stakeholders to enhance customer service. The platform supports call center performance improvement and enhanced service delivery across administrations and business lines.

Consult Toolbox is a consult management tool that integrates with VistA to support Community Care consult creation. Consult Toolbox provides additional data fields that standardize consult data and provide critical content to the Community Care consult. Consult Toolbox is also used to initiate the Decision Support Tool.

The Eligibility and Enrollment System provides Veteran Community Care eligibility information to downstream systems and will be enhanced to support MISSION specific eligibility requirements for June 6th, 2019.

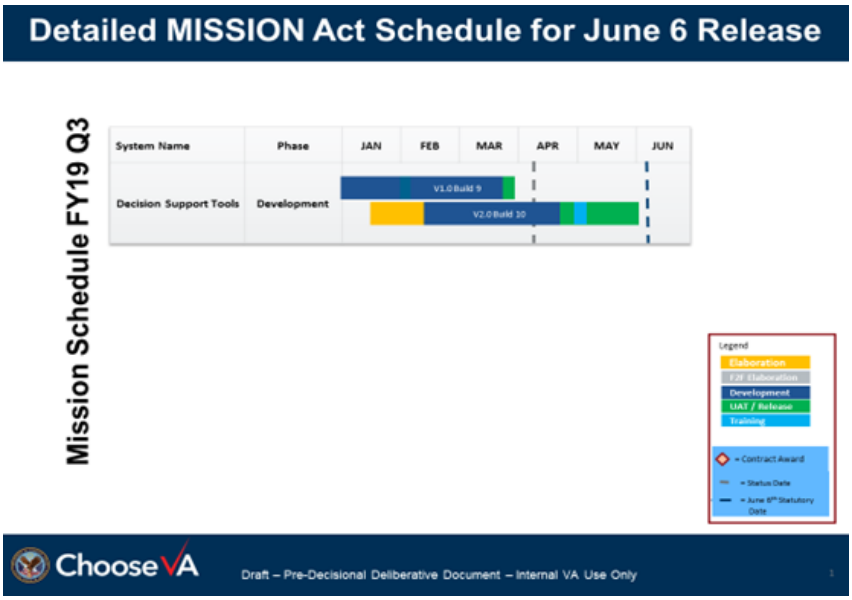
Question 11. Please provide documentation of the overall timeline and expected dates of key milestones related to the delivery of the Decision Support Tool (DST) for the Veterans Community Care Program (VCCP)—from contract solicitation to release of the final product.

Response. VA expects between 10,000 and 15,000 clinical consults per day, where anywhere from one to three staff members accessing each consult. The latest DST statistics show there is an average of 38,000 technical uses of DST per day, which is in line with expectation of high user adoption.



DST Test and Deployment Schedule

Activity	Start	End
DST and VistA Final Software Quality Assurance Testing	4/5/19	4/20/19
CTB Initial Operating Capability (Limited Production Release)	4/11/19	4/20/19
CTB ITOPS (IT Operations – Solution Delivery) Testing (6 – 8 weeks)	4/11/19	4/29/19
DST and VistA Final User Acceptance (Build 10)	4/22/19	4/30/19
DST and VistA Initial Operating Capability (Limited Production Release)	5/2/19	5/21/19
CTB National Deployment (Completed by Region)	5/6/19	5/22/19
DST and VistA National Deployment (VistA Patch Release)	5/22/19	6/3/19



Question 12. According to the March 1, 2019, U.S. Digital Service (USDS) sprint report on VA MISSION Act community care, VA only began actively developing the DST about six weeks earlier, and the DST project development timeline assumes a May 23, 2019, production release. As the USDS report points out, this leaves very little time to correct any errors or performance issues before the new Veterans Community Care Program (VCCP) must be implemented on June 6, 2019.

Question 12a. Given that the majority of the eligibility criteria for VCCP were set forth in the VA MISSION Act (with the exception of the designated access standards that the Secretary recently proposed), why did VA wait until January 2019 to begin developing the DST?

Response. The MISSION Act legislation was signed into law June 6, 2018, and discussions of implementation plans and related IT solutions began immediately. Technical requirements evolved with the development of regulation and policy proposals, and solution development was then able to begin in January 2019.

Question 13. This budget reflects a continued, steady increase in VA's mental health budget.

Question 13a. How is VA tracking the effectiveness of its mental health and suicide prevention programs?

Response. The Clay Hunt Suicide Prevention for American Veterans (SAV) Act (Public Law No. 114–2) requires an annual, independent 3rd party evaluation of VA's mental health care and suicide prevention programs. The first report was completed in December 2018. The reports are to:

- include evaluations of opioid prescribing/safety and services for women Veterans;
- consider effectiveness, cost effectiveness, and Veteran satisfaction;
- propose best practices including practices suggested by other Federal departments or agencies; and
- use metrics that are common and useful for practitioners.

Suicide prevention activities span a broad public health approach in which implementation factors are measured in the short term, and long-term outcomes are tracked over time. Measurement plans for interventions, including both performance/implementation metrics, and effectiveness/impact outcomes, aimed at the universal, selected, and indicated levels are underway.

Question 13b. How will this increased funding be used to recruit and retain more mental health professionals?

Response. The Office of Mental Health and Suicide Prevention (OMHSP) continues to work collaboratively with Workforce Management and Consulting (WMC) in enhancing hiring processes and opportunities across the enterprise.

• As of January 31, 2019, the Mental Health Hiring Initiative (MHHI) resulted in an increase of 1,045 mental health providers onboard in VHA with total hires of 3,956.

• Between June 2017 and March 2019, Suicide Prevention Coordinators increased from 360 to 444.

In FY 2018, VHA awarded 253 Mental Health Retention Education Debt Reduction Program (EDRP) awards, which was 23 percent of all EDRP awards. As a group, psychologists received the third most EDRP awards. Recent OMHSP and WMC efforts have included collaboration with the Office of Academic Affairs (OAA) establishing recruitment fairs for VHA trainees. Initial efforts focused on recruiting psychology trainees, and as the academic year progresses, efforts will focus on medical residents (psychiatry).

Question 13c. Is this funding sufficient to provide mental health care to newly eligible veterans, such as those with other than honorable discharges or those within the first year of transition?

Response. The overall influx of newly eligible Veterans associated with recent eligibility expansion efforts is unfamiliar territory for VHA. However, OMHSP has an established population health staffing model which allows for near real-time monitoring of staffing needs across VHA. Increases in Veteran demand for services will be reflected in decreasing Staff-To-Patient (SPR) ratios. VHA anticipates sufficient funding mechanisms are in place which allow VACO and individual VISNs the flexibility to rapidly address critical staffing shortages due to increased demand.

Question 13d. How will VA fund the President's newly signed Executive Order aimed at reducing veteran suicide?

Response. The Task Force roles and leads for the lines of effort (enabling support, state and local action to include grant structure, and the research strategy) are in the process of being determined. Role determinations and associated kick-off meetings are planned to occur in May 2019.

Question 14. This budget request includes $54 million for Comprehensive Addiction and Recovery Act Programs.

Question 14a. While the budget justification documents provide an overview of what VA has done to address opioid addiction, it does not include details on how the $54 million will be spent or what outcomes VA is attempting to achieve. Please provide clarity on what CARA programs will be improved with this funding.

Response.

A. Funding

Program	Dollars in FY 2020
Pain and Opioid Management (10P11)	$16,405,311
Office of Patient Advocacy, Comprehensive Addiction and Recovery Act (CARA) Section 924 (10H)	$7,458,689
CARA Section 933:	
Pilot Program on Integration of Complementary and Integrative Health and Related Issues for Veterans and Family Members of Veterans and CARA Section 931	
Expansion of Research and Education on and Delivery of Complementary and Integrative Health to Veterans, ''Creating Options for Veteran's Expedited Recovery'' or COVER (10NE)	$30,190,000
Total	$54,054,000

PAIN AND OPIOID MANAGEMENT CARA IMPROVEMENTS

• The Pain Management Program in the Office of Specialty Care Services (10P11) has historically received a partial allocation of the Comprehensive Addiction Recovery Act of 2016 (CARA) budgeted funds. If a similar amount is available in FY 2020, Specialty Care Services (SCS) anticipates supporting the following CARA and Opioid related programs:

– Expansion of the Opioid Overdose Education and Naloxone Distribution (OEND) program through funding Naloxone free to the field, development and delivery of new educational and training materials, and providing support to the expansion of Naloxone to first responders and in AED kits.

– Supporting the development and site integration of the CARA-mandated interdisciplinary pain management teams through training, education, and ma-

terial resources such as equipment, supplies, or personnel time to assist in setting up and managing the teams.

– Support and strengthen the VA/DOD Joint Pain Management Workgroup through funding personnel time, new training development, and support the JEC in developing, monitoring and tracking a strategic goal related to Opioid awareness between the agencies.

– Expanding and enhancing the implementation of high-risk patient reviews before prescribing opioids and during and after treatment utilizing tools such as Stratification Tool for Opioid Risk Mitigation (STORM) and Opioid Therapy Risk Report (OTRR).

– Supporting Federal initiatives to address the Opioid Crisis including the ODNCP National Drug Strategy, the President's Plan to Address the Opioid Crisis, and the Recommendations resulting from the White House Commission on Addressing the Opioid Epidemic.

– Supporting the expansion of the Stepped Care Opioid Use Disorder Training the Training (SCOUTT) initiative to sites beyond the original pilot sites and increase the number of VA providers with X-waivers to dispense and treat patients with buprenorphine for Opioid Use Disorder (OUD). This will include training material, resource time, and supplies to support the program expansion.

WHOLE HEALTH SYSTEM CARA IMPROVEMENTS

• Section 933 of the CARA legislation requires demonstration projects on integrating the delivery of Complementary and Integrative Health (CIH) services with other health care services provided by VA for Veterans with mental health conditions, chronic pain, and other chronic conditions. Rather than just adding these approaches into primary care, CIH approaches are delivered through a Whole Health System. This approach improves access and reduces the burden on primary care. Whole Health is an approach to health care that empowers and equips people to take charge of their health, well-being, and to live their life to the fullest, and is the primary delivery vehicle through which Veterans can access CIH services.

• The Whole Health System includes the following three components:

– *Empower:* The Pathway—in partnership with peers, empowers Veterans to explore mission, aspiration, and purpose, and begin personal health planning;

– *Equip:* Well-being Programs equip Veterans with self-care tools, skill-building, and support. Services may include proactive CIH approaches such as yoga, tai chi, or mindfulness.

– *Treat:* Whole Health Clinical Care—in VA, the community, or both, clinicians are trained in Whole Health and incorporate CIH approaches based on the Veteran's personalized health plan.

VA staff has been working with Veterans around the country to bring elements of this Whole Health approach to life. In conjunction with the CARA legislation, VA began implementation of the full Whole Health System in 18 Flagship Facilities in the beginning of FY 2018, the first wave of facilities in the national deployment of Whole Health. Flagship facility implementation of the Whole Health System will proceed over a 3-year period (FY 2018–FY 2020) and is supported by a well-proven collaborative model which drives large-scale organizational change.

• In FY 2020, Whole Health System (WHS) implementation and deployment will continue to make progress in the following areas:

– Continue to disseminate a comprehensive standardized Whole Health System model, deployment strategy, implementation guide, and resources for use by all field sites.

– Provide third year of funds to support the development and deployment across 18 Flagship facilities. Flagship sites were funded at $3.9 million over 4 years.

– Continue to train Veteran peers in the Introduction to Whole Health sessions for Veterans. Continue to train VA employees in Whole health. Over 10,000 VA employees trained in Whole Health to date; 5,500 more in FY 2019; Building VA's core faculty in Whole Health- 60 faculty trained thus far.

– Continue over 100 ongoing national Community of Practice Calls focused on learning from the field and sharing lessons learned. This strategy has proven to be a highly effective method of advancing Whole Health across the field.

– Continue to respond to all facilities requesting Whole Health support, requiring intensive work, onsite consultation, ongoing education, and provision of Whole Health tools and resources.

– Continue a robust Whole Health research agenda evaluating and addressing: patient outcomes, implementation, cost and utilization, and health care workforce across the 18 Flagship facilities.

– Continue to lead a robust, intentional effort to increase collaboration and build coalitions both internally and externally. These include strong partnerships with other national program offices, including: Mental Health and Suicide Prevention, Spinal Cord Injury, Women's Health, Primary Care, National Center for Health Promotion and Disease Prevention, Social Work, Patient Care Services, Nutrition and Food Services, Nursing, Chaplaincy, Connected Health, and HSRD.

– Continue random survey of Veterans with chronic pain at the 18 WH Flagship sites (Veterans Health and Life Survey) with a target of 10,000 respondents. Expecting preliminary findings on impact on Veteran quality of life, pain, patient engagement, life meaning, and purpose from this large cohort within the next 6 months.

– Continue research and dissemination of evidence of effectiveness for Battlefield Acupuncture (BFA), a specific ten-point auricular acupuncture protocol developed in DOD and now being widely used in VA used for pain. Data from a national outcome study on BFA looking at over 11,000 Veterans being treated shows on average a 2-point drop on the 0–10 pain scale from before to immediately after BFA treatment. BFA is also equally effective in patients on opioids as it is on patients not on opioids. To date, 2,400 VHA clinicians have been trained to offer BFA, and demand for this service continues to increase.

OFFICE OF PATIENT ADVOCACY (OPA) IMPROVEMENTS

• As per section 924 of CARA, the new Office of Patient Advocacy was established and directly reports to the Under Secretary for Health. OPA is tasked with ensuring the following:

– Patient Advocates truly advocate on behalf of Veterans with respect to health care received and sought when managing complaints;

– Responsibilities of the Patient Advocate are carried out at VA Medical facilities as per CARA requirements; and

– Patient Advocates receive consistent training.

STANDARDIZED COMPLAINT RESOLUTION PROCESS

• In process of standardizing the complaint resolution processes across the system with a goal that complaints will be resolved at the lowest level possible, preferably at the point of service. If that is not possible, the patient advocate will advocate on behalf of the Veteran to come to a resolution.

PATIENT ADVOCATE TRACKING SYSTEM—REPLACEMENT (PATS-R)

• Partnered with the VA Veterans Experience Office to develop a more user-friendly web-based system to manage Veteran complaints.
• Will more efficiently connect service lines to expedite resolution of Veteran complaints at the point of service.
• Shifts VHA organizational culture to resolving Veteran complaints at the point-of-service, in collaboration with Patient Advocates.
• Leverages technology to improve communication between all points of service no matter where Veteran is seen, to allow timely and efficient resolution.
• Will provide accurate and timely reports communicating trends on Veteran complaints at the facility, VISN and national levels.
• Will roll out in May 2019.

STAFFING METHODOLOGY

• Partnered with the VA Center for Healthcare Organizations and Implementation Research (CHOIR) and VHA Workforce Management to develop an evidence-based patient advocacy staffing model.
• This model will account for facility size, complexity and geographic region.

TRAINING & EDUCATION

• Community of Practices Calls are held monthly to provide live, consistent information and education to Patient Advocates.
• Continue to provide funding to the field to support VISN-level meeting/conferences/trainings focused on Patient Advocacy with focuses on Opioid Safety; Suicide Prevention; and/or Lesbian, Gay, Bisexual, and Transgender (LGBT) Care.

• New educational modules are currently under development in partnership with VHA Employee Education Systems (EES) focusing on the VHA Directive for Patient Advocacy Programs and New Patient Advocate Orientation.

Question 15. Public Law 115–182, the VA MISSION Act of 2018, authorized a higher ceiling for individual loan repayment under the Educational Debt Reduction Program.

Question 15a. Please describe how the Department developed its estimate of $5.5 million in increased usage as a result of the law's higher reimbursement amount.

Response. At the end of FY 2018, there were approximately 4,100 active participants in Educational Debt Reduction Program (EDRP); nearly 3,500 of these participants were approved in the last 4 fiscal years following the implementation of Choice Act changes. In FY 2018, physicians received the most EDRP awards, nurses ranked second, and psychologists were third.

VA projected $5.5 million in FY 2020, in addition to planned program growth, for the initial year of the increased award amounts based on the number of current program participants with awards exceeding $20,000 per year. Preceding MISSION Act 2018, the maximum award was $24,000 per year and 10 percent of participants receiving an EDRP award exceeded $20,000 per year. Therefore, VA projected 10 –15 percent (150–200) of applicants would be eligible for an increased award of up to $40,000 per year. $5.5 million only includes estimates for FY 2020; future year costs will increase to sustain recently approved participants and new applicants (The FY 2021 estimate is $7.5 million).

As anticipated, implementation of the $200,000 limit in FY 2019 authorized by MISSION Act is impacting new award costs. Awards for new participants under the $200,000 award amount are currently averaging $114,000, up from $77,000 under the previous $120,000 limit. VA medical centers are actively utilizing EDRP to fill VA's hardest to fill physician positions as demonstrated by the significant increase in physician awards which are near 50 percent of all EDRP awards received thus far for 2019.

Question 15b. How does VA ensure that funding is available for hard-to-fill positions even if a medical center director does not make a request for funding such positions?

Response. VA uses several processes to ensure funding is available for hard-to-fill positions identifying top shortage occupations at the facility level annually and monitoring each facility's usage of recruitment and retention incentives and EDRP awards toward those occupations throughout the year, shifting resources as needed.

Question 16. Section 212 of Public Law 115–46, the VA Choice and Quality Employment Act, authorized competitive pay for Physician Assistants.

Question 16a. Please provide the amount of funding in the budget request that will allow VA to provide this increased pay to Physician Assistants.

Response. A conversion average based on nine employees being paid from three different Physician Assistant (PA) schedules was used to arrive at this costing average. To arrive at an average upon conversion, the lowest pay schedule (the GS Rest of the US Locality Pay schedule) and two special rate schedules (Durham and San Francisco) were used. The costing was intended to show an average of the conversion costs only. In a sampling, the average PA will receive $5,108 upon conversion to the Nurse Locality Pay System. Employees at step 1 upon conversion will receive no increase. All other PAs at steps 2 through 10 will be placed at the first step that equals or exceeds their current rate of pay immediately prior to conversation; this will normally result in a 1 or 2 step increase. This would be a one-time cost of $12.3 million dollars to move all PAs to the Nurse Locality pay system. The 12.3 million represents an estimate of obligations and not a budget request number. This would increase the pay for all current PAs (steps 2–10) and then would revert to normal step increases which would be in line with current practices, which is why there is no cost for the future.

The average increase of $5,108 times the number of PAs currently at steps 2—10 was used—2,400 Physician Assistants in VHA at steps 2—10 x $5,108 = 12,259,200.00, or approximately $12 million.

This costing only provides an average of the initial cost increase upon conversion. It does not consider the ability of Medical Center Directors to subsequently adjust rates at any time they deem necessary post conversation.

Question 17. Since 2017, Congress has stepped in three times to provide additional funding so the Department would not exhaust Veterans Choice Program funding. In at least two of the instances, veterans were needlessly stressed and inconvenienced while VA sorted out its budgeting issues.

Question 17a. In detail, please provide how VA developed the estimate of funds necessary to carry out the Veterans Community Care Program.

Response. The Veterans Community Care Program projection in the 2020 President's Budget was developed by summing the following components:

- A base actuarial model (referred to as the Enrollee Health Care Projection Model [EHCPM]). The EHPCM is based on 2017 actuals and projects costs from demographic changes, intensity of medical services, and unit price changes.
- An incremental EHCPM run for the expanded access standards as stated in the Access Regulatory Impact Analysis.
- An incremental EHCPM run for the new Urgent Care benefit as stated in the Regulatory Impact Analysis.
- Adjustments for more recent actuals and programs excluded from the EHCPM. Programs that are excluded from the EHCPM but added after including CHAMPVA and the Long-Term Services and Supports (LTSS) State Home programs.

Additional detailed information on the forecasting of the MISSION Act may be found within the Regulatory Impact Analysis documents.

Question 17b. How has VA improved its process for projecting how much it needs for this type of a program since 2017?

Response. The estimates from the EHCPM supporting the 2020 VA health care budget and the MISSION Act are informed by VA's experience under Choice. The actual health care utilization experience of the Choice enrollees since the onset of the Choice program has provided invaluable insight into the reliance changes that are expected to continue for this population into the future. This experience also informed the expectations for the enrollees that will become eligible for similar community care access under the new MISSION Act drive-time standards.

Question 18. At the hearing, Secretary Wilkie briefly discussed the market area assessments that VA is currently undertaking, which will inform the VA MISSION Act's Asset and Infrastructure Review Commission. It is my understanding that through the market area assessment process, VA is evaluating its own current and future capacity, and the capacity of the community, to deliver health care services that will meet the needs of veterans in 96 regional markets nationwide. At a recent staff briefing, VA officials provided an overview of the Department's four-stage market assessment methodology: data collection, data validation, site visits, and development of recommendations.

Question 18a. At the staff briefing, VA officials said that the site visits the Department plans to conduct in each market would last between one half to one full day, and they would cover interviews with VA facility leadership, community providers, and area veterans service organizations. So that I can better understand VA's planned approach, please provide a sample site visit schedule, to include a list of topics that will be addressed during each of the interviews that will take place during each half-day to full-day site visit.

Response. A sample site visit interview schedule and a list of topics that will be addressed during each of the interviews are attached.

Sample Interview Schedules

Site Visits – Interview Participants

	Participants
VISN	1. Director 2. Chief Medical Officer 3. Deputy Network Director 4. Strategic Planner 5. Capital Asset Manager 6. VISN Business Implementation Manager
VAMC	1. Director 2. Chief of Staff 3. Associate Director for Patient Care Services (Nurse Executive) 4. Associate Director/Assistant Director 5. Chief of Community Managed Care, Purchased Care; Group Practice Manager 6. Planner 7. Director of Facilities/Engineering 8. Chief of Healthcare/Medical Administration Services 9. Director/Chief of Education/Research (Associate Chief of Staff for Education) 10. Director/Chief of Primary Care and/or Ambulatory Care Network 11. Director/Chief of Mental Health 12. Director/Chief of Medicine Services 13. Director/Chief of Surgery Services 14. Director/Chief of Extended Care and Rehab Medicine

Site Visits – Sample Schedule

VISN Office

Time	Interview Team 1
8-9:00	Interview 1
9-10:00	Interview 2
10-11:00	Interview 3
11-12:00	Interview 4
12-1:00	Interview 5

VAMC

Time	Interview Team 1 (Clinical Focus)	Interview Team 2 (Admin Focus)
7-8:00	Interview 1	Interview 2
8-9:00	Interview 3	Interview 4
9-10:00	Interview 5 (VAMC Director)	
10-11:00	Interview 6 (Chief of Staff)	
11-12:00	Interview 7	Interview 8
12-1:00	Lunch	
1-2:00	Interview 9	Interview 10
2-3:00	Interview 11	Interview 12 (if required)
3-4:00	Tour	
4-5:00		

MAHSO
MARKET AREA HEALTH SYSTEMS OPTIMIZATION

Market Area Health Systems Optimization
VISN Leadership Questionnaire

Thank you for your participation in the Market Area Health Systems Optimization market assessments. We are looking forward to meeting with you in person in a few weeks. In advance of our visit, we wanted to provide you with a sense of the types of questions that we will be asking so that you can have time to give them some thought and to discuss with your team. ***No written response is required.***

Strategy

1. What are the VISN's major strategic priorities that should be taken into account during the market assessments?

Market, Demographics, and Future Demand

2. What are the key trends anticipated for the Veteran population in your VISN over the next 10 years that VA needs to consider to best meet Veteran needs in the future? Why?

Supply

3. What are the major strengths and weaknesses of VA's current supply of programs, providers, and care locations in meeting the future needs of Veterans?
4. Are you presently studying or considering the addition of any new services to meet future Veteran demand?
5. What services presently located at VAMCs should be realigned to new or existing satellite HCCs or CBOCs to meet future Veteran demand?
6. Within your VISN, are there services that, for quality or cost effectiveness purposes, should be centralized or less distributed in the future?
7. What types of partnerships do you have in place to support patient care (e.g., with academic affiliates, DoD, other federal facilities, and commercial practices)? How do you see those partnerships changing over time?
8. What do you see as the major strengths and weaknesses of the local community providers in your VISN to help in meeting future Veteran demand?

Access, Quality, and Patient Satisfaction

9. What do you feel is the Veteran community's current perception of the VA services provided in the VISN with respect to their access and quality of service they receive? How is the VA "brand" viewed and what opportunities do you see for VA to improve this in the future?
10. When should VA rely on Community Care to improve access and quality for Veteran-centric care? What resources are necessary for VA to better manage coordination between VA-provided care and Community Care?
11. Should specialty care not provided at a VAMC be referred within the VA system or to the closest accessible provider? Why?

Other Missions and Partnerships

12. In addition to your patient care mission, can you describe your VISN facilities' role in meeting the education/training and research missions? What partnerships and other relationships do you have in the VISN related to your research and education and training missions?
13. How do these partnerships impact patient care?
14. Do you anticipate any changes to your training and research operations in the future?

Facility Resources

15. How well do your current facility resources and their locations support the programs and services needed to meet the current and future needs of Veterans? What challenges are you facing relative to existing infrastructure?
16. What facilities-related initiatives are underway, in planning now, or anticipated for the future to help improve the ability of your programs and services to meet future Veteran needs?

Other

17. How have you/do you/will you communicate to your stakeholders about the market assessment process?
18. Have you received any feedback from those groups to date?

MAHSO
MARKET AREA HEALTH SYSTEMS OPTIMIZATION

Market Area Health Systems Optimization
VAMC and Market Leadership Questionnaire

Thank you for your participation in the Market Area Health Systems Optimization market assessments. We are looking forward to meeting with you in person in a few weeks. In advance of our visit, we wanted to provide you with a sense of the types of questions that we will be asking so that you can have time to give them some thought and to discuss with your team. ***No written response is required.***

Market, Demographics, and Future Demand

1. What are the key trends anticipated for the Veteran population in your market over the next 10 years that VA needs to consider to best meet Veteran needs in the future? Why?

Supply

2. What are the major strengths and weaknesses of VA's current supply of programs, providers, and care locations in meeting the future needs of Veterans?
3. Are you presently studying or considering the addition of any new services to meet future Veteran demand?
4. What services presently located in your market should be realigned to new or existing satellite HCCs or CBOCs to meet future Veteran demand?
5. Within your market, are there services that, for quality or cost effectiveness purposes, should be centralized or less distributed in the future?
6. What types of partnerships do you have in place to support patient care (e.g., with academic affiliates, DoD, other federal facilities, and commercial practices)?
7. How do you see those partnerships changing over time?
8. What do you see as the major strengths and weaknesses of the local community providers in your market to help in meeting future Veteran demand?

Access, Quality, and Patient Satisfaction

9. What do you feel is the Veteran community's current perception of the VA services provided in the market with respect to their access and quality of service they receive? How is the VA "brand" viewed and what opportunities do you see for VA to improve this in the future?
10. When should VA rely on Community Care to improve access and quality for Veteran-centric care? What resources are necessary for VA to better manage coordination between VA-provided care and Community Care?
11. Should specialty care not provided at a VAMC be referred within the VA system or to the closest accessible provider? Why?

Other Missions and Partnerships

12. In addition to your patient care mission, can you describe the role your facility plays in meeting the research and education and training missions? What partnerships and other relationships do you have at the facility related to your research and education and training missions?
13. How do these partnerships impact patient care?
14. Do you anticipate any changes to your training and research operations in the future?

Facility Resources

15. How well do your current facility resources and their locations support the programs and services needed to meet the current and future needs of Veterans?
16. What challenges are you facing relative to existing infrastructure? What facilities-related initiatives are underway, in planning now, or anticipated for the future to help improve the ability of your programs and services to meet future Veteran needs?

Other

17. How have you/do you/will you communicate to your stakeholders about the market assessment process?
18. Have you received any feedback from those groups to date?

Question 18a (response continued)

All site visits to VA Medical Center (VAMC) parent facilities are full day visits. The team will also be visiting a limited number of Health Care Centers (HCC), VAMC child facilities, and multi-service Community-Based Outpatient Clinics (CBOC) that are key points of care in certain markets. These visits will be half-day visits consisting of facility walk-throughs and conversations with VA staff.

At each VAMC full day visit, the team will be meeting with each member of the executive leadership team, including the Director, Chief of Staff, and Associate/Assistant Director. The team will also meet with all service line directors, including but not limited to the Directors/Chiefs of Education, Research, Primary Care, Mental Health, Medicine, Surgery, Extended Care, Rehab Community Managed Care/Purchased Care, the Nurse Executive, and the Group Practice Manager. In addition, the team will be meeting with the facility planner, engineer, and any other role that is either recommended to the team or is integral to the facilities service offerings or critical support service.

Topics the interview team will address will vary depending on the interviewee and market conditions. The focus of the interviews is to obtain the interviewees' outlook of the future and to understand the local VAMC perspective on the needs of Veterans in their market, both now and in the future. In conjunction with collaborative data review sessions, these interviews will provide market assessment teams a holistic view of the market while developing high-performing networks of care.

Question 18b. Please provide VA's planned schedule of site visits for all 96 markets.

Response. The planned schedule to visit all 96 markets is divided into three phases. One-third of all VISNs are evaluated in each phase. Phase 1 is ongoing and includes markets in VISNs 2, 4, 5, 6, 16, and 17. Each VISN has a dedicated market assessment team, and site visits occur concurrently among all six VISNs. Ideally, each team will have time between visits to collaborate and share notes on previous site visits before traveling to the next market.

Question 18c. Does VA expect that the market area assessments will result in any observations or recommendations related to the condition of VA facilities or infrastructure (in general or on a facility-by-facility basis)?

Response. The purpose of the Market Assessments is to develop high-performing networks of care that include VA as the primary provider of care, supplemented by care in the community. Facility/infrastructure conditions will be considered when developing high-performing networks but will not be the sole factor under consideration. It is difficult to anticipate future opportunities until the process is complete. We anticipate the process will yield observations and opportunities in facilities and infrastructure, given their role in health care delivery.

Question 18d. If facility/infrastructure conditions will be part of the market assessments, what are the qualifications of those personnel (be they VA employees or VA contractors) doing the market assessments when it comes to evaluating the facilities and infrastructure?

Response. The purpose of the Market Assessments is to develop high-performing networks of care that include VA as the primary provider of care, supplemented by care in the community. Facility/infrastructure conditions will be considered, including building ages, active capital projects, and VA-provided Facility Condition Assessments (FCA) when developing opportunities.

The market assessment team, consisting of both VA and contractor employees, includes degreed professionals covering the entire range of architectural, engineering, health care planning, and construction management expertise. Team credentials include professional engineers and registered architects. These professionals have significant experience in VA, other Federal, and commercial health care facilities planning and management.

Question 18e. What degrees and credentials do they have, what pre-visit research will they conduct on the facilities' infrastructure, and how much time during each visit is allocated to infrastructure review?

Response. The purpose of the Market Assessments is to develop high-performing networks of care that include VA as the primary provider of care, supplemented by care in the community. Facility/infrastructure conditions will be considered when developing high-performing networks but will not be the sole factor under consideration. Degrees and credentials for market assessment team members are indicated in the response to question 18d. The team also includes clinicians and data analysts to provide comprehensive analysis of each market.

Pre-visit research includes a review of VA-provided Facility Conditions Assessment (FCA) information, major, minor, and non-recurring maintenance projects; a review of VA Office of Inspector General (OIG) facility-related findings; a review of

building engineering system studies commissioned by the VAMC or VISN Capital Asset Manager where available; a review of campus master planning documents; a review of the campus facility inventory, square footage, subsequent major capital improvements, historic designation; and a site-by-site review of this material with each facility chief health care engineer and strategic planner or appropriate designee as well as an onsite tour of the facility during the site visit.

Market assessments are a collaborative process between VISN and facility leadership, the Office of Policy and Planning, Office of Construction and Facilities Management, and a contractor team. The review process for each market spans months, and infrastructure review for each facility is integrated into the broader review process to develop high-performing networks of care. Facility infrastructure review is included in comprehensive data assessments, pre-visit market meetings, site visit interviews, and post-visit collaboration sessions and out briefs. In addition to a site visit tour, facility and space considerations are addressed in each interview.

Question 18f. To what extent are engineers involved in this aspect of the market area assessments?

Response. Engineers and health care architects from the VAMC, VISN, Office of Construction and Facilities Management, and contract team are involved in all facility-related aspects of the market assessments as the team develops opportunities for high-performing networks of care. This includes assessments of existing data, pre-visit market meetings, site visit interviews, and post-visit collaboration sessions and out briefs. The collective expertise of these professionally-degreed team members is used to evaluate the medical functional state for key infrastructure elements within each major facility.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. SHERROD BROWN TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. When will the Department decide to act on your recommendation not to appeal the Procopio decision?

Response. Prior to issuance of the court's decision in Procopio, VA began researching some of the complexities related to determining the Veteran population that served within the 12 nautical miles of the Republic of Vietnam and assessing the potential workload. VA spoke with members of the U.S. Navy and the National Archives Records Administration to determine the available service records, such as deck logs. VA provided its regional offices with procedural guidance to ensure that claims received for Blue Water Navy (BWN) Veterans are properly tracked in its system of records. In addition, VA's internal work groups are developing policy guidance, training, and strategic outreach materials that will ensure these Veterans are aware of their eligibility for benefits and services. VA is also updating its costing for mandatory funding to support benefits paid to BWN Veterans as well as the additional administrative costs and personnel that are necessary to address all Veteran claims. VA anticipates a surge in claims and appeals that will result in significant claims Therefore, VA's implementation must include plans to maintain an acceptable level of claims processing for all Veteran claimants. These ongoing efforts are necessary in order to comply with the court's order.

Question 1a. Please provide me with a detailed breakdown of VA's decisionmaking process related to the National Academies recommendations regarding bladder cancer, hyperthyroidism, hypertension and Parkinson's like symptoms?

Response. VA uses the process described in the attached directive—VA Directive 0215. The first step is the formation of a technical workgroup comprised of subject matter experts who review the report (e.g. Veterans and Agent Orange 2018—Vol. 11) from the National Academy of Medicine (NAM, note this used to be called the Institute of Medicine) in depth and also consider scientific evidence published since the NAM's cutoff date for new literature for that report. This technical workgroup then summarizes the findings and makes potential recommendations to report them to the NAM Strategic Workgroup (made up of Agency leaders and other experts).

The NAM Strategic Workgroup then makes recommendations on its findings to the VA Task Force composed of Agency Leaders, who in turn discuss the conclusions and make the final recommendations (including any potential presumptions) to the Secretary.

Department of Veterans Affairs
Washington, DC 20420

VA DIRECTIVE 0215
Transmittal Sheet
May 2, 2016

Management of Institute of Medicine Reports

1. REASON FOR ISSUE. This directive establishes Departmental policy which delineates responsibilities for addressing National Academy of Sciences (NAS) Institute of Medicine (IOM) reports.

2. SUMMARY OF CONTENTS/MAJOR CHANGES. This directive sets forth policies, roles, and responsibilities for managing VA's IOM Task Force, Strategic Work Group, and Technical Work Groups (TWGs).

3. RESPONSIBLE OFFICE. Deputy Assistant Secretary for Policy (008A), Office of Policy and Planning (008).

4. RELATED HANDBOOK. None.

5. RESCISSION. None.

CERTIFIED BY:

/s/
LaVerne H. Council
Assistant Secretary for
Information and Technology

BY DIRECTION OF THE SECRETARY OF VETERANS AFFAIRS:

/s/
Linda Schwartz
Assistant Secretary for
Policy and Planning

Distribution: Electronic Only

Management of Institute of Medicine Reports

1. PURPOSE. This directive establishes Departmental policy that delineates responsibilities for addressing National Academy of Sciences (NAS) Institute of Medicine (IOM) reports.

2. BACKGROUND. Over recent years, legislation, such as the Agent Orange Act of 1991, Pub. L. 102-4, 105 Stat. 11 (codified in part at 38 U.S.C. § 1116) and the Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1998, Pub. L. 105-277, 112 Stat. 2681, Title XVI—Service Connection for Persian Gulf War Illnesses (codified in part at 38 U.S.C. § 1118), has been enacted that directs VA to contract with NAS to evaluate available scientific evidence concerning Veterans' issues and publish related reports. These scientific reviews are typically conducted by NAS's Institute of Medicine.

3. POLICY. It is VA policy that IOM reports prepared as a result of legislative mandate are managed by the VA IOM Task Force (IOMTF) to facilitate coordination and collaboration across the Department and ensure that mandated requirements are met.

a. The IOMTF reviews and evaluates IOM reports and develops and presents related findings, recommendations, and/or responses to SECVA. See Appendix A for IOMTF membership. This body meets or is briefed quarterly.

b. The executive agent for IOMTF is the Deputy Assistant Secretary for Policy, Office of Policy and Planning (OPP). The executive agent is responsible for managing IOMTF activities; managing communications within the IOMTF and the IOM Strategic Work Group (SWG); coordinating meetings and briefings; and coordinating Department review and concurrence of recommendations and responses.

c. Under the direction of the IOMTF, the IOM SWG serves as the permanent body to monitor VA's review of, and responses to, IOM reports; provides advice and guidance to the Technical Work Groups (TWGs); and provides updates to IOMTF as needed. SWG will consist of members from across the Department, and will be assigned by their respective offices. This body meets monthly. See Appendix A for IOM SWG membership.

d. Under the direction of SWG, TWGs are formed to review IOM reports and develop any related findings, recommendations, and/or responses for IOMTF review, consideration, and approval. Members of TWGs will be determined based on the subject matter of the relevant IOM report. TWGs meet as needed.

4. RESPONSIBILITIES.

a. VA's IOM Task Force (IOMTF):

(1) Reviews and approves/disapproves TWG findings and recommendations that have been developed in response to IOM reports;

(2) Meets quarterly or is briefed quarterly on the status of, and issues related to, IOM studies;

(3) Provides direction and guidance to SWG and TWGs;

(4) Presents IOMTF findings, recommendations, and responses to IOM reports for SECVA approval/disapproval;

(5) Establishes the policies and processes for IOMTF and its sub-groups.

b. The IOM Strategic Work Group (SWG):

(1) Reviews TWGs' findings, recommendations, and responses for IOMTF approval;

(2) Provides advice and guidance to, and facilitates kick-off meetings of TWGs;

(3) Provides updates to IOMTF on IOM study status and issues.

c. IOM Technical Work Groups (TWGs):

(1) Review and evaluate IOM reports and develop related findings, recommendations, and/or responses;

(2) Participate in IOMTF and SWG meetings to provide status updates;

(3) Brief IOMTF on findings, recommendations, and/or responses to IOM reports;

(4) Assist IOMTF in presenting findings, recommendations, and/or responses to IOM reports to SECVA.

d. Executive Agent:

(1) Manages IOMTF activities;

(2) Manages communications between IOMTF and SWG;

(3) Coordinates IOMTF meetings and briefings;

(4) Coordinates Department review and concurrence of IOMTF recommendations and responses;

(5) Implements IOMTF administrative policies and processes

5. REFERENCES.

a. 38 USC Chapter 11

b. VA Framework for IOM Engagement and Reporting (OPP/VHA 2014)

c. VA's IOM Engagement and Reporting Process (OPP/VHA 2014)

d. VA IOM Process Roles and Responsibilities (OPP/VHA 2014)

Please contact OPP or the Veterans Health Administration for a copy of the above-referenced documents.

6. DEFINITIONS.

a. Department, VA. Generic references to the entire Department of Veterans Affairs, which includes VA Central Office and all field facilities.

b. SECVA. The Secretary of Veterans Affairs.

Membership

VA's IOM Task Force:

Assistant Secretary for Policy and Planning (Chair);

Under Secretary for Health;

Under Secretary for Benefits;

General Counsel;

Deputy Assistant Secretary for Policy (Executive Agent).

VA's IOM Task Force's Strategic Work Group:

Veterans Health Administration (Chair);

Veterans Benefits Administration;

Office of Policy and Planning;

Office of General Counsel;

Office of the Secretary of Veterans Affairs;

Office of Congressional and Legislative Affairs;

Office of Public Affairs.

Question 1b. Please provide me with VA's analysis regarding total number of veterans effected, and the cost associated with extending service connection to each specific illness.

Response. VA's estimates for the cost and number of Veterans impacted by the Procopio decision are being finalized. Once VA's estimates are finalized, estimates will be shared with the Committee.

VA's estimates for the cost and number of Veterans impacted by potential presumptive conditions associated with Agent Orange are being finalized. If the Secretary decides to add any presumptive conditions, VA's estimates will be shared with the Committee.

Question 2. Please provide me with the following information for all the VAMCs in Ohio:

Question 2a. The extent to which directors have utilized the direct hiring authority provided by OPM?

Response. On January 24, 2018, VA was granted direct hiring authority by the Office of Personnel Management (OPM) for the following occupations: accountant, boiler plant operator, general engineer, health science specialist (Veterans Crisis Line), health technician, histopathology technician, human resource assistant, human resource specialist, information technology specialist, personnel security specialist, police officer, realty specialist, utility systems operator, and utility systems repair. On October 11, 2018, OPM granted direct hiring authority for an additional eighteen STEM positions.

Since January 2018, there have been 74 people hired into Ohio medical facilities for the occupations granted direct hiring authority, 22 percent were hired using the direct hiring authority.

Question 2b. The extent to which the directors have utilized the student loan repayment increase that Congress provided in the MISSION Act to incentivize healthcare professionals to work at VA.

Response. VAMCs are actively utilizing EDRP to fill VA's hardest to fill physician positions as demonstrated by the significant increase in physician awards which are nearly 50 percent of all EDRP awards received thus far for 2019, up from 31 percent overall for FY 2018.

Question 3. Throughout Ohio, we have heard that staffing shortages have cause excessive wait times for vitals, EKG's, blood draws, longer stays in the emergency department. We have also heard that VAMC director and clinical management decisions meant in-patient units could not receive inpatient care. I have several workforce management questions and would like information from all the VAMCs in Ohio.

Question 3a. What is the optimal nursing and ancillary staffing model?

Response.

• Primary Care Teams (PACT) the model is 3:1, 2 professional/clinical staff (RN and LPN or Health technician) and 1 clerical/admin support staff for each provider (MD or APRN).

• Inpatient and Long-Term Care units, staffing levels are determined based on the type of unit, acuity of care and support services available in the facility. The model uses hours per patient day (HPPD) for units that provide 24/7 care. The hours are based on the clinical skill level of staff required (RN, LPN, and Nursing Assistant). Each unit has a staff panel that formally makes recommendations to facility executive leadership for staffing every 2 years or earlier if the patient population, acuity level, or volume changes. Facility leadership reviews the recommendations and provides concurrence or guidance for adjustments.

Below are national averages for skill mix percentages across VHA, Data source: VSSC national average Feb YTD FY 2019 for Critical Care Clusters, Medical, Surgical Clusters and CLC Clusters (excluding Small houses).

– Critical Care Units: 93 percent RN, 7 percent Nursing Assistant or Health Technician.

– Medical and Surgical Units: 68–70 percent RN, 5 percent LPN and 21–25 percent Nursing Assistant.

– Long Term Care Units: 34 percent RN, 21 percent LPN and 44 percent Nursing Assistant.

Question 3b. What is the ratio of RNs, LPNs, NAs, Health Technicians and ancillary providers to patients in all direct patient care areas?

Response. Ratio models are not used since ratios do not reflect patient acuity or support services available within the facility in determining appropriate staffing levels.

Question 3c. What is the call-off rates and injuries rates associated with direct patient care and ancillary care?

Question 3d. Please breakdown the number of many managers and clinicians who have been redirected from direct patient care to administrative tasks?

Question 3e. Does this cause a disproportionate manager/supervisor ratio to employee?

Response. Please see table that follows for questions 3c–3e.

		Chillicothe VAMC	Cincinnati VAMC	Cleveland VAMC	Columbus VAMC	Dayton VAMC
Question 3c	What is the call-off rates and injuries rates associated with direct patient care and ancillary care?	I do not have these statistics.	Direct patient care call-off rate for FY 18 is: 14% including RNs, NAs & HTs.	Nursing averages 4.7 unexpected absences per 100 employees for the past 12 month in direct patient care.	Our OSHA recordable injury rate for FY18 was 2.07, and the lost time claims rate (call off rate) was 0.0.	FY18 call-off rates (measured as a percentage of call-off per FTE of 1664 direct care hours) for nursing were as follows: Acute/Specialty Care—7.62%, Mental Health—6.70%, and CLC—9.46% with an overall nursing rate of 8.36%. For FY18, there were 65 cases where clinical employees were injured, per the OSHA 300 log. We had 217 total injuries (rate of .09 with 2444 FTE) through our current reporting system but are unable to easily separate clinical and administrative staff in this database. We will be able to distinguish this information in the future, as our database has changed and provides for a more robust reporting ability.
Question 3d	Please breakdown the number of many managers and clinicians who have been redirected from direct patient care to administrative tasks?	None. The numbers of managers and assistant nurse managers are determined in the Staffing Methodology calculations.	Inpatient Managers may be pulled from their primary responsibilities to cover the NOD, HUC, Telemonitor, and Virtual Monitor. We do not currently capture the hours they are staffing HUC, Telemonitoring, and Virtual Monitoring. The managers have been used in the NOD role, during their regular tour 5% of their regularly scheduled hours.	No managers have been permanently redirected from direct patient care to administrative tasks. There are currently 4 direct patient care employees who have been temporarily assigned administrative tasks.	3, reassignments	For FY18, 3 Nurse Managers and 4 Registered Nurses within Nursing Service.
Question 3e	Does this cause a disproportionate manager/supervisor ratio to employee?	No.	When this occurs, it reduces the manager: employee ratio by 25% resulting in 3 managers covering 5 units.	No.	No.	No.

Question 3f. Provide a breakdown of employees disciplined or terminated under section 714 of the VA Accountability and Whistle Blower Act. Please include by race, grade, discipline, and issue that led to termination.

Response. Please see tables below.

Chillicothe 3f Response

Grade	Discipline	Issue
GS-5	Removal	Unexcused absence
GS-11	Removal	Unexcused absence
GS-6	Removal	Unexcused absence
WG-2	Removal	Unexcused absence
GS-9	Removal	Medical Inability
WG-2	Removal	Unexcused absence

Cincinnati 3f Response

Grade	Offense	Action	Cases
GS-4	Disrespectful or abusive language/conduct	Removal	1
GS-4	Drug/Alcohol related	Removal	1
GS-5	Conduct Unbecoming a federal employee	Probationary Termination	1
GS-5	Disrespectful or abusive language/conduct	Probationary Termination	1
GS-5	Failure to follow policy	Probationary Termination	1
GS-5	Failure to properly request leave	Probationary Termination	1
GS-5	Improper conduct on VA premisis without VA endorsement	Probationary Termination	1
GS-5	Unexcused or unauthorized absence/tardiness	Probationary Termination	3
GS-5	Failure to meet a condition of employement	Removal	1
GS-5	Unexcused or unauthorized absence/tardiness	Removal	7
GS-6	Performance Issues	Probationary Termination	1
GS-6	Conduct Unbecoming a federal employee	Removal	1
GS-6	Unexcused or unauthorized absence/tardiness	Removal	3
GS-8	Failure to follow policy	Demotion	1
Title 38	Failure to meet a condition of employement	Probationary Termination	1
Title 38	Unexcused or unauthorized absence/tardiness	Probationary Termination	1
Title 38	Conduct Unbecoming a federal employee	Removal	1
Title 38	Failure to maintain licensure requirements of position	Removal	1
Title 38	Unauthorized delivery of care	Removal	1
Title 38	Conviction	Suspension—Indefinite	1
WG-1	Failure to maintain a regular work schedule	Probationary Termination	1
WG-1	Unexcused or unauthorized absence/tardiness	Probationary Termination	4
WG-1	Unexcused or unauthorized absence/tardiness	Removal	2
WG-2	Disrespectful or abusive language/conduct	Probationary Termination	1
WG-2	Unexcused or unauthorized absence/tardiness	Probationary Termination	5
WG-2	Disrespectful or abusive language/conduct	Removal	1
WG-2	Drug/Alcohol related	Removal	1
WG-2	Failure to meet a condition of employement	Removal	1
WG-2	Unexcused or unauthorized absence/tardiness	Removal	6
WG-3	Unexcused or unauthorized absence/tardiness	Probationary Termination	1
WG-3	Unexcused or unauthorized absence/tardiness	Removal	2
WG-5	Conviction	Suspension—Indefinite	1
WG-6	Disrespectful or abusive language/conduct	Probationary Termination	1
			57

Cleveland 3f Response

Position Title	Grade	Type of Discipline	Charge(s)
Nursing Assistant	5	15 Day Suspension	AWOL, Failure to Follow Proper Leave Request Procedures & Failure to Follow Instructions
LPN	6	Removal	Conduct Unbecoming a LPN (7 Spec); Failure to Follow Instruction
Nursing Assistant	3	Last Chance Agreement	15 charges AWOL, 5 charges failure to follow proper leave request procedures & 2 charges failure to follow instructions
LPN	6	Proposed Removal	AWOL (15 Specs) Failure to Follow Leave Procedures (10 Specs)

Cleveland 3f Response—Continued

Position Title	Grade	Type of Discipline	Charge(s)
Nursing Assistant ...	5	Removal	Carelessness in the Performance of Duties (5 Spec); Conduct Unbecoming a Federal Employee
Health Technician ...	7	Notice to Effect Removal	Violation of last chance-Inappropriate Conduct
Health Technician ...	6	15 Day Suspension	2 charges conduct unbecoming & 1 charge failure to timely transport patient
Health Technician ...	6	Removal	1 charge inappropriate conduct
LPN	6	Removal	Medical Inability
Nursing Assistant ...	5	Last Chance Agreement	3 charges AWOL & 2 charges failue to follow proper leave request procedures
Nursing Assistant ...	5	Removal	Inappropriate Interaction with Patient (3 specs)
LPN	6	Last Chance Agreement	3 charges inappropriate conduct
Nursing Assistant ...	5	Last Chance Agreement	3 charges inappropriate conduct, 1 charge AWOL & 1 charge failure to follow proper leave request procedures
Nursing Assistant ...	5	Removal	Failure of critical element, 1 charge AWOL , 1 charge failure to follow proper leave request procedures, 1 charge lack of due care & 1 charge making unfounded statements
Nursing Assistant ...	6	Removal	Carelessness in the Performance of Duties (2 Spec); Conduct Unbecoming a Federal Employee
Health Technician ...	6	Removal	AWOL (3 Spec); Failure to Follow Leave Request Procedures (3 Spec); Inappropriate Conduct (4 Spec)

Columbus 3f Response

Issue(s)	714 Disciplinary Proposal and Decision Actions	Grade
Muni-Court Conviction	Proposed Removal/Removal Decision	GS-5
Off duty misconduct (domestic violence)	Proposed Removal/Resignation prior to issuance of decision ...	GS-11
Unacceptable Conduct (Threatening Behaviors) ...	Proposed Removal/Removal Decision	GS-5
Sleeping on duty/Inappropriate Comments	Proposed Demotion/Demotion Decision	GS-7
Off duty misconduct (domestic violence)	Proposed Removal/Resignation prior to issuance of decision ...	NV-2
AWOL, Lack of Candor	Proposed Removal/Removal decision	GS-06
Conduct unbecoming a federal employee	Proposed Removal/Resignation prior to issuance of decision ...	GS-9
Privacy violation	Proposed Removal/(1) day suspension decision	GS-09
Unacceptable Disrespectful Conduct	Proposed Removal/(14) day suspension decision	GS-06
Unacceptable Disrespectful Conduct	Proposed Removal/Employee retired prior to issuance of decision.	GS-09
Failure to disclose or provide accurate information.	Proposed Removal/Removal decision (MSPB filed—Settlement Agrmt—Employee returned to a different vacant position).	NV-3
Conduct unbecoming a federal employee	Proposed Removal/DAB held/EE returned to former position	GS-06
Leave and Attendance Issues	Proposed Removal/(5) day suspension decision	GS-06
Insubordination	Proposed Removal/(7) day suspension decision	NV-02
Unsatisfactory Performance	Proposed Demotion/Demotion Decision to a different vacant position.	GS-12
Unprofessional Conduct	Proposed Removal/Written counseling decision	GS-06
AWOL	Proposed Removal/Employee retired prior to issuance of decision.	GS-09
Conduct unbecoming a federal employee	Proposed Removal/(5) day suspension decision	GS-06
Failure to meet standard of care	Proposed Removal/Demotion Decision to a different vacant position.	GS-05
Medical Inability to Perform	Proposed Removal/Removal Decision	GS-15
Unauthorized possession of firearm on VA property/Unfit for Duty.	Proposed Removal/Removal Decision(MSPB filed—Settlement Agreement Employee will be returning to a different vacant position).	GS-09
Conduct unbecoming	Proposed Removal/(5) day suspension decision	NV-01
Failure to Supervise	Proposed Demotion/Demotion Decision	GS-06
Sleeping on duty/Conduct unbecoming	Proposed Removal/currently awaiting Director's decision	NV-03
AWOL/Failure to follow leave procedures/Failure to provide accurate information.	Proposed Removal/ OAWP complaint filed pausing Director's decision.	GS-06

Dayton 3f Response

Issue	Grade	Clinical	Non-Clinical	Type of Discipline
AWOL, Failure to Follow Leave Requesting Procedures	VN-2	x		Suspension
HIPAA/Privacy Violations	VN- 2	x		Suspension
Loss of Controlled Substance	GS-7		x	Indefinite Suspension
Untimely Documentation, Failure to Follow Supervisor Instruction, Unethical Conduct, Endangering Safety of a Veteran Patient.	VM-15	x		Discharge
Failure to follow supervisory instructions	GS-6		x	Removal
AWOL/Failed Last Chance Agreement	WG-2		x	Removal
AWOL	GS-7		x	Removal
Inappropriate Conduct	VN-2	x		Discharge
AWOL, Failure to Follow Leave Requesting Procedures	WG-3		x	Removal
Unauthorized Use of PIV Card; Accessing an Unauthorized Area; Unauthorized Possession of Govt property.	WG-2		x	Removal
AWOL; Failure to Follow Leave Requesting Procedures	GS-5	x		Removal
Negligence; Inappropriate Conduct	WG-10		x	Removal
Inappropriate Conduct, Failure to Follow VA Directive	VM-15	x		Discharge
Failure to Follow Supervisory Instructions/Poor Workmanship	WS-3		x	Removal
AWOL	WG-2		x	21-Day Suspension
Using an Unauthorized Area for Research and Breaks; Sleeping on Duty.	WG-8		x	Removal/Failed Last Chance Agreement
Using an Unauthorized Area for Research and Breaks	WG-10		x	Removal

Question 4. Last year's MILCON-VA appropriations bill, Pub. L. 115–244, direct VA to do a pilot program related to hospice care to develop best practices and techniques for Vietnam era veterans.

It has come to my attention that VA decided to use the $1 million of funding associated with this provision on salaries, and not on the broad implementation of the pilot program with non-profit hospice and palliative care providers with Vietnam veteran centric programs as directed in report language.

Question 4a. How $1 million budget remains?

Response. The entire $1 million has been obligated to implement a strategic plan that has included collaboration with non-profit hospice and palliative care providers.

Question 4b. Does VA plan to reprogram that funding to allow non-profit hospice and palliative care providers with Vietnam veteran centric programs to ramp up its care delivery yet this year and help actual Vietnam veterans on the ground?

Response. VHA implementation of this initiative has included collaboration with non-profit hospices. The prolonged government contracting process would not have permitted effective implementation of identified best practices for this 1-year initiative. If additional funding becomes available, competitive bid contracting to engage high performing community hospices that have a demonstrated commitment to the care of Veterans could significantly expand the dissemination of the best practices and techniques identified in this first year of the initiative.

Multifaceted Approach to Improve Care

As outlined in the 180-day report to Congress on this initiative, VHA is rapidly moving forward to the following:

• Identify the unique characteristics and quality elements at end of life for Vietnam-era Veterans through analysis of medical records and bereaved family surveys;

• Develop three "Train the Trainer" curricula on identifying and addressing Post Traumatic Stress Disorder (PTSD), Moral Injury, and Suicide intent specifically for Vietnam-era Veterans on hospice; and

• Collaborate with the National Hospice and Palliative Care Organization (NHPCO) to conduct semi-structured interviews with Vietnam-era Veterans on hospice and their families to learn about quality issues directly from hospice users.

Additionally, VHA has collaborated with NHPCO to survey community hospice partners in the *We Honor Veterans* program (www.WeHonorVeterans.org) to learn more about their best practices and insights on how to improve the care Vietnam-era Veterans.

Initial Findings

The initial findings from analysis of qualitative open-ended comments from 2,781 inpatient decedent Vietnam-era Veterans' family members has identified the fol-

lowing themes as highly valued: *compassionate staff, ceremonies that honor the life of the Veteran, information on VA benefits, accommodations for family, genuine expressions of condolence, and attendance at memorial services.* Several of these themes (e.g., compassionate care) are similar to those desired elements voiced by non-Veterans and their families. A small number of family members of Vietnam-era Veterans reported war-era specific concerns such as the following: *the need for greater assistance for Veterans' struggles with PTSD, sensitivity to triggers for PTSD, and greater recognition of the impact of exposure to Agent Orange.* VA will further explore these Vietnam-era specific concerns.

Preliminary analysis of nearly 100,000 VA inpatient decedents indicate that there are unique characteristics among Vietnam-era Veterans (e.g., increased Agent Orange exposure and higher prevalence of substance use disorder) as compared to pre-Vietnam-era Veterans. Other notable characteristics among Vietnam-era Veterans (e.g., increased prevalence of depression and anxiety), may reflect emerging challenges in Veterans of subsequent war eras. For example, unadjusted scores on bereaved families' perceptions of end of life care show Vietnam-era Veteran families rate care lower in quality than pre-Vietnam (WWII, Korean and Post-Korean). However, these differences are negligible after accounting for differences in Veteran age at death. Further analyses are required to determine meaningful trends on quality perceptions and elements.

Actions to Improve Care and Next Steps

Translating the findings from these analyses into actionable protocols while empowering community hospices is the next major step for this 1-year initiative. For example, VHA has identified high-performing facility teams to be trained and then disseminate the newly developed Train-the-Trainer curricula to community hospices (with a projection of more than 1,000 front-line staff to receive these trainings by the end of the year) and build collaborative networks of care to support enhanced access to telehealth for Veterans receiving community hospice care. In collaboration with the National Hospice and Palliative Care Organization and the National Partnership for Hospice Innovation, VHA will develop best practice hospice protocols based on the substantial evidence revealed as part of this initiative and pilot these over the final months of this fiscal year to determine feasibility for broader dissemination.

Question 4c. It has also come to my attention that VA decided to focus areas of care on suicide prevention, moral injury and PTSD therapy. How did VA make that decision, and was it made in consultation with the Committees regarding congressional intent of the underlying hospice care provision?

Response. VHA has responded to all Committee inquiries into this initiative and has sought to meet or exceed the intent of any guidance provided by the Committees. The development and dissemination of expertise in the three areas mentioned above is only part of VHA's actions for this initiative, however, the decision to develop "Train the Trainer" curricula on PTSD, Moral Injury, and Suicide Prevention specifically for Vietnam-era Veterans in hospice was made in collaboration with subject matter experts from the following VHA programs: Palliative and Hospice Care, National Center on PTSD and Suicide Prevention, Office of Mental Health, Office of Care Coordination, Office of Patient Centered Care and Culture Transformation, National Chaplaincy Center, and the Office of Nursing Service, as well as incorporating guidance from the National Hospice and Palliative Care Organization. These offices and community hospice partners agreed that reducing the suffering in these three areas was and is a top priority for this initiative as outlined "... to develop the techniques, best practices and support mechanisms to serve these veterans ... ." For example, in a survey of community hospices, many shared they do not screen for nor have the capacity to address the symptoms of PTSD, Moral Injury, and Suicide Intent. Through dissemination of expertise in these three areas, community hospices will be more empowered to meet the specific needs of Vietnam-era Veterans in hospice.

Question 5. On December 20, 2018, I signed onto a letter led by Senator Carper regarding the closure of Education Corporation of America schools and its impact on veterans and their families. My colleagues and I have not yet received the answer to Questions from that letter and have included them here for a thorough response.

Question 5a. When did ECA notify the VA about the planned closures for each campus?

Response. VA received a letter from Education Corporation of America's (ECA) chief executive on December 12, 2018, officially advising VA of the closure and the effective date of closure for each of its locations.

Question 5b. When and how did the VA notify GI Bill recipients about the closures for each campus?

Response. Once VA was officially aware of the school's closure (December 12, 2018), VA notified affected students within the 5 business days required by law. All students impacted by the closure received a notice at their address of record. VA also posted notices of the closure on its Web site and social media pages with the following message and active link to more information on December 7th:

> "VA is aware of the abrupt closure of facilities associated with Education Corporation of America (ECA), which operated several chains of schools, to include Virginia College, Brightwood College, Golf Academy of America, and Ecotech Institute, throughout the Nation. VA is coordinating with the various State Approving Agencies (SAA) and is in the process of gathering the specific details surrounding this closure."

Additionally, the assistance provided to students by VA is in the form of the links and information contained in the 5-day outreach letter to students. A copy of this letter is attached below. Education Call Center agents were available to answer questions and provide assistance to students with school closure questions. Last, VA coordinated with Veterans Service Organizations (VSOs) to notify any affected students or provide support services.

DEPARTMENT OF VETERANS AFFAIRS
VA Regional Office
PO Box 8888
Muskogee, OK 74402-8888

Current Date

In Reply Refer To: 351/22

JOHN D VETERAN
123 ANYWHERE ST
ANYWHERE, OK 12345

J D Veter
XXX-XX-6789

Dear Mr. Veteran:

We are sending you this letter because our records indicate you attended training at (Facility claimant attended) and received education benefits from the Department of Veterans Affairs' (VA). Due to (Facility claimant attended) closure or disapproval on (Month, day, year) students could potentially be eligible for restoration of entitlement under the Harry W. Colmery Veterans Education Assistance Act of 2017.

What are the Requirements for Restoration of Entitlement

As a result of the Harry W. Colmery Veterans Educational Assistance Act of 2017, VA has the authority to restore GI Bill benefits that were previously used at a school that has either lost VA approval and/or the school closes. Below are the requirements for restoration of entitlement:

- The institutition closes, or
- After the date on which the individual enrolls at the institution, the VA modifies regulations or policies which affect the facility's approval to receive benefits, and
- The facility's disapproval/closure occurred during an active enrollment period, and
- The facility has the student actively enrolled in a term at the school/facility at the time of the disapproval/closure, and
- The actively enrolled student was unable to complete their course or program as a result of the disapproval/closure, and
- The actively enrolled student did not receive credit or lost training time towards the completion of the program of education being pursued.

What We Determined

We have determined that your school closure or disapproval did not meet one or more of the above requirements under the Harry W. Colmery Veterans Educational Assistance Act of 2017.

Where Can I Find More Help

- If you feel you qualify for entitlement restoration please complete and return the Entitlement Restoration enclosure, which can be found at (https://www.benefits.va.gov/GIBILL/docs/EntitlmentRestoration.pdf).
- VA's GI Bill Comparison Tool (https://www.vets.gov/gi-bill-comparison-tool) can help you review and compare alternative schools.
- Student Veterans of America (http://studentveterans.org/) has a network of over 1,400 student chapters at colleges and universities and their staff can provide answers to your questions.
- Reach out to Veterans of Foreign Wars (https://www.vfw.org). They offer emergency assistance grants to students affected by school closures.
- Free lawyers and advice are available for students from Veterans Education Success. Visit their website at http://veteranseducationsuccess.org/ or email directly, help@VeteransEducationSuccess.org.
- The Department of Education has a page dedicated to school closures. Visit https://studentaid.ed.gov/sa/about/announcements/closed-school for more information.
- The American Legion (https://www.legion.org/serviceofficers) has service officers in every state that can provide answers to questions about education benefits, federal student loans and credit transferability.
- The State Approving Agencies (http://nasaa-vetseducation.com/Contacts.aspx) are working with schools to identify those that will accept transfers.

What If I Have Student Loans

If you are a GI Bill beneficiary who also has federal student loans, consider visiting the Department of Education's Federal Student Aid webpage (https://studentaid.ed.gov/sa/) for Closed School Discharge, which has information regarding loan forgiveness criteria for students whose schools close abruptly.

If You Have Questions or Need Assistance

If you have questions or need assistance, contact the Department of Veterans Affairs at 1-888-GI-BILL-1 (1-888-442-4551). If you use the Telecommunications Device for the Deaf (TDD), the Federal number is 711. See the "If You Need Help" enclosure for contact information.

We understand the extremely difficult situation this closure has caused, and wish to assist you as much as possible in continuing your educational goals.

Sincerely yours,

3

CSS XXX-XX-6789
Veter, J D

P. Stephens
Education Officer
22/ (VCE's initials)
Enclosure(s): If You Need Help

Question 5c. How many Post-9/11 GI Bill recipients were enrolled at ECA colleges at the time of the announced closure? Please provide GI Bill enrollment data for each campus.

Response. There were 1,389 students enrolled at ECA colleges who were using Post-9/11 GI Bill benefits at the time of closure. Please see the enrollment data spreadsheets below.

ECA School List

AY Paid	Facility Code	Institution Name	State	TF Paid	YR Paid	Total Amt
AY14	21001418	Virginia College	LA	$ 205,117.26	$ 900.85	$ 206,018.11
AY14	21001618	Virginia College	LA	$ 436,804.01	$ 439.97	$ 437,243.98
AY14	21004336	Virginia College	OK	$ 16,080.00	$ -	$ 16,080.00
AY14	21014146	Virginia College	VA	$ 553,377.23	$ 3,154.47	$ 556,531.70
AY14	21014806	Ecotech Institute	CO	$ 1,641,824.69	$ 1,202.52	$ 1,643,027.21
AY14	21802301	Virginia College	AL	$ 4,601,957.92	$ 45,352.69	$ 4,647,310.61
AY14	21802340	Virginia College	SC	$ 165,591.23	$ 392.49	$ 165,983.72
AY14	21802440	Virginia College	SC	$ 761,599.39	$ -	$ 761,599.39
AY14	21802640	Virginia College	SC	$ 948,500.31	$ 175.84	$ 948,676.15
AY14	21802740	Virginia College	SC	$ 287,646.83	$ -	$ 287,646.83
AY14	21802840	Virginia College	SC	$ 239,322.97	$ 623.45	$ 239,946.42
AY14	21904042	Virginia College	TN	$ 346,047.84	$ 1,732.49	$ 347,780.33
AY14	21905133	Virginia College	NC	$ 123,755.29	$ -	$ 123,755.29
AY14	21917211	Virginia College	GA	$ 1,440,912.26	$ 6,452.59	$ 1,447,364.85
AY14	21917311	Virginia College	GA	$ 341,752.35	$ 2,133.83	$ 343,886.18
AY14	21917611	Virginia College	GA	$ 1,573,589.86	$ 3,046.72	$ 1,576,636.58
AY14	21917811	Virginia College	GA	$ 2,319,763.88	$ 3,040.87	$ 2,322,804.75
AY14	21952301	Virginia College	AL	$ 1,014,559.55	$ -	$ 1,014,559.55
AY14	21953101	Virginia College	AL	$ 453,810.15	$ 1,593.98	$ 455,404.13
AY14	21958101	Virginia College	AL	$ 956,763.11	$ 4,379.51	$ 961,142.62
AY14	219B6110	Virginia College	FL	$ 1,740,635.54	$ 13,734.72	$ 1,754,370.26
AY14	24001805	Brightwood College	CA	$ 96,486.33	$ -	$ 96,486.33
AY14	24003305	Brightwood College	CA	$ 112,435.90	$ -	$ 112,435.90
AY14	24005705	Brightwood College	CA	$ 244,348.18	$ 1,102.98	$ 245,451.16
AY14	24008205	Brightwood College	CA	$ 303,260.96	$ -	$ 303,260.96
AY14	24033943	Virginia College	TX	$ 751,736.40	$ 3,105.03	$ 754,841.43
AY14	24035643	BRIGHTWOOD COLLEGE-MCALLEN	TX	$ 94,135.24	$ -	$ 94,135.24
AY14	24036043	BRIGHTWOOD COLLEGE-BEAUMONT	TX	$ 38,860.16	$ -	$ 38,860.16
AY14	24036143	BRIGHTWOOD COLLEGE-SAN ANTONIO SAN PEDRO	TX	$ 659,610.99	$ -	$ 659,610.99
AY14	24036243	BRIGHTWOOD COLLEGE-BROWNSVILLE	TX	$ 245,133.55	$ -	$ 245,133.55
AY14	24036343	BRIGHTWOOD COLLEGE-FRIENDSWOOD	TX	$ 66,820.41	$ -	$ 66,820.41
AY14	24036443	BRIGHTWOOD COLLEGE-SAN ANTONIO INGRAM	TX	$ 639,916.83	$ -	$ 639,916.83
AY14	24036643	BRIGHTWOOD COLLEGE-EL PASO	TX	$ 462,269.22	$ -	$ 462,269.22
AY14	24037343	BRIGHTWOOD COLLEGE-ARLINGTON	TX	$ 247,177.58	$ -	$ 247,177.58
AY14	24037543	BRIGHTWOOD COLLEGE-LAREDO	TX	$ 36,159.38	$ -	$ 36,159.38
AY14	24038643	Golf Academy of America	TX	$ 709,756.25	$ 25,658.55	$ 735,414.80
AY14	24039243	Virginia College	TX	$ 92,379.00	$ -	$ 92,379.00
AY14	24113440	Golf Academy of America	SC	$ 1,097,141.39	$ 40,174.69	$ 1,137,316.08
AY14	24201010	Golf Academy of America	FL	$ 1,149,219.00	$ 50,873.43	$ 1,200,092.43
AY14	24801005	Brightwood College	CA	$ 114,520.29	$ -	$ 114,520.29
AY14	24801324	Virginia College	MS	$ 357,622.41	$ -	$ 357,622.41
AY14	24801424	Virginia College	MS	$ 1,110,846.04	$ -	$ 1,110,846.04
AY14	24804405	Brightwood College	CA	$ 53,174.94	$ -	$ 53,174.94
AY14	24804605	Brightwood College	CA	$ 45,088.54	$ -	$ 45,088.54
AY14	24831905	Brightwood College	CA	$ 1,483,603.03	$ 4,834.75	$ 1,488,437.78
AY14	24832005	Brightwood College	CA	$ 2,632,406.05	$ 12,753.31	$ 2,645,159.36
AY14	24909105	Golf Academy of America	CA	$ 1,434,589.65	$ 58,438.92	$ 1,493,028.57
AY14	24912133	Brightwood College	NC	$ 64,281.23	$ -	$ 64,281.23
AY14	24918414	Brightwood College	IN	$ 45,108.18	$ -	$ 45,108.18
AY14	24921520	Brightwood College	MD	$ 244,948.18	$ -	$ 244,948.18
AY14	24921720	Brightwood College	MD	$ 335,897.24	$ -	$ 335,897.24
AY14	24921920	Brightwood College	MD	$ 157,760.75	$ -	$ 157,760.75
AY14	24929403	Golf Academy of America	AZ	$ 958,194.58	$ 55,304.16	$ 1,013,498.74
AY14	24931614	Brightwood College	IN	$ 132,013.18	$ -	$ 132,013.18
AY14	24936405	Brightwood College	CA	$ 249,571.64	$ -	$ 249,571.64
AY14	24939438	Brightwood Career Institute	PA	$ 208,729.05	$ -	$ 208,729.05
AY14	24940638	Brightwood Career Institute	PA	$ 120,533.34	$ -	$ 120,533.34
AY14	24942438	Brightwood Career Institute	PA	$ 160,918.64	$ -	$ 160,918.64
AY14	24955442	Brightwood College	TN	$ 208,874.21	$ -	$ 208,874.21
AY14	24956438	Brightwood Career Institute	PA	$ 94,737.11	$ -	$ 94,737.11
AY14	24961438	Brightwood Career Institute	PA	$ 120,439.77	$ -	$ 120,439.77
AY14	24986435	Brightwood College	OH	$ 218,685.90	$ -	$ 218,685.90
AY14	24994410	Virginia College	FL	$ 915,801.48	$ 2,171.33	$ 917,972.81
AY14	249F1410	Virginia College	FL	$ 89,015.80	$ -	$ 89,015.80
AY14	249J2143	BRIGHTWOOD COLLEGE-DALLAS	TX	$ 206,801.90	$ -	$ 206,801.90
AY14	249L8143	BRIGHTWOOD COLLEGE-FORT WORTH	TX	$ 184,376.97	$ -	$ 184,376.97
AY14	25011906	Brightwood College	CO	$ 7,432.50	$ -	$ 7,432.50
AY14	25106731	Brightwood College	MN	$ 2,425.80	$ -	$ 2,425.80
AY14	28119823	Brightwood Career Institute	MN	$ 6,577.06	$ -	$ 6,577.06
AY15	21001418	Virginia College	LA	$ 244,522.96	$ -	$ 244,522.96
AY15	21001618	Virginia College	LA	$ 433,370.10	$ -	$ 433,370.10
AY15	21004336	Virginia College	OK	$ 4,020.00	$ -	$ 4,020.00
AY15	21014146	Virginia College	VA	$ 477,908.36	$ -	$ 477,908.36
AY15	21014806	Ecotech Institute	CO	$ 1,315,541.49	$ 4,631.60	$ 1,320,173.09
AY15	21802301	Virginia College	AL	$ 4,612,299.15	$ 2,397.59	$ 4,614,696.74
AY15	21802340	Virginia College	SC	$ 187,333.58	$ -	$ 187,333.58
AY15	21802440	Virginia College	SC	$ 556,968.73	$ 1,420.49	$ 558,389.22

AY Paid	Facility Code	Institution Name	State	TF Paid	YR Paid	Total Amt
AY15	21802640	Virginia College	SC	$ 985,640.77	$ 418.56	$ 986,059.33
AY15	21802740	Virginia College	SC	$ 244,805.65	$ -	$ 244,805.65
AY15	21802840	Virginia College	SC	$ 261,194.31	$ -	$ 261,194.31
AY15	21904042	Virginia College	TN	$ 229,239.29	$ -	$ 229,239.29
AY15	21905133	Virginia College	NC	$ 132,004.30	$ -	$ 132,004.30
AY15	21917211	Virginia College	GA	$ 1,291,040.12	$ -	$ 1,291,040.12
AY15	21917311	Virginia College	GA	$ 258,214.09	$ 670.49	$ 258,884.58
AY15	21917611	Virginia College	GA	$ 1,691,800.00	$ 1,091.49	$ 1,692,891.49
AY15	21917811	Virginia College	GA	$ 2,006,477.89	$ 2,290.48	$ 2,008,768.37
AY15	21952301	Virginia College	AL	$ 997,130.47	$ -	$ 997,130.47
AY15	21953101	Virginia College	AL	$ 497,495.02	$ 476.49	$ 497,971.51
AY15	21958101	Virginia College	AL	$ 1,012,546.32	$ 972.99	$ 1,013,519.31
AY15	219B6110	Virginia College	FL	$ 2,050,748.86	$ 7,993.02	$ 2,058,741.88
AY15	24001805	Brightwood College	CA	$ 156,199.12	$ -	$ 156,199.12
AY15	24003305	Brightwood College	CA	$ 176,792.15	$ -	$ 176,792.15
AY15	24005705	Brightwood College	CA	$ 229,907.17	$ -	$ 229,907.17
AY15	24008205	Brightwood College	CA	$ 459,440.87	$ -	$ 459,440.87
AY15	24033943	Virginia College	TX	$ 800,151.22	$ 1,595.05	$ 801,746.27
AY15	24035643	BRIGHTWOOD COLLEGE-MCALLEN	TX	$ 95,542.29	$ -	$ 95,542.29
AY15	24036043	BRIGHTWOOD COLLEGE-BEAUMONT	TX	$ 111,871.33	$ -	$ 111,871.33
AY15	24036143	BRIGHTWOOD COLLEGE-SAN ANTONIO SAN PEDRO	TX	$ 794,951.97	$ -	$ 794,951.97
AY15	24036243	BRIGHTWOOD COLLEGE-BROWNSVILLE	TX	$ 239,756.20	$ -	$ 239,756.20
AY15	24036343	BRIGHTWOOD COLLEGE-FRIENDSWOOD	TX	$ 93,116.86	$ -	$ 93,116.86
AY15	24036443	BRIGHTWOOD COLLEGE-SAN ANTONIO INGRAM	TX	$ 523,634.14	$ -	$ 523,634.14
AY15	24036643	BRIGHTWOOD COLLEGE-EL PASO	TX	$ 568,616.07	$ 169.16	$ 568,785.23
AY15	24037343	BRIGHTWOOD COLLEGE-ARLINGTON	TX	$ 245,935.31	$ -	$ 245,935.31
AY15	24037543	BRIGHTWOOD COLLEGE-LAREDO	TX	$ 53,179.74	$ -	$ 53,179.74
AY15	24038643	Golf Academy of America	TX	$ 1,153,629.36	$ 39,964.20	$ 1,193,593.56
AY15	24039243	Virginia College	TX	$ 262,710.13	$ -	$ 262,710.13
AY15	24113440	Golf Academy of America	SC	$ 1,146,991.17	$ 45,444.32	$ 1,192,435.49
AY15	24201010	Golf Academy of America	FL	$ 1,187,088.82	$ 55,504.70	$ 1,242,593.52
AY15	24801005	Brightwood College	CA	$ 145,601.33	$ -	$ 145,601.33
AY15	24801324	Virginia College	MS	$ 300,950.46	$ 1,987.99	$ 302,938.45
AY15	24801424	Virginia College	MS	$ 789,317.29	$ -	$ 789,317.29
AY15	24804405	Brightwood College	CA	$ 23,199.64	$ -	$ 23,199.64
AY15	24804605	Brightwood College	CA	$ 28,170.40	$ -	$ 28,170.40
AY15	24831905	Brightwood College	CA	$ 1,073,670.62	$ 2,715.28	$ 1,076,385.90
AY15	24832005	Brightwood College	CA	$ 2,163,411.07	$ 869.73	$ 2,164,280.80
AY15	24909105	Golf Academy of America	CA	$ 1,328,387.62	$ 49,879.51	$ 1,378,267.13
AY15	24912133	Brightwood College	NC	$ 182,752.55	$ -	$ 182,752.55
AY15	24918414	Brightwood College	IN	$ 37,025.47	$ -	$ 37,025.47
AY15	24921520	Brightwood College	MD	$ 310,764.25	$ -	$ 310,764.25
AY15	24921720	Brightwood College	MD	$ 503,047.03	$ -	$ 503,047.03
AY15	24921920	Brightwood College	MD	$ 219,132.58	$ -	$ 219,132.58
AY15	24929403	Golf Academy of America	AZ	$ 857,584.13	$ 37,561.04	$ 895,145.17
AY15	24931614	Brightwood College	IN	$ 126,019.62	$ -	$ 126,019.62
AY15	24936405	Brightwood College	CA	$ 250,485.56	$ -	$ 250,485.56
AY15	24939438	Brightwood Career Institute	PA	$ 218,107.94	$ -	$ 218,107.94
AY15	24940638	Brightwood Career Institute	PA	$ 88,875.74	$ -	$ 88,875.74
AY15	24942438	Brightwood Career Institute	PA	$ 174,646.80	$ 1,853.66	$ 176,500.46
AY15	24955442	Brightwood College	TN	$ 212,602.94	$ -	$ 212,602.94
AY15	24956438	Brightwood Career Institute	PA	$ 56,211.65	$ -	$ 56,211.65
AY15	24961438	Brightwood Career Institute	PA	$ 120,276.00	$ -	$ 120,276.00
AY15	24986435	Brightwood College	OH	$ 243,408.03	$ -	$ 243,408.03
AY15	24994410	Virginia College	FL	$ 849,726.79	$ 1,727.98	$ 851,454.77
AY15	249F1410	Virginia College	FL	$ 132,963.33	$ -	$ 132,963.33
AY15	249J2143	BRIGHTWOOD COLLEGE-DALLAS	TX	$ 164,602.77	$ -	$ 164,602.77
AY15	249L8143	BRIGHTWOOD COLLEGE-FORT WORTH	TX	$ 152,588.95	$ -	$ 152,588.95
AY15	25011906	Brightwood College	CO	$ 35,025.14	$ -	$ 35,025.14
AY15	25106731	Brightwood College	MN	$ 6,183.72	$ -	$ 6,183.72
AY15	28119823	Brightwood Career Institute	MN	$ 8,087.44	$ -	$ 8,087.44
AY16	21001418	Virginia College	LA	$ 360,366.43	$ -	$ 360,366.43
AY16	21001618	Virginia College	LA	$ 340,216.09	$ -	$ 340,216.09
AY16	21014146	Virginia College	VA	$ 552,826.36	$ -	$ 552,826.36
AY16	21014806	Ecotech Institute	CO	$ 1,487,538.22	$ 624.77	$ 1,488,162.99
AY16	21802301	Virginia College	AL	$ 3,612,037.77	$ 12,023.80	$ 3,624,061.57
AY16	21802340	Virginia College	SC	$ 200,699.05	$ -	$ 200,699.05
AY16	21802440	Virginia College	SC	$ 635,607.07	$ -	$ 635,607.07
AY16	21802640	Virginia College	SC	$ 945,932.48	$ 3,177.23	$ 949,109.71
AY16	21802740	Virginia College	SC	$ 224,696.48	$ -	$ 224,696.48
AY16	21802840	Virginia College	SC	$ 279,279.82	$ -	$ 279,279.82
AY16	21904042	Virginia College	TN	$ 282,679.02	$ -	$ 282,679.02
AY16	21905133	Virginia College	NC	$ 164,275.39	$ -	$ 164,275.39
AY16	21917211	Virginia College	GA	$ 1,150,241.45	$ 1,997.14	$ 1,152,238.59
AY16	21917311	Virginia College	GA	$ 223,801.47	$ -	$ 223,801.47
AY16	21917611	Virginia College	GA	$ 1,541,694.56	$ 934.21	$ 1,542,628.77
AY16	21917811	Virginia College	GA	$ 1,794,921.93	$ -	$ 1,794,921.93

AY Paid	Facility Code	Institution Name	State	TF Paid	YR Paid	Total Amt
AY16	21952301	Virginia College	AL	$ 715,291.04	$ -	$ 715,291.04
AY16	21953101	Virginia College	AL	$ 636,198.56	$ -	$ 636,198.56
AY16	21958101	Virginia College	AL	$ 710,874.82	$ 560.33	$ 711,435.15
AY16	219B6110	Virginia College	FL	$ 2,022,173.39	$ 3,164.10	$ 2,025,337.49
AY16	24001805	Brightwood College	CA	$ 94,334.27	$ -	$ 94,334.27
AY16	24003305	Brightwood College	CA	$ 226,617.38	$ -	$ 226,617.38
AY16	24005705	Brightwood College	CA	$ 439,084.85	$ -	$ 439,084.85
AY16	24008205	Brightwood College	CA	$ 384,947.08	$ 1,985.45	$ 386,932.53
AY16	24033943	Virginia College	TX	$ 721,071.32	$ 368.56	$ 721,439.88
AY16	24035643	BRIGHTWOOD COLLEGE-MCALLEN	TX	$ 72,546.21	$ -	$ 72,546.21
AY16	24036043	BRIGHTWOOD COLLEGE-BEAUMONT	TX	$ 161,708.16	$ -	$ 161,708.16
AY16	24036143	BRIGHTWOOD COLLEGE-SAN ANTONIO SAN PEDRO	TX	$ 584,559.05	$ -	$ 584,559.05
AY16	24036243	BRIGHTWOOD COLLEGE-BROWNSVILLE	TX	$ 231,187.87	$ -	$ 231,187.87
AY16	24036343	BRIGHTWOOD COLLEGE-FRIENDSWOOD	TX	$ 178,821.64	$ -	$ 178,821.64
AY16	24036443	BRIGHTWOOD COLLEGE-SAN ANTONIO INGRAM	TX	$ 663,806.01	$ -	$ 663,806.01
AY16	24036643	BRIGHTWOOD COLLEGE-EL PASO	TX	$ 618,548.70	$ -	$ 618,548.70
AY16	24037343	BRIGHTWOOD COLLEGE-ARLINGTON	TX	$ 279,518.09	$ 2,794.86	$ 282,312.95
AY16	24037543	BRIGHTWOOD COLLEGE-LAREDO	TX	$ 106,894.35	$ -	$ 106,894.35
AY16	24038643	Golf Academy of America	TX	$ 989,838.06	$ 17,277.24	$ 1,007,115.30
AY16	24039243	Virginia College	TX	$ 198,071.30	$ -	$ 198,071.30
AY16	24042043	BRIGHTWOOD COLLEGE-CORPUS CHRISTI	TX	$ 244,498.39	$ -	$ 244,498.39
AY16	24042143	BRIGHTWOOD COLLEGE-HOUSTON	TX	$ 139,543.18	$ -	$ 139,543.18
AY16	24113440	Golf Academy of America	SC	$ 859,754.87	$ 36,811.88	$ 896,566.75
AY16	24201010	Golf Academy of America	FL	$ 1,150,231.91	$ 44,841.99	$ 1,195,073.90
AY16	24801005	Brightwood College	CA	$ 57,252.30	$ -	$ 57,252.30
AY16	24801324	Virginia College	MS	$ 235,340.07	$ -	$ 235,340.07
AY16	24801424	Virginia College	MS	$ 775,810.25	$ -	$ 775,810.25
AY16	24804405	Brightwood College	CA	$ 37,841.54	$ -	$ 37,841.54
AY16	24804605	Brightwood College	CA	$ 60,454.84	$ -	$ 60,454.84
AY16	24831905	Brightwood College	CA	$ 1,252,416.76	$ 3,521.40	$ 1,255,938.16
AY16	24832005	Brightwood College	CA	$ 2,749,393.95	$ 43,254.38	$ 2,792,648.33
AY16	24909105	Golf Academy of America	CA	$ 1,401,989.89	$ 48,697.96	$ 1,450,687.85
AY16	24912133	Brightwood College	NC	$ 180,334.30	$ -	$ 180,334.30
AY16	24918414	Brightwood College	IN	$ 99,339.51	$ -	$ 99,339.51
AY16	24921520	Brightwood College	MD	$ 346,607.32	$ -	$ 346,607.32
AY16	24921720	Brightwood College	MD	$ 445,222.98	$ -	$ 445,222.98
AY16	24921920	Brightwood College	MD	$ 342,836.37	$ -	$ 342,836.37
AY16	24929403	Golf Academy of America	AZ	$ 630,841.47	$ 27,250.86	$ 658,092.33
AY16	24931614	Brightwood College	IN	$ 86,661.93	$ -	$ 86,661.93
AY16	24936405	Brightwood College	CA	$ 353,318.54	$ 7,461.34	$ 360,779.88
AY16	24939438	Brightwood Career Institute	PA	$ 249,668.72	$ -	$ 249,668.72
AY16	24940638	Brightwood Career Institute	PA	$ 182,586.76	$ -	$ 182,586.76
AY16	24942438	Brightwood Career Institute	PA	$ 189,025.65	$ 1,661.43	$ 190,687.08
AY16	24955442	Brightwood College	TN	$ 258,039.48	$ 5,294.68	$ 263,334.16
AY16	24956438	Brightwood Career Institute	PA	$ 99,821.83	$ -	$ 99,821.83
AY16	24961438	Brightwood Career Institute	PA	$ 166,314.31	$ -	$ 166,314.31
AY16	24986435	Brightwood College	OH	$ 189,295.94	$ 3,470.27	$ 192,766.21
AY16	24994410	Virginia College	FL	$ 529,570.32	$ 527.36	$ 530,097.68
AY16	249F1410	Virginia College	FL	$ 146,574.21	$ -	$ 146,574.21
AY16	249J2143	BRIGHTWOOD COLLEGE-DALLAS	TX	$ 206,361.43	$ -	$ 206,361.43
AY16	249L8143	BRIGHTWOOD COLLEGE-FORT WORTH	TX	$ 128,006.34	$ -	$ 128,006.34
AY16	25011906	Brightwood College	CO	$ 19,254.27	$ -	$ 19,254.27
AY16	25106731	Brightwood College	MN	$ 3,252.17	$ -	$ 3,252.17
AY16	28119823	Brightwood Career Institute	MN	$ 13,327.13	$ -	$ 13,327.13
AY17	21001418	Virginia College	LA	$ 245,879.31	$ 525.27	$ 246,404.58
AY17	21001618	Virginia College	LA	$ 245,450.67	$ -	$ 245,450.67
AY17	21014146	Virginia College	VA	$ 454,065.70	$ -	$ 454,065.70
AY17	21014806	Ecotech Institute	CO	$ 1,282,349.25	$ -	$ 1,282,349.25
AY17	21802301	Virginia College	AL	$ 917,940.63	$ 2,442.00	$ 920,382.63
AY17	21802340	Virginia College	SC	$ 150,933.91	$ -	$ 150,933.91
AY17	21802440	Virginia College	SC	$ 363,249.53	$ -	$ 363,249.53
AY17	21802640	Virginia College	SC	$ 495,734.14	$ -	$ 495,734.14
AY17	21802740	Virginia College	SC	$ 143,609.64	$ -	$ 143,609.64
AY17	21802840	Virginia College	SC	$ 190,500.49	$ -	$ 190,500.49
AY17	21904042	Virginia College	TN	$ 323,598.00	$ 200.77	$ 323,798.77
AY17	21905133	Virginia College	NC	$ 178,024.33	$ -	$ 178,024.33
AY17	21917211	Virginia College	GA	$ 730,637.54	$ -	$ 730,637.54
AY17	21917311	Virginia College	GA	$ 160,234.83	$ -	$ 160,234.83
AY17	21917611	Virginia College	GA	$ 1,264,188.68	$ 476.49	$ 1,264,665.17
AY17	21917811	Virginia College	GA	$ 935,408.43	$ 1,129.77	$ 936,538.20
AY17	21952301	Virginia College	AL	$ 163,055.06	$ -	$ 163,055.06
AY17	21953101	Virginia College	AL	$ 268,999.24	$ 200.77	$ 269,200.01
AY17	21958101	Virginia College	AL	$ 143,779.72	$ -	$ 143,779.72
AY17	219B6110	Virginia College	FL	$ 1,563,557.79	$ -	$ 1,563,557.79
AY17	24001805	Brightwood College	CA	$ 100,410.18	$ -	$ 100,410.18
AY17	24003305	Brightwood College	CA	$ 387,190.70	$ -	$ 387,190.70
AY17	24005705	Brightwood College	CA	$ 333,898.00	$ -	$ 333,898.00

AY Paid	Facility Code	Institution Name	State	TF Paid	YR Paid	Total Amt
AY17	24008205	Brightwood College	CA	$ 457,574.92	$ -	$ 457,574.92
AY17	24033943	Virginia College	TX	$ 411,155.88	$ 3,432.09	$ 414,587.97
AY17	24035643	BRIGHTWOOD COLLEGE-MCALLEN	TX	$ 73,378.53	$ -	$ 73,378.53
AY17	24036043	BRIGHTWOOD COLLEGE-BEAUMONT	TX	$ 62,301.80	$ -	$ 62,301.80
AY17	24036143	BRIGHTWOOD COLLEGE-SAN ANTONIO SAN PEDRO	TX	$ 552,298.34	$ 1,513.96	$ 553,812.30
AY17	24036243	BRIGHTWOOD COLLEGE-BROWNSVILLE	TX	$ 199,733.70	$ -	$ 199,733.70
AY17	24036343	BRIGHTWOOD COLLEGE-FRIENDSWOOD	TX	$ 121,037.71	$ -	$ 121,037.71
AY17	24036443	BRIGHTWOOD COLLEGE-SAN ANTONIO INGRAM	TX	$ 891,849.25	$ 112.07	$ 891,961.32
AY17	24036643	BRIGHTWOOD COLLEGE-EL PASO	TX	$ 325,899.72	$ -	$ 325,899.72
AY17	24037343	BRIGHTWOOD COLLEGE-ARLINGTON	TX	$ 142,195.54	$ -	$ 142,195.54
AY17	24037543	BRIGHTWOOD COLLEGE-LAREDO	TX	$ 117,525.16	$ -	$ 117,525.16
AY17	24038643	Golf Academy of America	TX	$ 982,524.10	$ 14,598.30	$ 997,122.40
AY17	24039243	Virginia College	TX	$ 172,705.01	$ -	$ 172,705.01
AY17	24042043	BRIGHTWOOD COLLEGE-CORPUS CHRISTI	TX	$ 275,101.55	$ -	$ 275,101.55
AY17	24042143	BRIGHTWOOD COLLEGE-HOUSTON	TX	$ 128,209.37	$ -	$ 128,209.37
AY17	24113440	Golf Academy of America	SC	$ 529,961.81	$ 12,096.08	$ 542,057.89
AY17	24201010	Golf Academy of America	FL	$ 990,525.07	$ 26,080.07	$ 1,016,605.14
AY17	24801005	Brightwood College	CA	$ 119,440.00	$ -	$ 119,440.00
AY17	24801324	Virginia College	MS	$ 105,223.97	$ -	$ 105,223.97
AY17	24801424	Virginia College	MS	$ 363,192.60	$ -	$ 363,192.60
AY17	24804405	Brightwood College	CA	$ 20,895.09	$ -	$ 20,895.09
AY17	24804605	Brightwood College	CA	$ 32,926.44	$ -	$ 32,926.44
AY17	24831905	Brightwood College	CA	$ 1,389,982.64	$ 6,512.29	$ 1,396,494.93
AY17	24832005	Brightwood College	CA	$ 2,331,078.91	$ 876.73	$ 2,331,955.64
AY17	24909105	Golf Academy of America	CA	$ 1,208,656.30	$ 14,998.75	$ 1,223,655.05
AY17	24912133	Brightwood College	NC	$ 200,741.67	$ 2,608.46	$ 203,350.13
AY17	24918414	Brightwood College	IN	$ 60,514.25	$ -	$ 60,514.25
AY17	24921520	Brightwood College	MD	$ 306,872.96	$ -	$ 306,872.96
AY17	24921720	Brightwood College	MD	$ 318,053.20	$ -	$ 318,053.20
AY17	24921920	Brightwood College	MD	$ 164,703.61	$ -	$ 164,703.61
AY17	24929403	Golf Academy of America	AZ	$ 661,271.97	$ 12,591.39	$ 673,863.36
AY17	24931614	Brightwood College	IN	$ 94,877.91	$ -	$ 94,877.91
AY17	24936405	Brightwood College	CA	$ 405,764.82	$ -	$ 405,764.82
AY17	24939438	Brightwood Career Institute	PA	$ 278,517.75	$ 1,224.99	$ 279,742.74
AY17	24940638	Brightwood Career Institute	PA	$ 86,238.63	$ -	$ 86,238.63
AY17	24942438	Brightwood Career Institute	PA	$ 210,140.18	$ -	$ 210,140.18
AY17	24955442	Brightwood College	TN	$ 128,718.05	$ -	$ 128,718.05
AY17	24956438	Brightwood Career Institute	PA	$ 70,876.41	$ 1,977.05	$ 72,853.46
AY17	24961438	Brightwood Career Institute	PA	$ 80,683.86	$ -	$ 80,683.86
AY17	24986435	Brightwood College	OH	$ 253,218.02	$ -	$ 253,218.02
AY17	24994410	Virginia College	FL	$ 523,356.32	$ 225.02	$ 523,581.34
AY17	249F1410	Virginia College	FL	$ 103,590.69	$ -	$ 103,590.69
AY17	249J2143	BRIGHTWOOD COLLEGE-DALLAS	TX	$ 217,699.66	$ -	$ 217,699.66
AY17	249L8143	BRIGHTWOOD COLLEGE-FORT WORTH	TX	$ 89,300.49	$ -	$ 89,300.49
AY17	25011906	Brightwood College	CO	$ 17,073.49	$ -	$ 17,073.49
AY17	25106731	Brightwood College	MN	$ 5,959.48	$ -	$ 5,959.48
AY17	28119823	Brightwood Career Institute	MN	$ 2,164.80	$ -	$ 2,164.80
AY18	21001418	Virginia College	LA	$ 48,817.99	$ -	$ 48,817.99
AY18	21001618	Virginia College	LA	$ 81,651.53	$ -	$ 81,651.53
AY18	21014146	Virginia College	VA	$ 141,040.62	$ -	$ 141,040.62
AY18	21014806	Ecotech Institute	CO	$ 381,287.69	$ -	$ 381,287.69
AY18	21802301	Virginia College	AL	$ 92,210.52	$ 812.94	$ 93,023.46
AY18	21802340	Virginia College	SC	$ 23,871.34	$ -	$ 23,871.34
AY18	21802440	Virginia College	SC	$ 133,166.38	$ -	$ 133,166.38
AY18	21802640	Virginia College	SC	$ 164,582.14	$ -	$ 164,582.14
AY18	21802740	Virginia College	SC	$ 40,307.98	$ -	$ 40,307.98
AY18	21802840	Virginia College	SC	$ 48,893.98	$ -	$ 48,893.98
AY18	21904042	Virginia College	TN	$ 78,986.68	$ -	$ 78,986.68
AY18	21905133	Virginia College	NC	$ 78,936.41	$ -	$ 78,936.41
AY18	21917211	Virginia College	GA	$ 283,850.05	$ -	$ 283,850.05
AY18	21917311	Virginia College	GA	$ 31,638.94	$ -	$ 31,638.94
AY18	21917611	Virginia College	GA	$ 485,510.01	$ -	$ 485,510.01
AY18	21917811	Virginia College	GA	$ 182,914.63	$ -	$ 182,914.63
AY18	21952301	Virginia College	AL	$ 24,977.32	$ -	$ 24,977.32
AY18	21953101	Virginia College	AL	$ 59,006.33	$ -	$ 59,006.33
AY18	21958101	Virginia College	AL	$ 42,390.33	$ -	$ 42,390.33
AY18	219B6110	Virginia College	FL	$ 568,600.56	$ 1,652.36	$ 570,252.92
AY18	24001805	Brightwood College	CA	$ 4,371.28	$ -	$ 4,371.28
AY18	24003305	Brightwood College	CA	$ 96,697.52	$ -	$ 96,697.52
AY18	24005705	Brightwood College	CA	$ 147,159.90	$ -	$ 147,159.90
AY18	24008205	Brightwood College	CA	$ 185,184.09	$ 3,195.40	$ 188,379.49
AY18	24033943	Virginia College	TX	$ 151,150.76	$ -	$ 151,150.76
AY18	24035643	BRIGHTWOOD COLLEGE-MCALLEN	TX	$ 33,753.38	$ -	$ 33,753.38
AY18	24036043	BRIGHTWOOD COLLEGE-BEAUMONT	TX	$ 4,004.06	$ -	$ 4,004.06
AY18	24036143	BRIGHTWOOD COLLEGE-SAN ANTONIO SAN PEDRO	TX	$ 174,108.00	$ -	$ 174,108.00
AY18	24036243	BRIGHTWOOD COLLEGE-BROWNSVILLE	TX	$ 38,603.97	$ -	$ 38,603.97
AY18	24036343	BRIGHTWOOD COLLEGE-FRIENDSWOOD	TX	$ 34,049.70	$ -	$ 34,049.70

AY Paid	Facility Code	Institution Name	State	TF Paid	YR Paid	Total Amt
AY18	24036443	BRIGHTWOOD COLLEGE-SAN ANTONIO INGRAM	TX	$ 369,143.80	$ 2,530.89	$ 371,674.69
AY18	24036643	BRIGHTWOOD COLLEGE-EL PASO	TX	$ 129,699.83	$ -	$ 129,699.83
AY18	24037343	BRIGHTWOOD COLLEGE-ARLINGTON	TX	$ 50,139.88	$ -	$ 50,139.88
AY18	24037543	BRIGHTWOOD COLLEGE-LAREDO	TX	$ 12,157.28	$ -	$ 12,157.28
AY18	24038643	Golf Academy of America	TX	$ 370,372.81	$ 4,296.64	$ 374,669.45
AY18	24039243	Virginia College	TX	$ 48,739.11	$ -	$ 48,739.11
AY18	24042043	BRIGHTWOOD COLLEGE-CORPUS CHRISTI	TX	$ 78,821.58	$ 2,935.35	$ 81,756.93
AY18	24042143	BRIGHTWOOD COLLEGE-HOUSTON	TX	$ 42,200.41	$ -	$ 42,200.41
AY18	24113440	Golf Academy of America	SC	$ 148,085.01	$ -	$ 148,085.01
AY18	24201010	Golf Academy of America	FL	$ 368,898.96	$ -	$ 368,898.96
AY18	24801005	Brightwood College	CA	$ 48,308.65	$ 3,033.54	$ 51,342.19
AY18	24801324	Virginia College	MS	$ 27,726.84	$ -	$ 27,726.84
AY18	24801424	Virginia College	MS	$ 123,725.34	$ -	$ 123,725.34
AY18	24804405	Brightwood College	CA	$ 23,964.93	$ -	$ 23,964.93
AY18	24804605	Brightwood College	CA	$ 4,067.93	$ -	$ 4,067.93
AY18	24831905	Brightwood College	CA	$ 388,713.93	$ 6,886.80	$ 395,600.73
AY18	24832005	Brightwood College	CA	$ 885,255.92	$ 28,743.75	$ 913,999.67
AY18	24909105	Golf Academy of America	CA	$ 392,391.51	$ 3,788.87	$ 396,180.38
AY18	24912133	Brightwood College	NC	$ 62,769.03	$ -	$ 62,769.03
AY18	24918414	Brightwood College	IN	$ 1,668.60	$ -	$ 1,668.60
AY18	24921520	Brightwood College	MD	$ 56,715.90	$ -	$ 56,715.90
AY18	24921720	Brightwood College	MD	$ 104,443.38	$ -	$ 104,443.38
AY18	24921920	Brightwood College	MD	$ 53,453.83	$ -	$ 53,453.83
AY18	24929403	Golf Academy of America	AZ	$ 258,801.65	$ 6,920.10	$ 265,721.75
AY18	24931614	Brightwood College	IN	$ 34,652.53	$ -	$ 34,652.53
AY18	24936405	Brightwood College	CA	$ 107,144.60	$ 3,715.41	$ 110,860.01
AY18	24939438	Brightwood Career Institute	PA	$ 42,793.27	$ -	$ 42,793.27
AY18	24940638	Brightwood Career Institute	PA	$ 14,039.30	$ -	$ 14,039.30
AY18	24942438	Brightwood Career Institute	PA	$ 106,242.23	$ -	$ 106,242.23
AY18	24955442	Brightwood College	TN	$ 64,418.86	$ -	$ 64,418.86
AY18	24956438	Brightwood Career Institute	PA	$ 7,900.53	$ -	$ 7,900.53
AY18	24961438	Brightwood Career Institute	PA	$ 38,604.04	$ -	$ 38,604.04
AY18	24986435	Brightwood College	OH	$ 27,109.92	$ -	$ 27,109.92
AY18	24994410	Virginia College	FL	$ 159,759.20	$ -	$ 159,759.20
AY18	249F1410	Virginia College	FL	$ 14,599.85	$ -	$ 14,599.85
AY18	249J2143	BRIGHTWOOD COLLEGE-DALLAS	TX	$ 73,677.98	$ -	$ 73,677.98
AY18	249L8143	BRIGHTWOOD COLLEGE-FORT WORTH	TX	$ 33,510.72	$ -	$ 33,510.72
AY18	25011906	Brightwood College	CO	$ 5,534.00	$ -	$ 5,534.00
AY18	25106731	Brightwood College	MN	$ 2,505.24	$ -	$ 2,505.24
AY18	28119823	Brightwood Career Institute	MN	$ 498.25	$ -	$ 498.25

ECA COLLEGES BY INSTITUTION NAME

	A	B	C	D
1		Column Labels		
2		AY14		
3	Row Labels	Sum of TF_PAID	Sum of YR_PAID	Sum of TOTAL_AMT
4	Brightwood Career Institute			
5	MN	$6,577.06	$0.00	$6,577.06
6	28119823	$6,577.06	$0.00	$6,577.06
7	PA	$705,357.91	$0.00	$705,357.91
8	24939438	$208,729.05	$0.00	$208,729.05
9	24940638	$120,533.34	$0.00	$120,533.34
10	24942438	$160,918.64	$0.00	$160,918.64
11	24956438	$94,737.11	$0.00	$94,737.11
12	24961438	$120,439.77	$0.00	$120,439.77
13	Brightwood Career Institute Total	$711,934.97	$0.00	$711,934.97
14	Brightwood College			
15	CA	$5,334,895.86	$18,691.04	$5,353,586.90
16	24001805	$96,486.33	$0.00	$96,486.33
17	24003305	$112,435.90	$0.00	$112,435.90
18	24005705	$244,348.18	$1,102.98	$245,451.16
19	24008205	$303,260.96	$0.00	$303,260.96
20	24801005	$114,520.29	$0.00	$114,520.29
21	24804405	$53,174.94	$0.00	$53,174.94
22	24804605	$45,088.54	$0.00	$45,088.54
23	24831905	$1,483,603.03	$4,834.75	$1,488,437.78
24	24832005	$2,632,406.05	$12,753.31	$2,645,159.36
25	24936405	$249,571.64	$0.00	$249,571.64
26	CO	$7,432.50	$0.00	$7,432.50
27	25011906	$7,432.50	$0.00	$7,432.50
28	IN	$177,121.36	$0.00	$177,121.36
29	24918414	$45,108.18	$0.00	$45,108.18
30	24931614	$132,013.18	$0.00	$132,013.18
31	MD	$738,606.17	$0.00	$738,606.17
32	24921520	$244,948.18	$0.00	$244,948.18
33	24921720	$335,897.24	$0.00	$335,897.24
34	24921920	$157,760.75	$0.00	$157,760.75
35	MN	$2,425.80	$0.00	$2,425.80
36	25106731	$2,425.80	$0.00	$2,425.80
37	NC	$64,281.23	$0.00	$64,281.23
38	24912133	$64,281.23	$0.00	$64,281.23
39	OH	$218,685.90	$0.00	$218,685.90
40	24986435	$218,685.90	$0.00	$218,685.90
41	TN	$208,874.21	$0.00	$208,874.21
42	24955442	$208,874.21	$0.00	$208,874.21
43	Brightwood College Total	$6,752,323.03	$18,691.04	$6,771,014.07
44	BRIGHTWOOD COLLEGE-ARLINGTON			
45	TX	$247,177.58	$0.00	$247,177.58
46	24037343	$247,177.58	$0.00	$247,177.58
47	BRIGHTWOOD COLLEGE-ARLINGTON Total	$247,177.58	$0.00	$247,177.58
48	BRIGHTWOOD COLLEGE-BEAUMONT			
49	TX	$38,860.16	$0.00	$38,860.16
50	24036043	$38,860.16	$0.00	$38,860.16
51	BRIGHTWOOD COLLEGE-BEAUMONT Total	$38,860.16	$0.00	$38,860.16
52	BRIGHTWOOD COLLEGE-BROWNSVILLE			
53	TX	$245,133.55	$0.00	$245,133.55
54	24036243	$245,133.55	$0.00	$245,133.55
55	BRIGHTWOOD COLLEGE-BROWNSVILLE Total	$245,133.55	$0.00	$245,133.55
56	BRIGHTWOOD COLLEGE-CORPUS CHRISTI			
57	TX			
58	24042043			
59	BRIGHTWOOD COLLEGE-CORPUS CHRISTI Total			
60	BRIGHTWOOD COLLEGE-DALLAS			
61	TX	$206,801.90	$0.00	$206,801.90
62	249J2143	$206,801.90	$0.00	$206,801.90
63	BRIGHTWOOD COLLEGE-DALLAS Total	$206,801.90	$0.00	$206,801.90
64	BRIGHTWOOD COLLEGE-EL PASO			
65	TX	$462,269.22	$0.00	$462,269.22
66	24036643	$462,269.22	$0.00	$462,269.22
67	BRIGHTWOOD COLLEGE-EL PASO Total	$462,269.22	$0.00	$462,269.22

	A	B	C	D
1		Column Labels		
2		AY14		
3	Row Labels	Sum of TF_PAID	Sum of YR_PAID	Sum of TOTAL_AMT
68	BRIGHTWOOD COLLEGE-FORT WORTH			
69	TX	$184,376.97	$0.00	$184,376.97
70	249L8143	$184,376.97	$0.00	$184,376.97
71	BRIGHTWOOD COLLEGE-FORT WORTH Total	$184,376.97	$0.00	$184,376.97
72	BRIGHTWOOD COLLEGE-FRIENDSWOOD			
73	TX	$66,820.41	$0.00	$66,820.41
74	24036343	$66,820.41	$0.00	$66,820.41
75	BRIGHTWOOD COLLEGE-FRIENDSWOOD Total	$66,820.41	$0.00	$66,820.41
76	BRIGHTWOOD COLLEGE-HOUSTON			
77	TX			
78	24042143			
79	BRIGHTWOOD COLLEGE-HOUSTON Total			
80	BRIGHTWOOD COLLEGE-LAREDO			
81	TX	$36,159.38	$0.00	$36,159.38
82	24037543	$36,159.38	$0.00	$36,159.38
83	BRIGHTWOOD COLLEGE-LAREDO Total	$36,159.38	$0.00	$36,159.38
84	BRIGHTWOOD COLLEGE-MCALLEN			
85	TX	$94,135.24	$0.00	$94,135.24
86	24035643	$94,135.24	$0.00	$94,135.24
87	BRIGHTWOOD COLLEGE-MCALLEN Total	$94,135.24	$0.00	$94,135.24
88	BRIGHTWOOD COLLEGE-SAN ANTONIO INGRAM			
89	TX	$639,916.83	$0.00	$639,916.83
90	24036443	$639,916.83	$0.00	$639,916.83
91	BRIGHTWOOD COLLEGE-SAN ANTONIO INGRAM T	$639,916.83	$0.00	$639,916.83
92	BRIGHTWOOD COLLEGE-SAN ANTONIO SAN PEDRO			
93	TX	$659,610.99	$0.00	$659,610.99
94	24036143	$659,610.99	$0.00	$659,610.99
95	BRIGHTWOOD COLLEGE-SAN ANTONIO SAN PEDR	$659,610.99	$0.00	$659,610.99
96	Ecotech Institute			
97	CO	$1,641,824.69	$1,202.52	$1,643,027.21
98	21014806	$1,641,824.69	$1,202.52	$1,643,027.21
99	Ecotech Institute Total	$1,641,824.69	$1,202.52	$1,643,027.21
100	Golf Academy of America			
101	AZ	$958,194.58	$55,304.16	$1,013,498.74
102	24929403	$958,194.58	$55,304.16	$1,013,498.74
103	CA	$1,434,589.65	$58,438.92	$1,493,028.57
104	24909105	$1,434,589.65	$58,438.92	$1,493,028.57
105	FL	$1,149,219.00	$50,873.43	$1,200,092.43
106	24201010	$1,149,219.00	$50,873.43	$1,200,092.43
107	SC	$1,097,141.39	$40,174.69	$1,137,316.08
108	24113440	$1,097,141.39	$40,174.69	$1,137,316.08
109	TX	$709,756.25	$25,658.55	$735,414.80
110	24038643	$709,756.25	$25,658.55	$735,414.80
111	Golf Academy of America Total	$5,348,900.87	$230,449.75	$5,579,350.62
112	Virginia College			
113	AL	$7,027,090.73	$51,326.18	$7,078,416.91
114	21802301	$4,601,957.92	$45,352.69	$4,647,310.61
115	21952301	$1,014,559.55	$0.00	$1,014,559.55
116	21953101	$453,810.15	$1,593.98	$455,404.13
117	21958101	$956,763.11	$4,379.51	$961,142.62
118	FL	$2,745,452.82	$15,906.05	$2,761,358.87
119	219B6110	$1,740,635.54	$13,734.72	$1,754,370.26
120	24994410	$915,801.48	$2,171.33	$917,972.81
121	249F1410	$89,015.80	$0.00	$89,015.80
122	GA	$5,676,018.35	$14,674.01	$5,690,692.36
123	21917211	$1,440,912.26	$6,452.59	$1,447,364.85
124	21917311	$341,752.35	$2,133.83	$343,886.18
125	21917611	$1,573,589.86	$3,046.72	$1,576,636.58
126	21917811	$2,319,763.88	$3,040.87	$2,322,804.75
127	LA	$641,921.27	$1,340.82	$643,262.09
128	21001418	$205,117.26	$900.85	$206,018.11
129	21001618	$436,804.01	$439.97	$437,243.98
130	MS	$1,468,468.45	$0.00	$1,468,468.45
131	24801324	$357,622.41	$0.00	$357,622.41

	A	B	C	D
1		Column Labels		
2		AY14		
3	Row Labels	Sum of TF_PAID	Sum of YR_PAID	Sum of TOTAL_AMT
132	24801424	$1,110,846.04	$0.00	$1,110,846.04
133	**NC**	**$123,755.29**	**$0.00**	**$123,755.29**
134	21905133	$123,755.29	$0.00	$123,755.29
135	**OK**	**$16,080.00**	**$0.00**	**$16,080.00**
136	21004336	$16,080.00	$0.00	$16,080.00
137	**SC**	**$2,402,660.73**	**$1,191.78**	**$2,403,852.51**
138	21802340	$165,591.23	$392.49	$165,983.72
139	21802440	$761,599.39	$0.00	$761,599.39
140	21802640	$948,500.31	$175.84	$948,676.15
141	21802740	$287,646.83	$0.00	$287,646.83
142	21802840	$239,322.97	$623.45	$239,946.42
143	**TN**	**$346,047.84**	**$1,732.49**	**$347,780.33**
144	21904042	$346,047.84	$1,732.49	$347,780.33
145	**TX**	**$844,115.40**	**$3,105.03**	**$847,220.43**
146	24033943	$751,736.40	$3,105.03	$754,841.43
147	24039243	$92,379.00	$0.00	$92,379.00
148	**VA**	**$553,377.23**	**$3,154.47**	**$556,531.70**
149	21014146	$553,377.23	$3,154.47	$556,531.70
150	**Virginia College Total**	**$21,844,988.11**	**$92,430.83**	**$21,937,418.94**
151	**Grand Total**	**$39,181,233.90**	**$342,774.14**	**$39,524,008.04**

	A	E	F	G
1				
2		AY15		
3	Row Labels	Sum of TF_PAID	Sum of YR_PAID	Sum of TOTAL_AMT
4	**Brightwood Career Institute**			
5	**MN**	**$8,087.44**	**$0.00**	**$8,087.44**
6	28119823	$8,087.44	$0.00	$8,087.44
7	**PA**	**$658,118.13**	**$1,853.66**	**$659,971.79**
8	24939438	$218,107.94	$0.00	$218,107.94
9	24940638	$88,875.74	$0.00	$88,875.74
10	24942438	$174,646.80	$1,853.66	$176,500.46
11	24956438	$56,211.65	$0.00	$56,211.65
12	24961438	$120,276.00	$0.00	$120,276.00
13	**Brightwood Career Institute Total**	**$666,205.57**	**$1,853.66**	**$668,059.23**
14	**Brightwood College**			
15	**CA**	**$4,706,877.93**	**$3,585.01**	**$4,710,462.94**
16	24001805	$156,199.12	$0.00	$156,199.12
17	24003305	$176,792.15	$0.00	$176,792.15
18	24005705	$229,907.17	$0.00	$229,907.17
19	24008205	$459,440.87	$0.00	$459,440.87
20	24801005	$145,601.33	$0.00	$145,601.33
21	24804405	$23,199.64	$0.00	$23,199.64
22	24804605	$28,170.40	$0.00	$28,170.40
23	24831905	$1,073,670.62	$2,715.28	$1,076,385.90
24	24832005	$2,163,411.07	$869.73	$2,164,280.80
25	24936405	$250,485.56	$0.00	$250,485.56
26	**CO**	**$35,025.14**	**$0.00**	**$35,025.14**
27	25011906	$35,025.14	$0.00	$35,025.14
28	**IN**	**$163,045.09**	**$0.00**	**$163,045.09**
29	24918414	$37,025.47	$0.00	$37,025.47
30	24931614	$126,019.62	$0.00	$126,019.62
31	**MD**	**$1,032,943.86**	**$0.00**	**$1,032,943.86**
32	24921520	$310,764.25	$0.00	$310,764.25
33	24921720	$503,047.03	$0.00	$503,047.03
34	24921920	$219,132.58	$0.00	$219,132.58
35	**MN**	**$6,183.72**	**$0.00**	**$6,183.72**
36	25106731	$6,183.72	$0.00	$6,183.72
37	**NC**	**$182,752.55**	**$0.00**	**$182,752.55**
38	24912133	$182,752.55	$0.00	$182,752.55
39	**OH**	**$243,408.03**	**$0.00**	**$243,408.03**
40	24986435	$243,408.03	$0.00	$243,408.03
41	**TN**	**$212,602.94**	**$0.00**	**$212,602.94**
42	24955442	$212,602.94	$0.00	$212,602.94
43	**Brightwood College Total**	**$6,582,839.26**	**$3,585.01**	**$6,586,424.27**
44	**BRIGHTWOOD COLLEGE-ARLINGTON**			
45	**TX**	**$245,935.31**	**$0.00**	**$245,935.31**
46	24037343	$245,935.31	$0.00	$245,935.31
47	**BRIGHTWOOD COLLEGE-ARLINGTON Total**	**$245,935.31**	**$0.00**	**$245,935.31**
48	**BRIGHTWOOD COLLEGE-BEAUMONT**			
49	**TX**	**$111,871.33**	**$0.00**	**$111,871.33**
50	24036043	$111,871.33	$0.00	$111,871.33
51	**BRIGHTWOOD COLLEGE-BEAUMONT Total**	**$111,871.33**	**$0.00**	**$111,871.33**
52	**BRIGHTWOOD COLLEGE-BROWNSVILLE**			
53	**TX**	**$239,756.20**	**$0.00**	**$239,756.20**
54	24036243	$239,756.20	$0.00	$239,756.20
55	**BRIGHTWOOD COLLEGE-BROWNSVILLE Total**	**$239,756.20**	**$0.00**	**$239,756.20**
56	**BRIGHTWOOD COLLEGE-CORPUS CHRISTI**			
57	**TX**			
58	24042043			
59	**BRIGHTWOOD COLLEGE-CORPUS CHRISTI Total**			
60	**BRIGHTWOOD COLLEGE-DALLAS**			
61	**TX**	**$164,602.77**	**$0.00**	**$164,602.77**
62	249J2143	$164,602.77	$0.00	$164,602.77
63	**BRIGHTWOOD COLLEGE-DALLAS Total**	**$164,602.77**	**$0.00**	**$164,602.77**
64	**BRIGHTWOOD COLLEGE-EL PASO**			
65	**TX**	**$568,616.07**	**$169.16**	**$568,785.23**
66	24036643	$568,616.07	$169.16	$568,785.23
67	**BRIGHTWOOD COLLEGE-EL PASO Total**	**$568,616.07**	**$169.16**	**$568,785.23**

	A	E	F	G
1				
2		AY15		
3	Row Labels	Sum of TF_PAID	Sum of YR_PAID	Sum of TOTAL_AMT
68	**BRIGHTWOOD COLLEGE-FORT WORTH**			
69	**TX**	**$152,588.95**	**$0.00**	**$152,588.95**
70	249L8143	$152,588.95	$0.00	$152,588.95
71	**BRIGHTWOOD COLLEGE-FORT WORTH Total**	**$152,588.95**	**$0.00**	**$152,588.95**
72	**BRIGHTWOOD COLLEGE-FRIENDSWOOD**			
73	**TX**	**$93,116.86**	**$0.00**	**$93,116.86**
74	24036343	$93,116.86	$0.00	$93,116.86
75	**BRIGHTWOOD COLLEGE-FRIENDSWOOD Total**	**$93,116.86**	**$0.00**	**$93,116.86**
76	**BRIGHTWOOD COLLEGE-HOUSTON**			
77	**TX**			
78	24042143			
79	**BRIGHTWOOD COLLEGE-HOUSTON Total**			
80	**BRIGHTWOOD COLLEGE-LAREDO**			
81	**TX**	**$53,179.74**	**$0.00**	**$53,179.74**
82	24037543	$53,179.74	$0.00	$53,179.74
83	**BRIGHTWOOD COLLEGE-LAREDO Total**	**$53,179.74**	**$0.00**	**$53,179.74**
84	**BRIGHTWOOD COLLEGE-MCALLEN**			
85	**TX**	**$95,542.29**	**$0.00**	**$95,542.29**
86	24035643	$95,542.29	$0.00	$95,542.29
87	**BRIGHTWOOD COLLEGE-MCALLEN Total**	**$95,542.29**	**$0.00**	**$95,542.29**
88	**BRIGHTWOOD COLLEGE-SAN ANTONIO INGRAM**			
89	**TX**	**$523,634.14**	**$0.00**	**$523,634.14**
90	24036443	$523,634.14	$0.00	$523,634.14
91	**BRIGHTWOOD COLLEGE-SAN ANTONIO INGRAM T**	**$523,634.14**	**$0.00**	**$523,634.14**
92	**BRIGHTWOOD COLLEGE-SAN ANTONIO SAN PED**			
93	**TX**	**$794,951.97**	**$0.00**	**$794,951.97**
94	24036143	$794,951.97	$0.00	$794,951.97
95	**BRIGHTWOOD COLLEGE-SAN ANTONIO SAN PEDR**	**$794,951.97**	**$0.00**	**$794,951.97**
96	**Ecotech Institute**			
97	**CO**	**$1,315,541.49**	**$4,631.60**	**$1,320,173.09**
98	21014806	$1,315,541.49	$4,631.60	$1,320,173.09
99	**Ecotech Institute Total**	**$1,315,541.49**	**$4,631.60**	**$1,320,173.09**
100	**Golf Academy of America**			
101	**AZ**	**$857,584.13**	**$37,561.04**	**$895,145.17**
102	24929403	$857,584.13	$37,561.04	$895,145.17
103	**CA**	**$1,328,387.62**	**$49,879.51**	**$1,378,267.13**
104	24909105	$1,328,387.62	$49,879.51	$1,378,267.13
105	**FL**	**$1,187,088.82**	**$55,504.70**	**$1,242,593.52**
106	24201010	$1,187,088.82	$55,504.70	$1,242,593.52
107	**SC**	**$1,146,991.17**	**$45,444.32**	**$1,192,435.49**
108	24113440	$1,146,991.17	$45,444.32	$1,192,435.49
109	**TX**	**$1,153,629.36**	**$39,964.20**	**$1,193,593.56**
110	24038643	$1,153,629.36	$39,964.20	$1,193,593.56
111	**Golf Academy of America Total**	**$5,673,681.10**	**$228,353.77**	**$5,902,034.87**
112	**Virginia College**			
113	**AL**	**$7,119,470.96**	**$3,847.07**	**$7,123,318.03**
114	21802301	$4,612,299.15	$2,397.59	$4,614,696.74
115	21952301	$997,130.47	$0.00	$997,130.47
116	21953101	$497,495.02	$476.49	$497,971.51
117	21958101	$1,012,546.32	$972.99	$1,013,519.31
118	**FL**	**$3,033,438.98**	**$9,721.00**	**$3,043,159.98**
119	219B6110	$2,050,748.86	$7,993.02	$2,058,741.88
120	24994410	$849,726.79	$1,727.98	$851,454.77
121	249F1410	$132,963.33	$0.00	$132,963.33
122	**GA**	**$5,247,532.10**	**$4,052.46**	**$5,251,584.56**
123	21917211	$1,291,040.12	$0.00	$1,291,040.12
124	21917311	$258,214.09	$670.49	$258,884.58
125	21917611	$1,691,800.00	$1,091.49	$1,692,891.49
126	21917811	$2,006,477.89	$2,290.48	$2,008,768.37
127	**LA**	**$677,893.06**	**$0.00**	**$677,893.06**
128	21001418	$244,522.96	$0.00	$244,522.96
129	21001618	$433,370.10	$0.00	$433,370.10
130	**MS**	**$1,090,267.75**	**$1,987.99**	**$1,092,255.74**
131	24801324	$300,950.46	$1,987.99	$302,938.45

	A	E	F	G
1				
2		AY15		
3	Row Labels	Sum of TF_PAID	Sum of YR_PAID	Sum of TOTAL_AMT
132	24801424	$789,317.29	$0.00	$789,317.29
133	**NC**	**$132,004.30**	**$0.00**	**$132,004.30**
134	21905133	$132,004.30	$0.00	$132,004.30
135	**OK**	**$4,020.00**	**$0.00**	**$4,020.00**
136	21004336	$4,020.00	$0.00	$4,020.00
137	**SC**	**$2,235,943.04**	**$1,839.05**	**$2,237,782.09**
138	21802340	$187,333.58	$0.00	$187,333.58
139	21802440	$556,968.73	$1,420.49	$558,389.22
140	21802640	$985,640.77	$418.56	$986,059.33
141	21802740	$244,805.65	$0.00	$244,805.65
142	21802840	$261,194.31	$0.00	$261,194.31
143	**TN**	**$229,239.29**	**$0.00**	**$229,239.29**
144	21904042	$229,239.29	$0.00	$229,239.29
145	**TX**	**$1,062,861.35**	**$1,595.05**	**$1,064,456.40**
146	24033943	$800,151.22	$1,595.05	$801,746.27
147	24039243	$262,710.13	$0.00	$262,710.13
148	**VA**	**$477,908.36**	**$0.00**	**$477,908.36**
149	21014146	$477,908.36	$0.00	$477,908.36
150	**Virginia College Total**	**$21,310,579.19**	**$23,042.62**	**$21,333,621.81**
151	**Grand Total**	**$38,592,642.24**	**$261,635.82**	**$38,854,278.06**

	A	H	I	J
1				
2		AY16		
3	Row Labels	Sum of TF_PAID	Sum of YR_PAID	Sum of TOTAL_AMT
4	**Brightwood Career Institute**			
5	**MN**	**$13,327.13**	**$0.00**	**$13,327.13**
6	28119823	$13,327.13	$0.00	$13,327.13
7	**PA**	**$887,417.27**	**$1,661.43**	**$889,078.70**
8	24939438	$249,668.72	$0.00	$249,668.72
9	24940638	$182,586.76	$0.00	$182,586.76
10	24942438	$189,025.65	$1,661.43	$190,687.08
11	24956438	$99,821.83	$0.00	$99,821.83
12	24961438	$166,314.31	$0.00	$166,314.31
13	**Brightwood Career Institute Total**	**$900,744.40**	**$1,661.43**	**$902,405.83**
14	**Brightwood College**			
15	**CA**	**$5,655,661.51**	**$56,222.57**	**$5,711,884.08**
16	24001805	$94,334.27	$0.00	$94,334.27
17	24003305	$226,617.38	$0.00	$226,617.38
18	24005705	$439,084.85	$0.00	$439,084.85
19	24008205	$384,947.08	$1,985.45	$386,932.53
20	24801005	$57,252.30	$0.00	$57,252.30
21	24804405	$37,841.54	$0.00	$37,841.54
22	24804605	$60,454.84	$0.00	$60,454.84
23	24831905	$1,252,416.76	$3,521.40	$1,255,938.16
24	24832005	$2,749,393.95	$43,254.38	$2,792,648.33
25	24936405	$353,318.54	$7,461.34	$360,779.88
26	**CO**	**$19,254.27**	**$0.00**	**$19,254.27**
27	25011906	$19,254.27	$0.00	$19,254.27
28	**IN**	**$186,001.44**	**$0.00**	**$186,001.44**
29	24918414	$99,339.51	$0.00	$99,339.51
30	24931614	$86,661.93	$0.00	$86,661.93
31	**MD**	**$1,134,666.67**	**$0.00**	**$1,134,666.67**
32	24921520	$346,607.32	$0.00	$346,607.32
33	24921720	$445,222.98	$0.00	$445,222.98
34	24921920	$342,836.37	$0.00	$342,836.37
35	**MN**	**$3,252.17**	**$0.00**	**$3,252.17**
36	25106731	$3,252.17	$0.00	$3,252.17
37	**NC**	**$180,334.30**	**$0.00**	**$180,334.30**
38	24912133	$180,334.30	$0.00	$180,334.30
39	**OH**	**$189,295.94**	**$3,470.27**	**$192,766.21**
40	24986435	$189,295.94	$3,470.27	$192,766.21
41	**TN**	**$258,039.48**	**$5,294.68**	**$263,334.16**
42	24955442	$258,039.48	$5,294.68	$263,334.16
43	**Brightwood College Total**	**$7,626,505.78**	**$64,987.52**	**$7,691,493.30**
44	**BRIGHTWOOD COLLEGE-ARLINGTON**			
45	**TX**	**$279,518.09**	**$2,794.86**	**$282,312.95**
46	24037343	$279,518.09	$2,794.86	$282,312.95
47	**BRIGHTWOOD COLLEGE-ARLINGTON Total**	**$279,518.09**	**$2,794.86**	**$282,312.95**
48	**BRIGHTWOOD COLLEGE-BEAUMONT**			
49	**TX**	**$161,708.16**	**$0.00**	**$161,708.16**
50	24036043	$161,708.16	$0.00	$161,708.16
51	**BRIGHTWOOD COLLEGE-BEAUMONT Total**	**$161,708.16**	**$0.00**	**$161,708.16**
52	**BRIGHTWOOD COLLEGE-BROWNSVILLE**			
53	**TX**	**$231,187.87**	**$0.00**	**$231,187.87**
54	24036243	$231,187.87	$0.00	$231,187.87
55	**BRIGHTWOOD COLLEGE-BROWNSVILLE Total**	**$231,187.87**	**$0.00**	**$231,187.87**
56	**BRIGHTWOOD COLLEGE-CORPUS CHRISTI**			
57	**TX**	**$244,498.39**	**$0.00**	**$244,498.39**
58	24042043	$244,498.39	$0.00	$244,498.39
59	**BRIGHTWOOD COLLEGE-CORPUS CHRISTI Total**	**$244,498.39**	**$0.00**	**$244,498.39**
60	**BRIGHTWOOD COLLEGE-DALLAS**			
61	**TX**	**$206,361.43**	**$0.00**	**$206,361.43**
62	249J2143	$206,361.43	$0.00	$206,361.43
63	**BRIGHTWOOD COLLEGE-DALLAS Total**	**$206,361.43**	**$0.00**	**$206,361.43**
64	**BRIGHTWOOD COLLEGE-EL PASO**			
65	**TX**	**$618,548.70**	**$0.00**	**$618,548.70**
66	24036643	$618,548.70	$0.00	$618,548.70
67	**BRIGHTWOOD COLLEGE-EL PASO Total**	**$618,548.70**	**$0.00**	**$618,548.70**

	A	H	I	J
1				
2		AY16		
3	Row Labels	Sum of TF_PAID	Sum of YR_PAID	Sum of TOTAL_AMT
68	**BRIGHTWOOD COLLEGE-FORT WORTH**			
69	**TX**	**$128,006.34**	**$0.00**	**$128,006.34**
70	249L8143	$128,006.34	$0.00	$128,006.34
71	**BRIGHTWOOD COLLEGE-FORT WORTH Total**	**$128,006.34**	**$0.00**	**$128,006.34**
72	**BRIGHTWOOD COLLEGE-FRIENDSWOOD**			
73	**TX**	**$178,821.64**	**$0.00**	**$178,821.64**
74	24036343	$178,821.64	$0.00	$178,821.64
75	**BRIGHTWOOD COLLEGE-FRIENDSWOOD Total**	**$178,821.64**	**$0.00**	**$178,821.64**
76	**BRIGHTWOOD COLLEGE-HOUSTON**			
77	**TX**	**$139,543.18**	**$0.00**	**$139,543.18**
78	24042143	$139,543.18	$0.00	$139,543.18
79	**BRIGHTWOOD COLLEGE-HOUSTON Total**	**$139,543.18**	**$0.00**	**$139,543.18**
80	**BRIGHTWOOD COLLEGE-LAREDO**			
81	**TX**	**$106,894.35**	**$0.00**	**$106,894.35**
82	24037543	$106,894.35	$0.00	$106,894.35
83	**BRIGHTWOOD COLLEGE-LAREDO Total**	**$106,894.35**	**$0.00**	**$106,894.35**
84	**BRIGHTWOOD COLLEGE-MCALLEN**			
85	**TX**	**$72,546.21**	**$0.00**	**$72,546.21**
86	24035643	$72,546.21	$0.00	$72,546.21
87	**BRIGHTWOOD COLLEGE-MCALLEN Total**	**$72,546.21**	**$0.00**	**$72,546.21**
88	**BRIGHTWOOD COLLEGE-SAN ANTONIO INGRAM**			
89	**TX**	**$663,806.01**	**$0.00**	**$663,806.01**
90	24036443	$663,806.01	$0.00	$663,806.01
91	**BRIGHTWOOD COLLEGE-SAN ANTONIO INGRAM T**	**$663,806.01**	**$0.00**	**$663,806.01**
92	**BRIGHTWOOD COLLEGE-SAN ANTONIO SAN PED**			
93	**TX**	**$584,559.05**	**$0.00**	**$584,559.05**
94	24036143	$584,559.05	$0.00	$584,559.05
95	**BRIGHTWOOD COLLEGE-SAN ANTONIO SAN PEDR**	**$584,559.05**	**$0.00**	**$584,559.05**
96	**Ecotech Institute**			
97	**CO**	**$1,487,538.22**	**$624.77**	**$1,488,162.99**
98	21014806	$1,487,538.22	$624.77	$1,488,162.99
99	**Ecotech Institute Total**	**$1,487,538.22**	**$624.77**	**$1,488,162.99**
100	**Golf Academy of America**			
101	**AZ**	**$630,841.47**	**$27,250.86**	**$658,092.33**
102	24929403	$630,841.47	$27,250.86	$658,092.33
103	**CA**	**$1,401,989.89**	**$48,697.96**	**$1,450,687.85**
104	24909105	$1,401,989.89	$48,697.96	$1,450,687.85
105	**FL**	**$1,150,231.91**	**$44,841.99**	**$1,195,073.90**
106	24201010	$1,150,231.91	$44,841.99	$1,195,073.90
107	**SC**	**$859,754.87**	**$36,811.88**	**$896,566.75**
108	24113440	$859,754.87	$36,811.88	$896,566.75
109	**TX**	**$989,838.06**	**$17,277.24**	**$1,007,115.30**
110	24038643	$989,838.06	$17,277.24	$1,007,115.30
111	**Golf Academy of America Total**	**$5,032,656.20**	**$174,879.93**	**$5,207,536.13**
112	**Virginia College**			
113	**AL**	**$5,674,402.19**	**$12,584.13**	**$5,686,986.32**
114	21802301	$3,612,037.77	$12,023.80	$3,624,061.57
115	21952301	$715,291.04	$0.00	$715,291.04
116	21953101	$636,198.56	$0.00	$636,198.56
117	21958101	$710,874.82	$560.33	$711,435.15
118	**FL**	**$2,698,317.92**	**$3,691.46**	**$2,702,009.38**
119	219B6110	$2,022,173.39	$3,164.10	$2,025,337.49
120	24994410	$529,570.32	$527.36	$530,097.68
121	249F1410	$146,574.21	$0.00	$146,574.21
122	**GA**	**$4,710,659.41**	**$2,931.35**	**$4,713,590.76**
123	21917211	$1,150,241.45	$1,997.14	$1,152,238.59
124	21917311	$223,801.47	$0.00	$223,801.47
125	21917611	$1,541,694.56	$934.21	$1,542,628.77
126	21917811	$1,794,921.93	$0.00	$1,794,921.93
127	**LA**	**$700,582.52**	**$0.00**	**$700,582.52**
128	21001418	$360,366.43	$0.00	$360,366.43
129	21001618	$340,216.09	$0.00	$340,216.09
130	**MS**	**$1,011,150.32**	**$0.00**	**$1,011,150.32**
131	24801324	$235,340.07	$0.00	$235,340.07

	A	H	I	J
1				
2		AY16		
3	Row Labels	Sum of TF_PAID	Sum of YR_PAID	Sum of TOTAL_AMT
132	24801424	$775,810.25	$0.00	$775,810.25
133	**NC**	**$164,275.39**	**$0.00**	**$164,275.39**
134	21905133	$164,275.39	$0.00	$164,275.39
135	**OK**			
136	21004336			
137	**SC**	**$2,286,214.90**	**$3,177.23**	**$2,289,392.13**
138	21802340	$200,699.05	$0.00	$200,699.05
139	21802440	$635,607.07	$0.00	$635,607.07
140	21802640	$945,932.48	$3,177.23	$949,109.71
141	21802740	$224,696.48	$0.00	$224,696.48
142	21802840	$279,279.82	$0.00	$279,279.82
143	**TN**	**$282,679.02**	**$0.00**	**$282,679.02**
144	21904042	$282,679.02	$0.00	$282,679.02
145	**TX**	**$919,142.62**	**$368.56**	**$919,511.18**
146	24033943	$721,071.32	$368.56	$721,439.88
147	24039243	$198,071.30	$0.00	$198,071.30
148	**VA**	**$552,826.36**	**$0.00**	**$552,826.36**
149	21014146	$552,826.36	$0.00	$552,826.36
150	**Virginia College Total**	**$19,000,250.65**	**$22,752.73**	**$19,023,003.38**
151	**Grand Total**	**$37,663,694.67**	**$267,701.24**	**$37,931,395.91**

	A	K	L	M
1				
2		AY17		
3	Row Labels	Sum of TF_PAID	Sum of YR_PAID	Sum of TOTAL_AMT
4	**Brightwood Career Institute**			
5	**MN**	**$2,164.80**	**$0.00**	**$2,164.80**
6	28119823	$2,164.80	$0.00	$2,164.80
7	**PA**	**$726,456.83**	**$3,202.04**	**$729,658.87**
8	24939438	$278,517.75	$1,224.99	$279,742.74
9	24940638	$86,238.63	$0.00	$86,238.63
10	24942438	$210,140.18	$0.00	$210,140.18
11	24956438	$70,876.41	$1,977.05	$72,853.46
12	24961438	$80,683.86	$0.00	$80,683.86
13	**Brightwood Career Institute Total**	**$728,621.63**	**$3,202.04**	**$731,823.67**
14	**Brightwood College**			
15	**CA**	**$5,579,161.70**	**$7,389.02**	**$5,586,550.72**
16	24001805	$100,410.18	$0.00	$100,410.18
17	24003305	$387,190.70	$0.00	$387,190.70
18	24005705	$333,898.00	$0.00	$333,898.00
19	24008205	$457,574.92	$0.00	$457,574.92
20	24801005	$119,440.00	$0.00	$119,440.00
21	24804405	$20,895.09	$0.00	$20,895.09
22	24804605	$32,926.44	$0.00	$32,926.44
23	24831905	$1,389,982.64	$6,512.29	$1,396,494.93
24	24832005	$2,331,078.91	$876.73	$2,331,955.64
25	24936405	$405,764.82	$0.00	$405,764.82
26	**CO**	**$17,073.49**	**$0.00**	**$17,073.49**
27	25011906	$17,073.49	$0.00	$17,073.49
28	**IN**	**$155,392.16**	**$0.00**	**$155,392.16**
29	24918414	$60,514.25	$0.00	$60,514.25
30	24931614	$94,877.91	$0.00	$94,877.91
31	**MD**	**$789,629.77**	**$0.00**	**$789,629.77**
32	24921520	$306,872.96	$0.00	$306,872.96
33	24921720	$318,053.20	$0.00	$318,053.20
34	24921920	$164,703.61	$0.00	$164,703.61
35	**MN**	**$5,959.48**	**$0.00**	**$5,959.48**
36	25106731	$5,959.48	$0.00	$5,959.48
37	**NC**	**$200,741.67**	**$2,608.46**	**$203,350.13**
38	24912133	$200,741.67	$2,608.46	$203,350.13
39	**OH**	**$253,218.02**	**$0.00**	**$253,218.02**
40	24986435	$253,218.02	$0.00	$253,218.02
41	**TN**	**$128,718.05**	**$0.00**	**$128,718.05**
42	24955442	$128,718.05	$0.00	$128,718.05
43	**Brightwood College Total**	**$7,129,894.34**	**$9,997.48**	**$7,139,891.82**
44	**BRIGHTWOOD COLLEGE-ARLINGTON**			
45	**TX**	**$142,195.54**	**$0.00**	**$142,195.54**
46	24037343	$142,195.54	$0.00	$142,195.54
47	**BRIGHTWOOD COLLEGE-ARLINGTON Total**	**$142,195.54**	**$0.00**	**$142,195.54**
48	**BRIGHTWOOD COLLEGE-BEAUMONT**			
49	**TX**	**$62,301.80**	**$0.00**	**$62,301.80**
50	24036043	$62,301.80	$0.00	$62,301.80
51	**BRIGHTWOOD COLLEGE-BEAUMONT Total**	**$62,301.80**	**$0.00**	**$62,301.80**
52	**BRIGHTWOOD COLLEGE-BROWNSVILLE**			
53	**TX**	**$199,733.70**	**$0.00**	**$199,733.70**
54	24036243	$199,733.70	$0.00	$199,733.70
55	**BRIGHTWOOD COLLEGE-BROWNSVILLE Total**	**$199,733.70**	**$0.00**	**$199,733.70**
56	**BRIGHTWOOD COLLEGE-CORPUS CHRISTI**			
57	**TX**	**$275,101.55**	**$0.00**	**$275,101.55**
58	24042043	$275,101.55	$0.00	$275,101.55
59	**BRIGHTWOOD COLLEGE-CORPUS CHRISTI Total**	**$275,101.55**	**$0.00**	**$275,101.55**
60	**BRIGHTWOOD COLLEGE-DALLAS**			
61	**TX**	**$217,699.66**	**$0.00**	**$217,699.66**
62	249J2143	$217,699.66	$0.00	$217,699.66
63	**BRIGHTWOOD COLLEGE-DALLAS Total**	**$217,699.66**	**$0.00**	**$217,699.66**
64	**BRIGHTWOOD COLLEGE-EL PASO**			
65	**TX**	**$325,899.72**	**$0.00**	**$325,899.72**
66	24036643	$325,899.72	$0.00	$325,899.72
67	**BRIGHTWOOD COLLEGE-EL PASO Total**	**$325,899.72**	**$0.00**	**$325,899.72**

	A	K	L	M
1				
2		AY17		
3	Row Labels	Sum of TF_PAID	Sum of YR_PAID	Sum of TOTAL_AMT
68	**BRIGHTWOOD COLLEGE-FORT WORTH**			
69	**TX**	**$89,300.49**	**$0.00**	**$89,300.49**
70	249L8143	$89,300.49	$0.00	$89,300.49
71	**BRIGHTWOOD COLLEGE-FORT WORTH Total**	**$89,300.49**	**$0.00**	**$89,300.49**
72	**BRIGHTWOOD COLLEGE-FRIENDSWOOD**			
73	**TX**	**$121,037.71**	**$0.00**	**$121,037.71**
74	24036343	$121,037.71	$0.00	$121,037.71
75	**BRIGHTWOOD COLLEGE-FRIENDSWOOD Total**	**$121,037.71**	**$0.00**	**$121,037.71**
76	**BRIGHTWOOD COLLEGE-HOUSTON**			
77	**TX**	**$128,209.37**	**$0.00**	**$128,209.37**
78	24042143	$128,209.37	$0.00	$128,209.37
79	**BRIGHTWOOD COLLEGE-HOUSTON Total**	**$128,209.37**	**$0.00**	**$128,209.37**
80	**BRIGHTWOOD COLLEGE-LAREDO**			
81	**TX**	**$117,525.16**	**$0.00**	**$117,525.16**
82	24037543	$117,525.16	$0.00	$117,525.16
83	**BRIGHTWOOD COLLEGE-LAREDO Total**	**$117,525.16**	**$0.00**	**$117,525.16**
84	**BRIGHTWOOD COLLEGE-MCALLEN**			
85	**TX**	**$73,378.53**	**$0.00**	**$73,378.53**
86	24035643	$73,378.53	$0.00	$73,378.53
87	**BRIGHTWOOD COLLEGE-MCALLEN Total**	**$73,378.53**	**$0.00**	**$73,378.53**
88	**BRIGHTWOOD COLLEGE-SAN ANTONIO INGRAM**			
89	**TX**	**$891,849.25**	**$112.07**	**$891,961.32**
90	24036443	$891,849.25	$112.07	$891,961.32
91	**BRIGHTWOOD COLLEGE-SAN ANTONIO INGRAM T**	**$891,849.25**	**$112.07**	**$891,961.32**
92	**BRIGHTWOOD COLLEGE-SAN ANTONIO SAN PED**			
93	**TX**	**$552,298.34**	**$1,513.96**	**$553,812.30**
94	24036143	$552,298.34	$1,513.96	$553,812.30
95	**BRIGHTWOOD COLLEGE-SAN ANTONIO SAN PEDR**	**$552,298.34**	**$1,513.96**	**$553,812.30**
96	**Ecotech Institute**			
97	**CO**	**$1,282,349.25**	**$0.00**	**$1,282,349.25**
98	21014806	$1,282,349.25	$0.00	$1,282,349.25
99	**Ecotech Institute Total**	**$1,282,349.25**	**$0.00**	**$1,282,349.25**
100	**Golf Academy of America**			
101	**AZ**	**$661,271.97**	**$12,591.39**	**$673,863.36**
102	24929403	$661,271.97	$12,591.39	$673,863.36
103	**CA**	**$1,208,656.30**	**$14,998.75**	**$1,223,655.05**
104	24909105	$1,208,656.30	$14,998.75	$1,223,655.05
105	**FL**	**$990,525.07**	**$26,080.07**	**$1,016,605.14**
106	24201010	$990,525.07	$26,080.07	$1,016,605.14
107	**SC**	**$529,961.81**	**$12,096.08**	**$542,057.89**
108	24113440	$529,961.81	$12,096.08	$542,057.89
109	**TX**	**$982,524.10**	**$14,598.30**	**$997,122.40**
110	24038643	$982,524.10	$14,598.30	$997,122.40
111	**Golf Academy of America Total**	**$4,372,939.25**	**$80,364.59**	**$4,453,303.84**
112	**Virginia College**			
113	**AL**	**$1,493,774.65**	**$2,642.77**	**$1,496,417.42**
114	21802301	$917,940.63	$2,442.00	$920,382.63
115	21952301	$163,055.06	$0.00	$163,055.06
116	21953101	$268,999.24	$200.77	$269,200.01
117	21958101	$143,779.72	$0.00	$143,779.72
118	**FL**	**$2,190,504.80**	**$225.02**	**$2,190,729.82**
119	219B6110	$1,563,557.79	$0.00	$1,563,557.79
120	24994410	$523,356.32	$225.02	$523,581.34
121	249F1410	$103,590.69	$0.00	$103,590.69
122	**GA**	**$3,090,469.48**	**$1,606.26**	**$3,092,075.74**
123	21917211	$730,637.54	$0.00	$730,637.54
124	21917311	$160,234.83	$0.00	$160,234.83
125	21917611	$1,264,188.68	$476.49	$1,264,665.17
126	21917811	$935,408.43	$1,129.77	$936,538.20
127	**LA**	**$491,329.98**	**$525.27**	**$491,855.25**
128	21001418	$245,879.31	$525.27	$246,404.58
129	21001618	$245,450.67	$0.00	$245,450.67
130	**MS**	**$468,416.57**	**$0.00**	**$468,416.57**
131	24801324	$105,223.97	$0.00	$105,223.97

	A	K	L	M
1				
2		AY17		
3	Row Labels	Sum of TF_PAID	Sum of YR_PAID	Sum of TOTAL_AMT
132	24801424	$363,192.60	$0.00	$363,192.60
133	**NC**	**$178,024.33**	**$0.00**	**$178,024.33**
134	21905133	$178,024.33	$0.00	$178,024.33
135	**OK**			
136	21004336			
137	**SC**	**$1,344,027.71**	**$0.00**	**$1,344,027.71**
138	21802340	$150,933.91	$0.00	$150,933.91
139	21802440	$363,249.53	$0.00	$363,249.53
140	21802640	$495,734.14	$0.00	$495,734.14
141	21802740	$143,609.64	$0.00	$143,609.64
142	21802840	$190,500.49	$0.00	$190,500.49
143	**TN**	**$323,598.00**	**$200.77**	**$323,798.77**
144	21904042	$323,598.00	$200.77	$323,798.77
145	**TX**	**$583,860.89**	**$3,432.09**	**$587,292.98**
146	24033943	$411,155.88	$3,432.09	$414,587.97
147	24039243	$172,705.01	$0.00	$172,705.01
148	**VA**	**$454,065.70**	**$0.00**	**$454,065.70**
149	21014146	$454,065.70	$0.00	$454,065.70
150	**Virginia College Total**	**$10,618,072.11**	**$8,632.18**	**$10,626,704.29**
151	**Grand Total**	**$27,328,407.40**	**$103,822.32**	**$27,432,229.72**

	A	N	O	P
1				
2		AY18		
3	Row Labels	Sum of TF_PAID	Sum of YR_PAID	Sum of TOTAL_AMT
4	**Brightwood Career Institute**			
5	**MN**	**$498.25**	**$0.00**	**$498.25**
6	28119823	$498.25	$0.00	$498.25
7	**PA**	**$209,579.37**	**$0.00**	**$209,579.37**
8	24939438	$42,793.27	$0.00	$42,793.27
9	24940638	$14,039.30	$0.00	$14,039.30
10	24942438	$106,242.23	$0.00	$106,242.23
11	24956438	$7,900.53	$0.00	$7,900.53
12	24961438	$38,604.04	$0.00	$38,604.04
13	**Brightwood Career Institute Total**	**$210,077.62**	**$0.00**	**$210,077.62**
14	**Brightwood College**			
15	**CA**	**$1,890,868.75**	**$45,574.90**	**$1,936,443.65**
16	24001805	$4,371.28	$0.00	$4,371.28
17	24003305	$96,697.52	$0.00	$96,697.52
18	24005705	$147,159.90	$0.00	$147,159.90
19	24008205	$185,184.09	$3,195.40	$188,379.49
20	24801005	$48,308.65	$3,033.54	$51,342.19
21	24804405	$23,964.93	$0.00	$23,964.93
22	24804605	$4,067.93	$0.00	$4,067.93
23	24831905	$388,713.93	$6,886.80	$395,600.73
24	24832005	$885,255.92	$28,743.75	$913,999.67
25	24936405	$107,144.60	$3,715.41	$110,860.01
26	**CO**	**$5,534.00**	**$0.00**	**$5,534.00**
27	25011906	$5,534.00	$0.00	$5,534.00
28	**IN**	**$36,321.13**	**$0.00**	**$36,321.13**
29	24918414	$1,668.60	$0.00	$1,668.60
30	24931614	$34,652.53	$0.00	$34,652.53
31	**MD**	**$214,613.11**	**$0.00**	**$214,613.11**
32	24921520	$56,715.90	$0.00	$56,715.90
33	24921720	$104,443.38	$0.00	$104,443.38
34	24921920	$53,453.83	$0.00	$53,453.83
35	**MN**	**$2,505.24**	**$0.00**	**$2,505.24**
36	25106731	$2,505.24	$0.00	$2,505.24
37	**NC**	**$62,769.03**	**$0.00**	**$62,769.03**
38	24912133	$62,769.03	$0.00	$62,769.03
39	**OH**	**$27,109.92**	**$0.00**	**$27,109.92**
40	24986435	$27,109.92	$0.00	$27,109.92
41	**TN**	**$64,418.86**	**$0.00**	**$64,418.86**
42	24955442	$64,418.86	$0.00	$64,418.86
43	**Brightwood College Total**	**$2,304,140.04**	**$45,574.90**	**$2,349,714.94**
44	**BRIGHTWOOD COLLEGE-ARLINGTON**			
45	**TX**	**$50,139.88**	**$0.00**	**$50,139.88**
46	24037343	$50,139.88	$0.00	$50,139.88
47	**BRIGHTWOOD COLLEGE-ARLINGTON Total**	**$50,139.88**	**$0.00**	**$50,139.88**
48	**BRIGHTWOOD COLLEGE-BEAUMONT**			
49	**TX**	**$4,004.06**	**$0.00**	**$4,004.06**
50	24036043	$4,004.06	$0.00	$4,004.06
51	**BRIGHTWOOD COLLEGE-BEAUMONT Total**	**$4,004.06**	**$0.00**	**$4,004.06**
52	**BRIGHTWOOD COLLEGE-BROWNSVILLE**			
53	**TX**	**$38,603.97**	**$0.00**	**$38,603.97**
54	24036243	$38,603.97	$0.00	$38,603.97
55	**BRIGHTWOOD COLLEGE-BROWNSVILLE Total**	**$38,603.97**	**$0.00**	**$38,603.97**
56	**BRIGHTWOOD COLLEGE-CORPUS CHRISTI**			
57	**TX**	**$78,821.58**	**$2,935.35**	**$81,756.93**
58	24042043	$78,821.58	$2,935.35	$81,756.93
59	**BRIGHTWOOD COLLEGE-CORPUS CHRISTI Total**	**$78,821.58**	**$2,935.35**	**$81,756.93**
60	**BRIGHTWOOD COLLEGE-DALLAS**			
61	**TX**	**$73,677.98**	**$0.00**	**$73,677.98**
62	249J2143	$73,677.98	$0.00	$73,677.98
63	**BRIGHTWOOD COLLEGE-DALLAS Total**	**$73,677.98**	**$0.00**	**$73,677.98**
64	**BRIGHTWOOD COLLEGE-EL PASO**			
65	**TX**	**$129,699.83**	**$0.00**	**$129,699.83**
66	24036643	$129,699.83	$0.00	$129,699.83
67	**BRIGHTWOOD COLLEGE-EL PASO Total**	**$129,699.83**	**$0.00**	**$129,699.83**

	A	N	O	P
1				
2		AY18		
3	Row Labels	Sum of TF_PAID	Sum of YR_PAID	Sum of TOTAL_AMT
68	**BRIGHTWOOD COLLEGE-FORT WORTH**			
69	**TX**	**$33,510.72**	**$0.00**	**$33,510.72**
70	249L8143	$33,510.72	$0.00	$33,510.72
71	**BRIGHTWOOD COLLEGE-FORT WORTH Total**	**$33,510.72**	**$0.00**	**$33,510.72**
72	**BRIGHTWOOD COLLEGE-FRIENDSWOOD**			
73	**TX**	**$34,049.70**	**$0.00**	**$34,049.70**
74	24036343	$34,049.70	$0.00	$34,049.70
75	**BRIGHTWOOD COLLEGE-FRIENDSWOOD Total**	**$34,049.70**	**$0.00**	**$34,049.70**
76	**BRIGHTWOOD COLLEGE-HOUSTON**			
77	**TX**	**$42,200.41**	**$0.00**	**$42,200.41**
78	24042143	$42,200.41	$0.00	$42,200.41
79	**BRIGHTWOOD COLLEGE-HOUSTON Total**	**$42,200.41**	**$0.00**	**$42,200.41**
80	**BRIGHTWOOD COLLEGE-LAREDO**			
81	**TX**	**$12,157.28**	**$0.00**	**$12,157.28**
82	24037543	$12,157.28	$0.00	$12,157.28
83	**BRIGHTWOOD COLLEGE-LAREDO Total**	**$12,157.28**	**$0.00**	**$12,157.28**
84	**BRIGHTWOOD COLLEGE-MCALLEN**			
85	**TX**	**$33,753.38**	**$0.00**	**$33,753.38**
86	24035643	$33,753.38	$0.00	$33,753.38
87	**BRIGHTWOOD COLLEGE-MCALLEN Total**	**$33,753.38**	**$0.00**	**$33,753.38**
88	**BRIGHTWOOD COLLEGE-SAN ANTONIO INGRAM**			
89	**TX**	**$369,143.80**	**$2,530.89**	**$371,674.69**
90	24036443	$369,143.80	$2,530.89	$371,674.69
91	**BRIGHTWOOD COLLEGE-SAN ANTONIO INGRAM T**	**$369,143.80**	**$2,530.89**	**$371,674.69**
92	**BRIGHTWOOD COLLEGE-SAN ANTONIO SAN PED**			
93	**TX**	**$174,108.00**	**$0.00**	**$174,108.00**
94	24036143	$174,108.00	$0.00	$174,108.00
95	**BRIGHTWOOD COLLEGE-SAN ANTONIO SAN PEDR**	**$174,108.00**	**$0.00**	**$174,108.00**
96	**Ecotech Institute**			
97	**CO**	**$381,287.69**	**$0.00**	**$381,287.69**
98	21014806	$381,287.69	$0.00	$381,287.69
99	**Ecotech Institute Total**	**$381,287.69**	**$0.00**	**$381,287.69**
100	**Golf Academy of America**			
101	**AZ**	**$258,801.65**	**$6,920.10**	**$265,721.75**
102	24929403	$258,801.65	$6,920.10	$265,721.75
103	**CA**	**$392,391.51**	**$3,788.87**	**$396,180.38**
104	24909105	$392,391.51	$3,788.87	$396,180.38
105	**FL**	**$368,898.96**	**$0.00**	**$368,898.96**
106	24201010	$368,898.96	$0.00	$368,898.96
107	**SC**	**$148,085.01**	**$0.00**	**$148,085.01**
108	24113440	$148,085.01	$0.00	$148,085.01
109	**TX**	**$370,372.81**	**$4,296.64**	**$374,669.45**
110	24038643	$370,372.81	$4,296.64	$374,669.45
111	**Golf Academy of America Total**	**$1,538,549.94**	**$15,005.61**	**$1,553,555.55**
112	**Virginia College**			
113	**AL**	**$218,584.50**	**$812.94**	**$219,397.44**
114	21802301	$92,210.52	$812.94	$93,023.46
115	21952301	$24,977.32	$0.00	$24,977.32
116	21953101	$59,006.33	$0.00	$59,006.33
117	21958101	$42,390.33	$0.00	$42,390.33
118	**FL**	**$742,959.61**	**$1,652.36**	**$744,611.97**
119	219B6110	$568,600.56	$1,652.36	$570,252.92
120	24994410	$159,759.20	$0.00	$159,759.20
121	249F1410	$14,599.85	$0.00	$14,599.85
122	**GA**	**$983,913.63**	**$0.00**	**$983,913.63**
123	21917211	$283,850.05	$0.00	$283,850.05
124	21917311	$31,638.94	$0.00	$31,638.94
125	21917611	$485,510.01	$0.00	$485,510.01
126	21917811	$182,914.63	$0.00	$182,914.63
127	**LA**	**$130,469.52**	**$0.00**	**$130,469.52**
128	21001418	$48,817.99	$0.00	$48,817.99
129	21001618	$81,651.53	$0.00	$81,651.53
130	**MS**	**$151,452.18**	**$0.00**	**$151,452.18**
131	24801324	$27,726.84	$0.00	$27,726.84

	A	N	O	P
1				
2		AY18		
3	Row Labels	Sum of TF_PAID	Sum of YR_PAID	Sum of TOTAL_AMT
132	24801424	$123,725.34	$0.00	$123,725.34
133	**NC**	**$78,936.41**	**$0.00**	**$78,936.41**
134	21905133	$78,936.41	$0.00	$78,936.41
135	**OK**			
136	21004336			
137	**SC**	**$410,821.82**	**$0.00**	**$410,821.82**
138	21802340	$23,871.34	$0.00	$23,871.34
139	21802440	$133,166.38	$0.00	$133,166.38
140	21802640	$164,582.14	$0.00	$164,582.14
141	21802740	$40,307.98	$0.00	$40,307.98
142	21802840	$48,893.98	$0.00	$48,893.98
143	**TN**	**$78,986.68**	**$0.00**	**$78,986.68**
144	21904042	$78,986.68	$0.00	$78,986.68
145	**TX**	**$199,889.87**	**$0.00**	**$199,889.87**
146	24033943	$151,150.76	$0.00	$151,150.76
147	24039243	$48,739.11	$0.00	$48,739.11
148	**VA**	**$141,040.62**	**$0.00**	**$141,040.62**
149	21014146	$141,040.62	$0.00	$141,040.62
150	**Virginia College Total**	**$3,137,054.84**	**$2,465.30**	**$3,139,520.14**
151	**Grand Total**	**$8,644,980.72**	**$68,512.05**	**$8,713,492.77**

	A	Q	R
1			
2		Total Sum of TF_PAID	Total Sum of YR_PAID
3	Row Labels		
4	**Brightwood Career Institute**		
5	**MN**	**$30,654.68**	**$0.00**
6	28119823	$30,654.68	$0.00
7	**PA**	**$3,186,929.51**	**$6,717.13**
8	24939438	$997,816.73	$1,224.99
9	24940638	$492,273.77	$0.00
10	24942438	$840,973.50	$3,515.09
11	24956438	$329,547.53	$1,977.05
12	24961438	$526,317.98	$0.00
13	**Brightwood Career Institute Total**	**$3,217,584.19**	**$6,717.13**
14	**Brightwood College**		
15	**CA**	**$23,167,465.75**	**$131,462.54**
16	24001805	$451,801.18	$0.00
17	24003305	$999,733.65	$0.00
18	24005705	$1,394,398.10	$1,102.98
19	24008205	$1,790,407.92	$5,180.85
20	24801005	$485,122.57	$3,033.54
21	24804405	$159,076.14	$0.00
22	24804605	$170,708.15	$0.00
23	24831905	$5,588,386.98	$24,470.52
24	24832005	$10,761,545.90	$86,497.90
25	24936405	$1,366,285.16	$11,176.75
26	**CO**	**$84,319.40**	**$0.00**
27	25011906	$84,319.40	$0.00
28	**IN**	**$717,881.18**	**$0.00**
29	24918414	$243,656.01	$0.00
30	24931614	$474,225.17	$0.00
31	**MD**	**$3,910,459.58**	**$0.00**
32	24921520	$1,265,908.61	$0.00
33	24921720	$1,706,663.83	$0.00
34	24921920	$937,887.14	$0.00
35	**MN**	**$20,326.41**	**$0.00**
36	25106731	$20,326.41	$0.00
37	**NC**	**$690,878.78**	**$2,608.46**
38	24912133	$690,878.78	$2,608.46
39	**OH**	**$931,717.81**	**$3,470.27**
40	24986435	$931,717.81	$3,470.27
41	**TN**	**$872,653.54**	**$5,294.68**
42	24955442	$872,653.54	$5,294.68
43	**Brightwood College Total**	**$30,395,702.45**	**$142,835.95**
44	**BRIGHTWOOD COLLEGE-ARLINGTON**		
45	**TX**	**$964,966.40**	**$2,794.86**
46	24037343	$964,966.40	$2,794.86
47	**BRIGHTWOOD COLLEGE-ARLINGTON Total**	**$964,966.40**	**$2,794.86**
48	**BRIGHTWOOD COLLEGE-BEAUMONT**		
49	**TX**	**$378,745.51**	**$0.00**
50	24036043	$378,745.51	$0.00
51	**BRIGHTWOOD COLLEGE-BEAUMONT Total**	**$378,745.51**	**$0.00**
52	**BRIGHTWOOD COLLEGE-BROWNSVILLE**		
53	**TX**	**$954,415.29**	**$0.00**
54	24036243	$954,415.29	$0.00
55	**BRIGHTWOOD COLLEGE-BROWNSVILLE Total**	**$954,415.29**	**$0.00**
56	**BRIGHTWOOD COLLEGE-CORPUS CHRISTI**		
57	**TX**	**$598,421.52**	**$2,935.35**
58	24042043	$598,421.52	$2,935.35
59	**BRIGHTWOOD COLLEGE-CORPUS CHRISTI Total**	**$598,421.52**	**$2,935.35**
60	**BRIGHTWOOD COLLEGE-DALLAS**		
61	**TX**	**$869,143.74**	**$0.00**
62	249J2143	$869,143.74	$0.00
63	**BRIGHTWOOD COLLEGE-DALLAS Total**	**$869,143.74**	**$0.00**
64	**BRIGHTWOOD COLLEGE-EL PASO**		
65	**TX**	**$2,105,033.54**	**$169.16**
66	24036643	$2,105,033.54	$169.16
67	**BRIGHTWOOD COLLEGE-EL PASO Total**	**$2,105,033.54**	**$169.16**

	A	Q	R
1			
2		Total Sum of TF_PAID	Total Sum of YR_PAID
3	Row Labels		
68	**BRIGHTWOOD COLLEGE-FORT WORTH**		
69	**TX**	**$587,783.47**	**$0.00**
70	249L8143	$587,783.47	$0.00
71	**BRIGHTWOOD COLLEGE-FORT WORTH Total**	**$587,783.47**	**$0.00**
72	**BRIGHTWOOD COLLEGE-FRIENDSWOOD**		
73	**TX**	**$493,846.32**	**$0.00**
74	24036343	$493,846.32	$0.00
75	**BRIGHTWOOD COLLEGE-FRIENDSWOOD Total**	**$493,846.32**	**$0.00**
76	**BRIGHTWOOD COLLEGE-HOUSTON**		
77	**TX**	**$309,952.96**	**$0.00**
78	24042143	$309,952.96	$0.00
79	**BRIGHTWOOD COLLEGE-HOUSTON Total**	**$309,952.96**	**$0.00**
80	**BRIGHTWOOD COLLEGE-LAREDO**		
81	**TX**	**$325,915.91**	**$0.00**
82	24037543	$325,915.91	$0.00
83	**BRIGHTWOOD COLLEGE-LAREDO Total**	**$325,915.91**	**$0.00**
84	**BRIGHTWOOD COLLEGE-MCALLEN**		
85	**TX**	**$369,355.65**	**$0.00**
86	24035643	$369,355.65	$0.00
87	**BRIGHTWOOD COLLEGE-MCALLEN Total**	**$369,355.65**	**$0.00**
88	**BRIGHTWOOD COLLEGE-SAN ANTONIO INGRAM**		
89	**TX**	**$3,088,350.03**	**$2,642.96**
90	24036443	$3,088,350.03	$2,642.96
91	**BRIGHTWOOD COLLEGE-SAN ANTONIO INGRAM T**	**$3,088,350.03**	**$2,642.96**
92	**BRIGHTWOOD COLLEGE-SAN ANTONIO SAN PED**		
93	**TX**	**$2,765,528.35**	**$1,513.96**
94	24036143	$2,765,528.35	$1,513.96
95	**BRIGHTWOOD COLLEGE-SAN ANTONIO SAN PEDR**	**$2,765,528.35**	**$1,513.96**
96	**Ecotech Institute**		
97	**CO**	**$6,108,541.34**	**$6,458.89**
98	21014806	$6,108,541.34	$6,458.89
99	**Ecotech Institute Total**	**$6,108,541.34**	**$6,458.89**
100	**Golf Academy of America**		
101	**AZ**	**$3,366,693.80**	**$139,627.55**
102	24929403	$3,366,693.80	$139,627.55
103	**CA**	**$5,766,014.97**	**$175,804.01**
104	24909105	$5,766,014.97	$175,804.01
105	**FL**	**$4,845,963.76**	**$177,300.19**
106	24201010	$4,845,963.76	$177,300.19
107	**SC**	**$3,781,934.25**	**$134,526.97**
108	24113440	$3,781,934.25	$134,526.97
109	**TX**	**$4,206,120.58**	**$101,794.93**
110	24038643	$4,206,120.58	$101,794.93
111	**Golf Academy of America Total**	**$21,966,727.36**	**$729,053.65**
112	**Virginia College**		
113	**AL**	**$21,533,323.03**	**$71,213.09**
114	21802301	$13,836,445.99	$63,029.02
115	21952301	$2,915,013.44	$0.00
116	21953101	$1,915,509.30	$2,271.24
117	21958101	$2,866,354.30	$5,912.83
118	**FL**	**$11,410,674.13**	**$31,195.89**
119	219B6110	$7,945,716.14	$26,544.20
120	24994410	$2,978,214.11	$4,651.69
121	249F1410	$486,743.88	$0.00
122	**GA**	**$19,708,592.97**	**$23,264.08**
123	21917211	$4,896,681.42	$8,449.73
124	21917311	$1,015,641.68	$2,804.32
125	21917611	$6,556,783.11	$5,548.91
126	21917811	$7,239,486.76	$6,461.12
127	**LA**	**$2,642,196.35**	**$1,866.09**
128	21001418	$1,104,703.95	$1,426.12
129	21001618	$1,537,492.40	$439.97
130	**MS**	**$4,189,755.27**	**$1,987.99**
131	24801324	$1,026,863.75	$1,987.99

	A	Q	R
1			
2		**Total Sum of TF_PAID**	**Total Sum of YR_PAID**
3	**Row Labels**		
132	24801424	$3,162,891.52	$0.00
133	**NC**	**$676,995.72**	**$0.00**
134	21905133	$676,995.72	$0.00
135	**OK**	**$20,100.00**	**$0.00**
136	21004336	$20,100.00	$0.00
137	**SC**	**$8,679,668.20**	**$6,208.06**
138	21802340	$728,429.11	$392.49
139	21802440	$2,450,591.10	$1,420.49
140	21802640	$3,540,389.84	$3,771.63
141	21802740	$941,066.58	$0.00
142	21802840	$1,019,191.57	$623.45
143	**TN**	**$1,260,550.83**	**$1,933.26**
144	21904042	$1,260,550.83	$1,933.26
145	**TX**	**$3,609,870.13**	**$8,500.73**
146	24033943	$2,835,265.58	$8,500.73
147	24039243	$774,604.55	$0.00
148	**VA**	**$2,179,218.27**	**$3,154.47**
149	21014146	$2,179,218.27	$3,154.47
150	**Virginia College Total**	**$75,910,944.90**	**$149,323.66**
151	**Grand Total**	**$151,410,958.93**	**$1,044,445.57**

	A	S
1		
2		Total Sum of TOTAL_AMT
3	Row Labels	
4	**Brightwood Career Institute**	
5	**MN**	**$30,654.68**
6	28119823	$30,654.68
7	**PA**	**$3,193,646.64**
8	24939438	$999,041.72
9	24940638	$492,273.77
10	24942438	$844,488.59
11	24956438	$331,524.58
12	24961438	$526,317.98
13	**Brightwood Career Institute Total**	**$3,224,301.32**
14	**Brightwood College**	
15	**CA**	**$23,298,928.29**
16	24001805	$451,801.18
17	24003305	$999,733.65
18	24005705	$1,395,501.08
19	24008205	$1,795,588.77
20	24801005	$488,156.11
21	24804405	$159,076.14
22	24804605	$170,708.15
23	24831905	$5,612,857.50
24	24832005	$10,848,043.80
25	24936405	$1,377,461.91
26	**CO**	**$84,319.40**
27	25011906	$84,319.40
28	**IN**	**$717,881.18**
29	24918414	$243,656.01
30	24931614	$474,225.17
31	**MD**	**$3,910,459.58**
32	24921520	$1,265,908.61
33	24921720	$1,706,663.83
34	24921920	$937,887.14
35	**MN**	**$20,326.41**
36	25106731	$20,326.41
37	**NC**	**$693,487.24**
38	24912133	$693,487.24
39	**OH**	**$935,188.08**
40	24986435	$935,188.08
41	**TN**	**$877,948.22**
42	24955442	$877,948.22
43	**Brightwood College Total**	**$30,538,538.40**
44	**BRIGHTWOOD COLLEGE-ARLINGTON**	
45	**TX**	**$967,761.26**
46	24037343	$967,761.26
47	**BRIGHTWOOD COLLEGE-ARLINGTON Total**	**$967,761.26**
48	**BRIGHTWOOD COLLEGE-BEAUMONT**	
49	**TX**	**$378,745.51**
50	24036043	$378,745.51
51	**BRIGHTWOOD COLLEGE-BEAUMONT Total**	**$378,745.51**
52	**BRIGHTWOOD COLLEGE-BROWNSVILLE**	
53	**TX**	**$954,415.29**
54	24036243	$954,415.29
55	**BRIGHTWOOD COLLEGE-BROWNSVILLE Total**	**$954,415.29**
56	**BRIGHTWOOD COLLEGE-CORPUS CHRISTI**	
57	**TX**	**$601,356.87**
58	24042043	$601,356.87
59	**BRIGHTWOOD COLLEGE-CORPUS CHRISTI Total**	**$601,356.87**
60	**BRIGHTWOOD COLLEGE-DALLAS**	
61	**TX**	**$869,143.74**
62	249J2143	$869,143.74
63	**BRIGHTWOOD COLLEGE-DALLAS Total**	**$869,143.74**
64	**BRIGHTWOOD COLLEGE-EL PASO**	
65	**TX**	**$2,105,202.70**
66	24036643	$2,105,202.70
67	**BRIGHTWOOD COLLEGE-EL PASO Total**	**$2,105,202.70**

	A	S
1		
2		Total Sum of TOTAL_AMT
3	Row Labels	
68	BRIGHTWOOD COLLEGE-FORT WORTH	
69	TX	$587,783.47
70	249L8143	$587,783.47
71	BRIGHTWOOD COLLEGE-FORT WORTH Total	$587,783.47
72	BRIGHTWOOD COLLEGE-FRIENDSWOOD	
73	TX	$493,846.32
74	24036343	$493,846.32
75	BRIGHTWOOD COLLEGE-FRIENDSWOOD Total	$493,846.32
76	BRIGHTWOOD COLLEGE-HOUSTON	
77	TX	$309,952.96
78	24042143	$309,952.96
79	BRIGHTWOOD COLLEGE-HOUSTON Total	$309,952.96
80	BRIGHTWOOD COLLEGE-LAREDO	
81	TX	$325,915.91
82	24037543	$325,915.91
83	BRIGHTWOOD COLLEGE-LAREDO Total	$325,915.91
84	BRIGHTWOOD COLLEGE-MCALLEN	
85	TX	$369,355.65
86	24035643	$369,355.65
87	BRIGHTWOOD COLLEGE-MCALLEN Total	$369,355.65
88	BRIGHTWOOD COLLEGE-SAN ANTONIO INGRAM	
89	TX	$3,090,992.99
90	24036443	$3,090,992.99
91	BRIGHTWOOD COLLEGE-SAN ANTONIO INGRAM T	$3,090,992.99
92	BRIGHTWOOD COLLEGE-SAN ANTONIO SAN PED	
93	TX	$2,767,042.31
94	24036143	$2,767,042.31
95	BRIGHTWOOD COLLEGE-SAN ANTONIO SAN PEDR	$2,767,042.31
96	Ecotech Institute	
97	CO	$6,115,000.23
98	21014806	$6,115,000.23
99	Ecotech Institute Total	$6,115,000.23
100	Golf Academy of America	
101	AZ	$3,506,321.35
102	24929403	$3,506,321.35
103	CA	$5,941,818.98
104	24909105	$5,941,818.98
105	FL	$5,023,263.95
106	24201010	$5,023,263.95
107	SC	$3,916,461.22
108	24113440	$3,916,461.22
109	TX	$4,307,915.51
110	24038643	$4,307,915.51
111	Golf Academy of America Total	$22,695,781.01
112	Virginia College	
113	AL	$21,604,536.12
114	21802301	$13,899,475.01
115	21952301	$2,915,013.44
116	21953101	$1,917,780.54
117	21958101	$2,872,267.13
118	FL	$11,441,870.02
119	219B6110	$7,972,260.34
120	24994410	$2,982,865.80
121	249F1410	$486,743.88
122	GA	$19,731,857.05
123	21917211	$4,905,131.15
124	21917311	$1,018,446.00
125	21917611	$6,562,332.02
126	21917811	$7,245,947.88
127	LA	$2,644,062.44
128	21001418	$1,106,130.07
129	21001618	$1,537,932.37
130	MS	$4,191,743.26
131	24801324	$1,028,851.74

	A	S
1		
2		**Total Sum of TOTAL_AMT**
3	**Row Labels**	
132	24801424	$3,162,891.52
133	**NC**	**$676,995.72**
134	21905133	$676,995.72
135	**OK**	**$20,100.00**
136	21004336	$20,100.00
137	**SC**	**$8,685,876.26**
138	21802340	$728,821.60
139	21802440	$2,452,011.59
140	21802640	$3,544,161.47
141	21802740	$941,066.58
142	21802840	$1,019,815.02
143	**TN**	**$1,262,484.09**
144	21904042	$1,262,484.09
145	**TX**	**$3,618,370.86**
146	24033943	$2,843,766.31
147	24039243	$774,604.55
148	**VA**	**$2,182,372.74**
149	21014146	$2,182,372.74
150	**Virginia College Total**	**$76,060,268.56**
151	**Grand Total**	**$152,455,404.50**

Brightwood Institutes by State

Brightwood Career Institute	28119823	MN
Virginia College	21004336	OK
Brightwood College	24918414	IN
Brightwood College	24931614	IN
Brightwood College	24986435	OH
Brightwood College	24955442	TN
Virginia College	21904042	TN
Golf Academy of America	24201010	FL
Virginia College	249F1410	FL
Virginia College	219B6110	FL
Virginia College	24994410	FL
Golf Academy of America	24113440	SC
Virginia College	21802440	SC
Virginia College	21802640	SC
Virginia College	21802340	SC
Virginia College	21802740	SC
Virginia College	21802840	SC
Golf Academy of America	24929403	AZ
Virginia College	21917211	GA
Virginia College	21917811	GA
Virginia College	21917311	GA
Virginia College	21917611	GA
Virginia College	21001418	LA
Virginia College	21001618	LA
Virginia College	24801424	MS
Virginia College	24801324	MS
Virginia College	21802301	AL
Virginia College	21952301	AL
Virginia College	21953101	AL
Virginia College	21958101	AL
Virginia College	21014146	VA
Brightwood Career Institute	24956438	PA
Brightwood Career Institute	24939438	PA
Brightwood Career Institute	24942438	PA
Brightwood Career Institute	24940638	PA
Brightwood Career Institute	24961438	PA
Brightwood College	24912133	NC
Virginia College	21905133	NC
Brightwood College	24801005	CA
Brightwood College	24005705	CA
Brightwood College	24804405	CA

Brightwood Institutes by State—Continued

Brightwood College	24008205	CA
Brightwood College	24001805	CA
Brightwood College	24003305	CA
Brightwood College	24936405	CA
Brightwood College	24832005	CA
Brightwood College	24804605	CA
Brightwood College	24831905	CA
Golf Academy of America	24909105	CA
Brightwood College	25011906	CO
Ecotech Institute	21014806	CO
Brightwood College	25106731	NM
BRIGHTWOOD COLLEGE-ARLINGTON	24037343	TX
BRIGHTWOOD COLLEGE-BEAUMONT	24036043	TX
BRIGHTWOOD COLLEGE-BROWNSVILLE	24036243	TX
BRIGHTWOOD COLLEGE-CORPUS CHRISTI	24042043	TX
BRIGHTWOOD COLLEGE-DALLAS	249J2143	TX
BRIGHTWOOD COLLEGE-EL PASO	24036643	TX
BRIGHTWOOD COLLEGE-FORT WORTH	249L8143	TX
BRIGHTWOOD COLLEGE-FRIENDSWOOD	24036343	TX
BRIGHTWOOD COLLEGE-HOUSTON	24042143	TX
BRIGHTWOOD COLLEGE-LAREDO	24037543	TX
BRIGHTWOOD COLLEGE-MCALLEN	24035643	TX
BRIGHTWOOD COLLEGE-SAN ANTONIO INGRAM	24036443	TX
BRIGHTWOOD COLLEGE-SAN ANTONIO SAN PEDRO	24036143	TX
Golf Academy of America	24038643	TX
Virginia College	24033943	TX
Virginia College	24039243	TX
Brightwood College	24921720	MD
Brightwood College	24921520	MD
Brightwood College	24921920	MD

Question 5d. Please describe the specific steps the VA has taken to identify and assist Post-9/11 GI Bill recipients affected by ECA closures.

Response. VA uses the data contained in its VA Online Certification of Enrollment (VA-ONCE) system to identify impacted Veterans; this is the system the schools used to certify Veteran attendance. The assistance provided to students by VA is in the form of the links and information contained in the 5-day outreach letter to students. A copy of this letter is attached to this reply. Education Call Center agents were available to answer questions and provide assistance to students with school closure questions. Last, VA coordinated with Veterans Service Organizations (VSOs) to notify any affected students or provide support services.

Question 5e. Under the Forever GI Bill, will ECA veterans be eligible for an additional housing allowance, and, if so, what is the duration of that relief?

Response. Students attending ECA locations that terminated their operations during the term will be eligible to receive their housing allowance until what would have been the conclusion of the term in which they were enrolled, or for 120 days, whichever comes first.

Question 5f. Please describe how the VA is coordinating with SAAs, the U.S. Department of Education, or ECA to provide information to GI Bill recipients on their transfer options.

Response. VA works closely with State Approving Agencies (SAA) to ensure that VA was aware of the ECA closure and allow for prompt notification to students regarding entitlement restoration; in ECA's case, VA also received a letter from the institution, which was helpful as ECA had numerous campuses in many states. VA does not work directly with Department of Education (ED) but is aware that ED posted information for students to notify them of options and VA monitors EDs activities. Please see https://studentaid.ed.gov/sa/sites/default/files/education-corporation-america.pdf.

Individual SAAs may post information directly on their Web site to assist students but often rely on their Higher Education Departments to post information for students. For an example, please see https://osar.bppe.ca.gov/closures/brightwood.shtml.

Question 5g. Please describe how the VA is ensuring that transfer options do not put student veterans at risk of further harm—such as providing guidance regarding institutions that have active caution flags on the GI Bill Comparison Tool.

Response. The 5-day letter VA sends to students upon notice that an institution has closed directs students to VA's Comparison Tool where caution flags can be found when researching prospective new institutions.

Question 5h. How much funding from the VA did each of ECA's schools receive in academic years 2014–2015, 2015–2016, 2016–2017, and 2017–2018?

Response.

Academic Year	Tuition and Fees	Yellow Ribbon	Total
AY14 (08-01-14 to 07-31-15)	$39,181,233.90	$342,774.14	$39,524,008.04
AY15 (08-01-15 to 07-31-16)	$38,592,642.24	$261,635.82	$38,854,278.06
AY16 (08-01-16 to 07-31-17)	$37,663,694.67	$267,701.24	$37,931,395.91
AY17 (08-01-17 to 07-31-18)	$27,328,407.40	$103,822.32	$27,432,229.72
AYTD18 (08-01-18 to 01-31-19)	$8,644,980.72	$68,512.05	$8,713,492.77
Total	$151,410,958.93	$1,044,445.57	$152,455,404.50

Please refer to the chart above for a summary total of payments paid to ECA schools for each academic year from 2014–2018. The latest available data to date for academic year 2018 is only available through 01–31–19. The accompanying pdf document below further expands payments by individual training institution, facility code, and academic year. Only school payment data (tuition and fees and Yellow Ribbon) is presented in the dataset.

Payments by Individual Training Institutions

Institution Name	State	Tuition & Fees Paid	Yellow Ribbon Paid	Total Amount Paid
Virginia College	LA	$ 205,117.26	$ 900.85	$ 206,018.11
Virginia College	LA	$ 436,804.01	$ 439.97	$ 437,243.98
Virginia College	OK	$ 16,080.00	$ -	$ 16,080.00
Virginia College	VA	$ 553,377.23	$ 3,154.47	$ 556,531.70
Ecotech Institute	CO	$1,641,824.69	$ 1,202.52	$ 1,643,027.21
Virginia College	AL	$4,601,957.92	$ 45,352.69	$ 4,647,310.61
Virginia College	SC	$ 165,591.23	$ 392.49	$ 165,983.72
Virginia College	SC	$ 761,599.39	$ -	$ 761,599.39
Virginia College	SC	$ 948,500.31	$ 175.84	$ 948,676.15
Virginia College	SC	$ 287,646.83	$ -	$ 287,646.83
Virginia College	SC	$ 239,322.97	$ 623.45	$ 239,946.42
Virginia College	TN	$ 346,047.84	$ 1,732.49	$ 347,780.33
Virginia College	NC	$ 123,755.29	$ -	$ 123,755.29
Virginia College	GA	$1,440,912.26	$ 6,452.59	$ 1,447,364.85
Virginia College	GA	$ 341,752.35	$ 2,133.83	$ 343,886.18
Virginia College	GA	$1,573,589.86	$ 3,046.72	$ 1,576,636.58
Virginia College	GA	$2,319,763.88	$ 3,040.87	$ 2,322,804.75
Virginia College	AL	$1,014,559.55	$ -	$ 1,014,559.55
Virginia College	AL	$ 453,810.15	$ 1,593.98	$ 455,404.13
Virginia College	AL	$ 956,763.11	$ 4,379.51	$ 961,142.62
Virginia College	FL	$1,740,635.54	$ 13,734.72	$ 1,754,370.26
Brightwood College	CA	$ 96,486.33	$ -	$ 96,486.33
Brightwood College	CA	$ 112,435.90	$ -	$ 112,435.90
Brightwood College	CA	$ 244,348.18	$ 1,102.98	$ 245,451.16
Brightwood College	CA	$ 303,260.96	$ -	$ 303,260.96
Virginia College	TX	$ 751,736.40	$ 3,105.03	$ 754,841.43

Payments by Individual Training Institutions

BRIGHTWOOD COLLEGE-MCALLEN	TX	$ 94,135.24	$ -	$ 94,135.24
BRIGHTWOOD COLLEGE-BEAUMONT	TX	$ 38,860.16	$ -	$ 38,860.16
BRIGHTWOOD COLLEGE-SAN ANTONIO SAN PEDRO	TX	$ 659,610.99	$ -	$ 659,610.99
BRIGHTWOOD COLLEGE-BROWNSVILLE	TX	$ 245,133.55	$ -	$ 245,133.55
BRIGHTWOOD COLLEGE-FRIENDSWOOD	TX	$ 66,820.41	$ -	$ 66,820.41
BRIGHTWOOD COLLEGE-SAN ANTONIO INGRAM	TX	$ 639,916.83	$ -	$ 639,916.83
BRIGHTWOOD COLLEGE-EL PASO	TX	$ 462,269.22	$ -	$ 462,269.22
BRIGHTWOOD COLLEGE-ARLINGTON	TX	$ 247,177.58	$ -	$ 247,177.58
BRIGHTWOOD COLLEGE-LAREDO	TX	$ 36,159.38	$ -	$ 36,159.38
Golf Academy of America	TX	$ 709,756.25	$ 25,658.55	$ 735,414.80
Virginia College	TX	$ 92,379.00	$ -	$ 92,379.00
Golf Academy of America	SC	$1,097,141.39	$ 40,174.69	$ 1,137,316.08
Golf Academy of America	FL	$1,149,219.00	$ 50,873.43	$ 1,200,092.43
Brightwood College	CA	$ 114,520.29	$ -	$ 114,520.29
Virginia College	MS	$ 357,622.41	$ -	$ 357,622.41
Virginia College	MS	$1,110,846.04	$ -	$ 1,110,846.04
Brightwood College	CA	$ 53,174.94	$ -	$ 53,174.94
Brightwood College	CA	$ 45,088.54	$ -	$ 45,088.54
Brightwood College	CA	$1,483,603.03	$ 4,834.75	$ 1,488,437.78
Brightwood College	CA	$2,632,406.05	$ 12,753.31	$ 2,645,159.36
Golf Academy of America	CA	$1,434,589.65	$ 58,438.92	$ 1,493,028.57
Brightwood College	NC	$ 64,281.23	$ -	$ 64,281.23
Brightwood College	IN	$ 45,108.18	$ -	$ 45,108.18
Brightwood College	MD	$ 244,948.18	$ -	$ 244,948.18
Brightwood College	MD	$ 335,897.24	$ -	$ 335,897.24
Brightwood College	MD	$ 157,760.75	$ -	$ 157,760.75
Golf Academy of America	AZ	$ 958,194.58	$ 55,304.16	$ 1,013,498.74

Payments by Individual Training Institutions

Brightwood College	IN	$ 132,013.18	$ -	$ 132,013.18
Brightwood College	CA	$ 249,571.64	$ -	$ 249,571.64
Brightwood Career Institute	PA	$ 208,729.05	$ -	$ 208,729.05
Brightwood Career Institute	PA	$ 120,533.34	$ -	$ 120,533.34
Brightwood Career Institute	PA	$ 160,918.64	$ -	$ 160,918.64
Brightwood College	TN	$ 208,874.21	$ -	$ 208,874.21
Brightwood Career Institute	PA	$ 94,737.11	$ -	$ 94,737.11
Brightwood Career Institute	PA	$ 120,439.77	$ -	$ 120,439.77
Brightwood College	OH	$ 218,685.90	$ -	$ 218,685.90
Virginia College	FL	$ 915,801.48	$ 2,171.33	$ 917,972.81
Virginia College	FL	$ 89,015.80	$ -	$ 89,015.80
BRIGHTWOOD COLLEGE-DALLAS	TX	$ 206,801.90	$ -	$ 206,801.90
BRIGHTWOOD COLLEGE-FORT WORTH	TX	$ 184,376.97	$ -	$ 184,376.97
Brightwood College	CO	$ 7,432.50	$ -	$ 7,432.50
Brightwood College	MN	$ 2,425.80	$ -	$ 2,425.80
Brightwood Career Institute	MN	$ 6,577.06	$ -	$ 6,577.06
Virginia College	LA	$ 244,522.96	$ -	$ 244,522.96
Virginia College	LA	$ 433,370.10	$ -	$ 433,370.10
Virginia College	OK	$ 4,020.00	$ -	$ 4,020.00
Virginia College	VA	$ 477,908.36	$ -	$ 477,908.36
Ecotech Institute	CO	$1,315,541.49	$ 4,631.60	$ 1,320,173.09
Virginia College	AL	$4,612,299.15	$ 2,397.59	$ 4,614,696.74
Virginia College	SC	$ 187,333.58	$ -	$ 187,333.58
Virginia College	SC	$ 556,968.73	$ 1,420.49	$ 558,389.22
Virginia College	SC	$ 985,640.77	$ 418.56	$ 986,059.33
Virginia College	SC	$ 244,805.65	$ -	$ 244,805.65
Virginia College	SC	$ 261,194.31	$ -	$ 261,194.31

Payments by Individual Training Institutions

Virginia College	TN	$ 229,239.29	$ -	$ 229,239.29
Virginia College	NC	$ 132,004.30	$ -	$ 132,004.30
Virginia College	GA	$1,291,040.12	$ -	$ 1,291,040.12
Virginia College	GA	$ 258,214.09	$ 670.49	$ 258,884.58
Virginia College	GA	$1,691,800.00	$ 1,091.49	$ 1,692,891.49
Virginia College	GA	$2,006,477.89	$ 2,290.48	$ 2,008,768.37
Virginia College	AL	$ 997,130.47	$ -	$ 997,130.47
Virginia College	AL	$ 497,495.02	$ 476.49	$ 497,971.51
Virginia College	AL	$1,012,546.32	$ 972.99	$ 1,013,519.31
Virginia College	FL	$2,050,748.86	$ 7,993.02	$ 2,058,741.88
Brightwood College	CA	$ 156,199.12	$ -	$ 156,199.12
Brightwood College	CA	$ 176,792.15	$ -	$ 176,792.15
Brightwood College	CA	$ 229,907.17	$ -	$ 229,907.17
Brightwood College	CA	$ 459,440.87	$ -	$ 459,440.87
Virginia College	TX	$ 800,151.22	$ 1,595.05	$ 801,746.27
BRIGHTWOOD COLLEGE-MCALLEN	TX	$ 95,542.29	$ -	$ 95,542.29
BRIGHTWOOD COLLEGE-BEAUMONT	TX	$ 111,871.33	$ -	$ 111,871.33
BRIGHTWOOD COLLEGE-SAN ANTONIO SAN PEDRO	TX	$ 794,951.97	$ -	$ 794,951.97
BRIGHTWOOD COLLEGE-BROWNSVILLE	TX	$ 239,756.20	$ -	$ 239,756.20
BRIGHTWOOD COLLEGE-FRIENDSWOOD	TX	$ 93,116.86	$ -	$ 93,116.86
BRIGHTWOOD COLLEGE-SAN ANTONIO INGRAM	TX	$ 523,634.14	$ -	$ 523,634.14
BRIGHTWOOD COLLEGE-EL PASO	TX	$ 568,616.07	$ 169.16	$ 568,785.23
BRIGHTWOOD COLLEGE-ARLINGTON	TX	$ 245,935.31	$ -	$ 245,935.31
BRIGHTWOOD COLLEGE-LAREDO	TX	$ 53,179.74	$ -	$ 53,179.74
Golf Academy of America	TX	$1,153,629.36	$ 39,964.20	$ 1,193,593.56
Virginia College	TX	$ 262,710.13	$ -	$ 262,710.13
Golf Academy of America	SC	$1,146,991.17	$ 45,444.32	$ 1,192,435.49

Payments by Individual Training Institutions

Golf Academy of America	FL	$1,187,088.82	$ 55,504.70	$ 1,242,593.52
Brightwood College	CA	$ 145,601.33	$ -	$ 145,601.33
Virginia College	MS	$ 300,950.46	$ 1,987.99	$ 302,938.45
Virginia College	MS	$ 789,317.29	$ -	$ 789,317.29
Brightwood College	CA	$ 23,199.64	$ -	$ 23,199.64
Brightwood College	CA	$ 28,170.40	$ -	$ 28,170.40
Brightwood College	CA	$1,073,670.62	$ 2,715.28	$ 1,076,385.90
Brightwood College	CA	$2,163,411.07	$ 869.73	$ 2,164,280.80
Golf Academy of America	CA	$1,328,387.62	$ 49,879.51	$ 1,378,267.13
Brightwood College	NC	$ 182,752.55	$ -	$ 182,752.55
Brightwood College	IN	$ 37,025.47	$ -	$ 37,025.47
Brightwood College	MD	$ 310,764.25	$ -	$ 310,764.25
Brightwood College	MD	$ 503,047.03	$ -	$ 503,047.03
Brightwood College	MD	$ 219,132.58	$ -	$ 219,132.58
Golf Academy of America	AZ	$ 857,584.13	$ 37,561.04	$ 895,145.17
Brightwood College	IN	$ 126,019.62	$ -	$ 126,019.62
Brightwood College	CA	$ 250,485.56	$ -	$ 250,485.56
Brightwood Career Institute	PA	$ 218,107.94	$ -	$ 218,107.94
Brightwood Career Institute	PA	$ 88,875.74	$ -	$ 88,875.74
Brightwood Career Institute	PA	$ 174,646.80	$ 1,853.66	$ 176,500.46
Brightwood College	TN	$ 212,602.94	$ -	$ 212,602.94
Brightwood Career Institute	PA	$ 56,211.65	$ -	$ 56,211.65
Brightwood Career Institute	PA	$ 120,276.00	$ -	$ 120,276.00
Brightwood College	OH	$ 243,408.03	$ -	$ 243,408.03
Virginia College	FL	$ 849,726.79	$ 1,727.98	$ 851,454.77
Virginia College	FL	$ 132,963.33	$ -	$ 132,963.33
BRIGHTWOOD COLLEGE-DALLAS	TX	$ 164,602.77	$ -	$ 164,602.77

Payments by Individual Training Institutions

BRIGHTWOOD COLLEGE-FORT WORTH	TX	$ 152,588.95	$ -	$ 152,588.95
Brightwood College	CO	$ 35,025.14	$ -	$ 35,025.14
Brightwood College	MN	$ 6,183.72	$ -	$ 6,183.72
Brightwood Career Institute	MN	$ 8,087.44	$ -	$ 8,087.44
Virginia College	LA	$ 360,366.43	$ -	$ 360,366.43
Virginia College	LA	$ 340,216.09	$ -	$ 340,216.09
Virginia College	VA	$ 552,826.36	$ -	$ 552,826.36
Ecotech Institute	CO	$1,487,538.22	$ 624.77	$ 1,488,162.99
Virginia College	AL	$3,612,037.77	$ 12,023.80	$ 3,624,061.57
Virginia College	SC	$ 200,699.05	$ -	$ 200,699.05
Virginia College	SC	$ 635,607.07	$ -	$ 635,607.07
Virginia College	SC	$ 945,932.48	$ 3,177.23	$ 949,109.71
Virginia College	SC	$ 224,696.48	$ -	$ 224,696.48
Virginia College	SC	$ 279,279.82	$ -	$ 279,279.82
Virginia College	TN	$ 282,679.02	$ -	$ 282,679.02
Virginia College	NC	$ 164,275.39	$ -	$ 164,275.39
Virginia College	GA	$1,150,241.45	$ 1,997.14	$ 1,152,238.59
Virginia College	GA	$ 223,801.47	$ -	$ 223,801.47
Virginia College	GA	$1,541,694.56	$ 934.21	$ 1,542,628.77
Virginia College	GA	$1,794,921.93	$ -	$ 1,794,921.93
Virginia College	AL	$ 715,291.04	$ -	$ 715,291.04
Virginia College	AL	$ 636,198.56	$ -	$ 636,198.56
Virginia College	AL	$ 710,874.82	$ 660.33	$ 711,435.15
Virginia College	FL	$2,022,173.39	$ 3,164.10	$ 2,025,337.49
Brightwood College	CA	$ 94,334.27	$ -	$ 94,334.27
Brightwood College	CA	$ 226,617.38	$ -	$ 226,617.38
Brightwood College	CA	$ 439,084.85	$ -	$ 439,084.85

Payments by Individual Training Institutions

Brightwood College	CA	$ 384,947.08	$ 1,985.45	$ 386,932.53
Virginia College	TX	$ 721,071.32	$ 368.56	$ 721,439.88
BRIGHTWOOD COLLEGE-MCALLEN	TX	$ 72,546.21	$ -	$ 72,546.21
BRIGHTWOOD COLLEGE-BEAUMONT	TX	$ 161,708.16	$ -	$ 161,708.16
BRIGHTWOOD COLLEGE-SAN ANTONIO SAN PEDRO	TX	$ 584,559.05	$ -	$ 584,559.05
BRIGHTWOOD COLLEGE-BROWNSVILLE	TX	$ 231,187.87	$ -	$ 231,187.87
BRIGHTWOOD COLLEGE-FRIENDSWOOD	TX	$ 178,821.64	$ -	$ 178,821.64
BRIGHTWOOD COLLEGE-SAN ANTONIO INGRAM	TX	$ 663,806.01	$ -	$ 663,806.01
BRIGHTWOOD COLLEGE-EL PASO	TX	$ 618,548.70	$ -	$ 618,548.70
BRIGHTWOOD COLLEGE-ARLINGTON	TX	$ 279,518.09	$ 2,794.86	$ 282,312.95
BRIGHTWOOD COLLEGE-LAREDO	TX	$ 106,894.35	$ -	$ 106,894.35
Golf Academy of America	TX	$ 989,838.06	$ 17,277.24	$ 1,007,115.30
Virginia College	TX	$ 198,071.30	$ -	$ 198,071.30
BRIGHTWOOD COLLEGE-CORPUS CHRISTI	TX	$ 244,498.39	$ -	$ 244,498.39
BRIGHTWOOD COLLEGE-HOUSTON	TX	$ 139,543.18	$ -	$ 139,543.18
Golf Academy of America	SC	$ 859,754.87	$ 36,811.88	$ 896,566.75
Golf Academy of America	FL	$1,150,231.91	$ 44,841.99	$ 1,195,073.90
Brightwood College	CA	$ 57,252.30	$ -	$ 57,252.30
Virginia College	MS	$ 235,340.07	$ -	$ 235,340.07
Virginia College	MS	$ 775,810.25	$ -	$ 775,810.25
Brightwood College	CA	$ 37,841.54	$ -	$ 37,841.54
Brightwood College	CA	$ 60,454.84	$ -	$ 60,454.84
Brightwood College	CA	$1,252,416.76	$ 3,521.40	$ 1,255,938.16
Brightwood College	CA	$2,749,393.95	$ 43,254.38	$ 2,792,648.33
Golf Academy of America	CA	$1,401,989.89	$ 48,697.96	$ 1,450,687.85
Brightwood College	NC	$ 180,334.30	$ -	$ 180,334.30
Brightwood College	IN	$ 99,339.51	$ -	$ 99,339.51

Payments by Individual Training Institutions

Brightwood College	MD	$ 346,607.32	$ -	$ 346,607.32
Brightwood College	MD	$ 445,222.98	$ -	$ 445,222.98
Brightwood College	MD	$ 342,836.37	$ -	$ 342,836.37
Golf Academy of America	AZ	$ 630,841.47	$ 27,250.86	$ 658,092.33
Brightwood College	IN	$ 86,661.93	$ -	$ 86,661.93
Brightwood College	CA	$ 353,318.54	$ 7,461.34	$ 360,779.88
Brightwood Career Institute	PA	$ 249,668.72	$ -	$ 249,668.72
Brightwood Career Institute	PA	$ 182,586.76	$ -	$ 182,586.76
Brightwood Career Institute	PA	$ 189,025.65	$ 1,661.43	$ 190,687.08
Brightwood College	TN	$ 258,039.48	$ 5,294.68	$ 263,334.16
Brightwood Career Institute	PA	$ 99,821.83	$ -	$ 99,821.83
Brightwood Career Institute	PA	$ 166,314.31	$ -	$ 166,314.31
Brightwood College	OH	$ 189,295.94	$ 3,470.27	$ 192,766.21
Virginia College	FL	$ 629,570.32	$ 627.36	$ 630,097.68
Virginia College	FL	$ 146,574.21	$ -	$ 146,574.21
BRIGHTWOOD COLLEGE-DALLAS	TX	$ 206,361.43	$ -	$ 206,361.43
BRIGHTWOOD COLLEGE-FORT WORTH	TX	$ 128,006.34	$ -	$ 128,006.34
Brightwood College	CO	$ 19,254.27	$ -	$ 19,254.27
Brightwood College	MN	$ 3,252.17	$ -	$ 3,252.17
Brightwood Career Institute	MN	$ 13,327.13	$ -	$ 13,327.13
Virginia College	LA	$ 245,879.31	$ 525.27	$ 246,404.58
Virginia College	LA	$ 245,450.67	$ -	$ 245,450.67
Virginia College	VA	$ 454,065.70	$ -	$ 454,065.70
Ecotech Institute	CO	$1,282,349.25	$ -	$ 1,282,349.25
Virginia College	AL	$ 917,940.63	$ 2,442.00	$ 920,382.63
Virginia College	SC	$ 150,933.91	$ -	$ 150,933.91
Virginia College	SC	$ 363,249.53	$ -	$ 363,249.53

Payments by Individual Training Institutions

Virginia College	SC	$ 495,734.14	$ -	$ 495,734.14
Virginia College	SC	$ 143,609.64	$ -	$ 143,609.64
Virginia College	SC	$ 190,500.49	$ -	$ 190,500.49
Virginia College	TN	$ 323,598.00	$ 200.77	$ 323,798.77
Virginia College	NC	$ 178,024.33	$ -	$ 178,024.33
Virginia College	GA	$ 730,637.54	$ -	$ 730,637.54
Virginia College	GA	$ 160,234.83	$ -	$ 160,234.83
Virginia College	GA	$1,264,188.68	$ 476.49	$ 1,264,665.17
Virginia College	GA	$ 935,408.43	$ 1,129.77	$ 936,538.20
Virginia College	AL	$ 163,055.06	$ -	$ 163,055.06
Virginia College	AL	$ 268,999.24	$ 200.77	$ 269,200.01
Virginia College	AL	$ 143,779.72	$ -	$ 143,779.72
Virginia College	FL	$1,563,557.79	$ -	$ 1,563,557.79
Brightwood College	CA	$ 100,410.18	$ -	$ 100,410.18
Brightwood College	CA	$ 387,190.70	$ -	$ 387,190.70
Brightwood College	CA	$ 333,898.00	$ -	$ 333,898.00
Brightwood College	CA	$ 457,574.92	$ -	$ 457,574.92
Virginia College	TX	$ 411,155.88	$ 3,432.09	$ 414,587.97
BRIGHTWOOD COLLEGE-MCALLEN	TX	$ 73,378.53	$ -	$ 73,378.53
BRIGHTWOOD COLLEGE-BEAUMONT	TX	$ 62,301.80	$ -	$ 62,301.80
BRIGHTWOOD COLLEGE-SAN ANTONIO SAN PEDRO	TX	$ 552,298.34	$ 1,513.96	$ 553,812.30
BRIGHTWOOD COLLEGE-BROWNSVILLE	TX	$ 199,733.70	$ -	$ 199,733.70
BRIGHTWOOD COLLEGE-FRIENDSWOOD	TX	$ 121,037.71	$ -	$ 121,037.71
BRIGHTWOOD COLLEGE-SAN ANTONIO INGRAM	TX	$ 891,849.25	$ 112.07	$ 891,961.32
BRIGHTWOOD COLLEGE-EL PASO	TX	$ 325,899.72	$ -	$ 325,899.72
BRIGHTWOOD COLLEGE-ARLINGTON	TX	$ 142,195.54	$ -	$ 142,195.54
BRIGHTWOOD COLLEGE-LAREDO	TX	$ 117,525.16	$ -	$ 117,525.16

Payments by Individual Training Institutions

Golf Academy of America	TX	$ 982,524.10	$ 14,598.30	$ 997,122.40
Virginia College	TX	$ 172,705.01	$ -	$ 172,705.01
BRIGHTWOOD COLLEGE-CORPUS CHRISTI	TX	$ 275,101.55	$ -	$ 275,101.55
BRIGHTWOOD COLLEGE-HOUSTON	TX	$ 128,209.37	$ -	$ 128,209.37
Golf Academy of America	SC	$ 529,961.81	$ 12,096.08	$ 642,057.89
Golf Academy of America	FL	$ 990,525.07	$ 26,080.07	$ 1,016,605.14
Brightwood College	CA	$ 119,440.00	$ -	$ 119,440.00
Virginia College	MS	$ 105,223.97	$ -	$ 105,223.97
Virginia College	MS	$ 363,192.60	$ -	$ 363,192.60
Brightwood College	CA	$ 20,895.09	$ -	$ 20,895.09
Brightwood College	CA	$ 32,926.44	$ -	$ 32,926.44
Brightwood College	CA	$1,389,982.64	$ 6,512.29	$ 1,396,494.93
Brightwood College	CA	$2,331,078.91	$ 876.73	$ 2,331,955.64
Golf Academy of America	CA	$1,208,656.30	$ 14,998.75	$ 1,223,655.05
Brightwood College	NC	$ 200,741.67	$ 2,608.46	$ 203,350.13
Brightwood College	IN	$ 60,514.25	$ -	$ 60,514.25
Brightwood College	MD	$ 306,872.96	$ -	$ 306,872.96
Brightwood College	MD	$ 318,053.20	$ -	$ 318,053.20
Brightwood College	MD	$ 164,703.61	$ -	$ 164,703.61
Golf Academy of America	AZ	$ 661,271.97	$ 12,591.39	$ 673,863.36
Brightwood College	IN	$ 94,877.91	$ -	$ 94,877.91
Brightwood College	CA	$ 405,764.82	$ -	$ 405,764.82
Brightwood Career Institute	PA	$ 278,517.75	$ 1,224.99	$ 279,742.74
Brightwood Career Institute	PA	$ 86,238.63	$ -	$ 86,238.63
Brightwood Career Institute	PA	$ 210,140.18	$ -	$ 210,140.18
Brightwood College	TN	$ 128,718.05	$ -	$ 128,718.05
Brightwood Career Institute	PA	$ 70,876.41	$ 1,977.05	$ 72,853.46

Payments by Individual Training Institutions

Brightwood Career Institute	PA	$ 80,683.86	$ -	$ 80,683.86
Brightwood College	OH	$ 253,218.02	$ -	$ 253,218.02
Virginia College	FL	$ 523,356.32	$ 225.02	$ 523,581.34
Virginia College	FL	$ 103,590.69	$ -	$ 103,590.69
BRIGHTWOOD COLLEGE-DALLAS	TX	$ 217,699.66	$ -	$ 217,699.66
BRIGHTWOOD COLLEGE-FORT WORTH	TX	$ 89,300.49	$ -	$ 89,300.49
Brightwood College	CO	$ 17,073.49	$ -	$ 17,073.49
Brightwood College	MN	$ 5,959.48	$ -	$ 5,959.48
Brightwood Career Institute	MN	$ 2,164.80	$ -	$ 2,164.80
Virginia College	LA	$ 48,817.99	$ -	$ 48,817.99
Virginia College	LA	$ 81,651.53	$ -	$ 81,651.53
Virginia College	VA	$ 141,040.62	$ -	$ 141,040.62
Ecotech Institute	CO	$ 381,287.69	$ -	$ 381,287.69
Virginia College	AL	$ 92,210.52	$ 812.94	$ 93,023.46
Virginia College	SC	$ 23,871.34	$ -	$ 23,871.34
Virginia College	SC	$ 133,166.38	$ -	$ 133,166.38
Virginia College	SC	$ 164,582.14	$ -	$ 164,582.14
Virginia College	SC	$ 40,307.98	$ -	$ 40,307.98
Virginia College	SC	$ 48,893.98	$ -	$ 48,893.98
Virginia College	TN	$ 78,986.68	$ -	$ 78,986.68
Virginia College	NC	$ 78,936.41	$ -	$ 78,936.41
Virginia College	GA	$ 283,850.05	$ -	$ 283,850.05
Virginia College	GA	$ 31,638.94	$ -	$ 31,638.94
Virginia College	GA	$ 485,510.01	$ -	$ 485,510.01
Virginia College	GA	$ 182,914.63	$ -	$ 182,914.63
Virginia College	AL	$ 24,977.32	$ -	$ 24,977.32
Virginia College	AL	$ 59,006.33	$ -	$ 59,006.33

Payments by Individual Training Institutions

Virginia College	AL	$ 42,390.33	$ -	$ 42,390.33
Virginia College	FL	$ 568,600.56	$ 1,652.36	$ 570,252.92
Brightwood College	CA	$ 4,371.28	$ -	$ 4,371.28
Brightwood College	CA	$ 96,697.52	$ -	$ 96,697.52
Brightwood College	CA	$ 147,159.90	$ -	$ 147,159.90
Brightwood College	CA	$ 185,184.09	$ 3,195.40	$ 188,379.49
Virginia College	TX	$ 151,150.76	$ -	$ 151,150.76
BRIGHTWOOD COLLEGE-MCALLEN	TX	$ 33,753.38	$ -	$ 33,753.38
BRIGHTWOOD COLLEGE-BEAUMONT	TX	$ 4,004.06	$ -	$ 4,004.06
BRIGHTWOOD COLLEGE-SAN ANTONIO SAN PEDRO	TX	$ 174,108.00	$ -	$ 174,108.00
BRIGHTWOOD COLLEGE-BROWNSVILLE	TX	$ 38,603.97	$ -	$ 38,603.97
BRIGHTWOOD COLLEGE-FRIENDSWOOD	TX	$ 34,049.70	$ -	$ 34,049.70
BRIGHTWOOD COLLEGE-SAN ANTONIO INGRAM	TX	$ 369,143.80	$ 2,530.89	$ 371,674.69
BRIGHTWOOD COLLEGE-EL PASO	TX	$ 129,699.83	$ -	$ 129,699.83
BRIGHTWOOD COLLEGE-ARLINGTON	TX	$ 50,139.88	$ -	$ 50,139.88
BRIGHTWOOD COLLEGE-LAREDO	TX	$ 12,157.28	$ -	$ 12,157.28
Golf Academy of America	TX	$ 370,372.81	$ 4,296.64	$ 374,669.45
Virginia College	TX	$ 48,739.11	$ -	$ 48,739.11
BRIGHTWOOD COLLEGE-CORPUS CHRISTI	TX	$ 78,821.58	$ 2,935.35	$ 81,756.93
BRIGHTWOOD COLLEGE-HOUSTON	TX	$ 42,200.41	$ -	$ 42,200.41
Golf Academy of America	SC	$ 148,085.01	$ -	$ 148,085.01
Golf Academy of America	FL	$ 368,898.96	$ -	$ 368,898.96
Brightwood College	CA	$ 48,308.65	$ 3,033.54	$ 51,342.19
Virginia College	MS	$ 27,726.84	$ -	$ 27,726.84
Virginia College	MS	$ 123,725.34	$ -	$ 123,725.34
Brightwood College	CA	$ 23,964.93	$ -	$ 23,964.93
Brightwood College	CA	$ 4,067.93	$ -	$ 4,067.93

Payments by Individual Training Institutions

Brightwood College	CA	$ 388,713.93	$ 6,886.80	$ 395,600.73
Brightwood College	CA	$ 885,255.92	$ 28,743.75	$ 913,999.67
Golf Academy of America	CA	$ 392,391.51	$ 3,788.87	$ 396,180.38
Brightwood College	NC	$ 62,769.03	$ -	$ 62,769.03
Brightwood College	IN	$ 1,668.60	$ -	$ 1,668.60
Brightwood College	MD	$ 56,715.90	$ -	$ 56,715.90
Brightwood College	MD	$ 104,443.38	$ -	$ 104,443.38
Brightwood College	MD	$ 53,453.83	$ -	$ 53,453.83
Golf Academy of America	AZ	$ 258,801.65	$ 6,920.10	$ 265,721.75
Brightwood College	IN	$ 34,652.53	$ -	$ 34,652.53
Brightwood College	CA	$ 107,144.60	$ 3,715.41	$ 110,860.01
Brightwood Career Institute	PA	$ 42,793.27	$ -	$ 42,793.27
Brightwood Career Institute	PA	$ 14,039.30	$ -	$ 14,039.30
Brightwood Career Institute	PA	$ 106,242.23	$ -	$ 106,242.23
Brightwood College	TN	$ 64,418.86	$ -	$ 64,418.86
Brightwood Career Institute	PA	$ 7,900.53	$ -	$ 7,900.53
Brightwood Career Institute	PA	$ 38,604.04	$ -	$ 38,604.04
Brightwood College	OH	$ 27,109.92	$ -	$ 27,109.92
Virginia College	FL	$ 159,759.20	$ -	$ 159,759.20
Virginia College	FL	$ 14,599.85	$ -	$ 14,599.85
BRIGHTWOOD COLLEGE-DALLAS	TX	$ 73,677.98	$ -	$ 73,677.98
BRIGHTWOOD COLLEGE-FORT WORTH	TX	$ 33,510.72	$ -	$ 33,510.72
Brightwood College	CO	$ 5,534.00	$ -	$ 5,534.00
Brightwood College	MN	$ 2,505.24	$ -	$ 2,505.24
Brightwood Career Institute	MN	$ 498.25	$ -	$ 498.25

13

Question 5i. Post-9/11 GI Bill beneficiaries have recently experienced delays and underpayments in housing benefits this year. How many students impacted by the ECA closures were also affected by delays in housing payments, and will ECA students who may have received incorrect housing allowances be retroactively reimbursed?

Response. VA is unable to tell how many ECA student were impacted by the fall 2018 delays in housing payments; however, ECA's closure did not impact VA's ability to correct those payments by January 1, 2019, in the event they were incorrectly paid. However, in the event an ECA student was attending a campus under section

107, ECA would need to report this information to VA for VA to re-adjudicate the claim to determine if additional funds should be issued to a student. VA will work individually with those ECA students who report an improper housing payment under section 107 in the event ECA in unwilling or unable to report due to their closure.

Question 5j. Please provide information on any efforts by the VA to limit, suspend, or withdraw ECA's participation in the Post-9/11 GI Bill program prior to their announced closure and within the last five years.

Response. There was no effort by VA to limit, suspend, or withdraw ECA's participation in the Post-9/11 GI Bill program prior to their announced closure or within the last 5 years; however, VA may not be aware of efforts on the part of individual SAAs in this regard. VA was not aware of any issues that would have impacted its approval status, financial stability is not a requirement for the approval of accredited programs, and VA has no statutory authority to limit, suspend, or withdraw a school's GI Bill approval because the school closes some of its campuses.

Question 5k. Please provide information on the overall number of student veteran complaints to the GI Bill Feedback System about schools owned by ECA and the VA's efforts to address them since 2014.

Response. Since 2014, Education Service (EDU) received a total of 28 complaints from students within the GI Bill Feedback System about schools owned by ECA. VA addressed each of the 28 complaints through initial contact with the student to gain additional details of the issue. VA then contacted the appropriate ECA institution with the issues and requested they respond within 45 days. Of the 28 complaints, 22 were resolved in a timely manner and six cases were identified as information only. Each of the cases are stored electronically and available to establish trends in support of the overall EDU strategy to safeguard the integrity of the GI Bill. Furthermore, the EDU Oversight and Accountability division has completed 128 compliance survey visits at the ECA institutions since 2014.

Question 6. In the last year, there have been two waves of school closures and the practical collapse of a most of the Dream Center Education Holdings (DCEH) campuses, affecting thousands of students across the country.

Question 6a. How many Post-9/11 GI Bill recipients were enrolled at DCEH schools at the time of the July 2018 reports that DCEH would stop enrolling students at 30 campuses and shut down those locations? Please provide GI Bill enrollment data for each campus. How many, if any, Post-9/11 GI Bill recipients transferred to online-only offerings when those 30 campuses ceased on campus offerings?

Response. Please see the excel spreadsheet for Dream Center Education Holdings (DCEH) student count by school at the time of the July 2018 reports that DCEH would stop enrolling students at 30 campuses and shut down those locations. Additionally, VA determined that 20 Chapter 33 education beneficiaries have transferred to online-only training.

Facility Name	Distinct Student Count
ARGOSY UNIVERSITY	1
Argosy University Atlanta	2
Argosy University San Francisco Bay Area—Alameda CA	9
Argosy University—American Samoa	5
ARGOSY UNIVERSITY—CHICAGO	1
ARGOSY UNIVERSITY—DENVER	9
Argosy University—Honolulu HI	24
ARGOSY UNIVERSITY—INLAND EMPIRE	20
Argosy University—Los Angeles CA	7
ARGOSY UNIVERSITY—NASHVILLE	11
Argosy University—Organe CA	8
ARGOSY UNIVERSITY—SAN DIEGO	17
ARGOSY UNIVERSITY—SARASOTA	1
Argosy University—Tampa FL	14
ARGOSY UNIVERSITY—TWIN CITIES	2
The Art Inst of Atlanta	3
The Art Inst of Austin	25
The Art Inst of California San Diego	15
The Art Inst of Dallas	24
The Art Inst of Houston	12
The Art Inst of Pittsburgh	1

Facility Name	Distinct Student Count
The Art Inst of Pittsburgh Online	20
The Art Inst of Virginia Beach	6
The Art Inst San Antonio	28
The Art Inst Tampa	5
THE ART INSTITUTE OF CALIFORNIA—INLAND EMPIRE—A CAMPUS OF ARGOSY UNIV	4
THE ART INSTITUTE OF LAS VEGAS	9
THE ART INSTITUTE OF SEATTLE	17
Distinct Grand Total	298

Question 6b. What communication did VA have with Post-9/11 GI Bill recipients enrolled in DCEH schools after the July 2018 reports of campus closures?

Response. VA did not provide any specific communications for DCEH's announcement in July 2018 that it would be closing some of its campuses as part of strategy to reduce its physical footprint. DCEH announced that it was suspending the enrollment of new students, and existing students were allowed to complete their classes, switch to another campus, or continue pursuing their programs online. This was a different scenario than the abrupt, mid-term closure in March 2019 which also included the online campuses of Argosy University and the Art Institutes.

Question 6c. How many Post-9/11 GI Bill recipients were enrolled at Argosy University and Art Institutes campuses that closed on March 8, 2019? Please provide the GI Bill enrollment data for each campus.

Response. VA's official count stands at 1,782 students who were using Post-9/11 GI Bill benefits, after a review of all received enrollment certifications from the associated schools. Please see accompanying pdf document with enrollment data for each campus.

Argosy University/Dream Center Closures

Institution	City	State	Number of Students
Argosy University – American Samoa	Pago Pago	AS	40
Argosy University - Phoenix ATS Chandler	Chandler	AZ	0
Argosy University - Phoenix	Phoenix	AZ	285
Argosy University - San Francisco Bay Area	Alameda	CA	4
Argosy University – Orange CA	Orange	CA	46
Argosy University - The Art Institute of California - Hollywood	North Hollywood	CA	140
Argosy University - Ai Hollywood (The Shed)	North Hollywood	CA	0
Argosy University - Los Angeles	Los Angeles	CA	31
Argosy University - The Art Institute of California - San Diego	San Diego	CA	275
Argosy University - Tampa	Tampa	FL	76
Argosy University - Atlanta	Atlanta	GA	72
Argosy University - Clay National Guard Center	Marietta	GA	0
Argosy University - Hilo Campus	Hilo	HI	0
Argosy University - Hawaii	Honolulu	HI	194
Argosy University - Maui Campus	Wailuku	HI	0
Argosy University - Chicago	Chicago	IL	19
Argosy University - Twin Cities	Eagan	MN	30
The Art Institute of Pittsburgh	Pittsburgh	PA	20
The Art Institute of Pittsburgh -Online Division	Pittsburgh	PA	363
Argosy University - Dallas	Dallas	TX	4
Argosy University - Salt Lake City	Draper	UT	4
Argosy University - UT National Guard Base, SLC	Salt Lake City	UT	0
Argosy University - Washington D.C. Area	Arlington	VA	32
Argosy University - Seattle	Seattle	WA	0
The Art Institute of Seattle	Seattle	WA	147
Total			**1,782**

Question 6d. When and how did VA notify GI Bill recipients about the closure for each DCEH campuses?

Response. VA informed GI Bill beneficiaries of actions taken by the Department of Education on three occasions through email and social media accounts (Facebook):

- March 1—Notified students of Department of Education's termination letter of Title IV funding to Argosy University (Facebook posted on February 28).
- March 8—Notified students of Dream Center Education Holdings motion with the court requesting permission for emergency sale or closure of its Argosy and Art Institute campuses on March 8.
- March 13—Notified beneficiaries of the closure of 25 Dream Center Education Holdings campuses and that VA was coordinating with the various State Approving Agencies (SAA) and gathering the specific details surrounding the closures. Also, informed students VA would contact current students attending institutions that closed advising them of their options and the possibility of having benefits restored within 5 days of official notification from its SAA partners.

The GI Bill restoration team completed all 5-day closure notification letters by March 21, 2019.

Question 6e. Describe the steps VA has taken to identify and assist Post-9/11 GI Bill recipients affected by the DCEH closures.

Response. VA reviewed its enrollment and payment records to identify students who were attending one of the impacted schools during the month of March 2019. They were then notified on three occasions through email and social media accounts. VA's notifications contained links to potential resources that could be of assistance to impacted students as shown below. Below, we have included copies of the original and updated notification letter being used as of May 20, 2019.

DEPARTMENT OF VETERANS AFFAIRS
VA Regional Office
PO Box 8888
Muskogee, OK 74402-8888

Current Date

In Reply Refer To: 351/22

JOHN D VETERAN
123 ANYWHERE ST
ANYWHERE, OK 12345

J D Veter
XXX-XX-6789

Dear Mr. Veteran:

We are sending you this letter because our records indicate you attended training at (Facility claimant attended) and received education benefits from the Department of Veterans Affairs' (VA). Due to (Facility claimant attended) closure or disapproval on (Month, day, year) students could potentially be eligible for restoration of entitlement under the Harry W. Colmery Veterans Education Assistance Act of 2017.

What are the Requirements for Restoration of Entitlement

As a result of the Harry W. Colmery Veterans Educational Assistance Act of 2017, VA has the authority to restore GI Bill benefits that were previously used at a school that has either lost VA approval and/or the school closes. Below are the requirements for restoration of entitlement:

- The institutition closes, or
- After the date on which the individual enrolls at the institution, the VA modifies regulations or policies which affect the facility's approval to receive benefits, and
- The facility's disapproval/closure occurred during an active enrollment period, and
- The facility has the student actively enrolled in a term at the school/facility at the time of the disapproval/closure, and
- The actively enrolled student was unable to complete their course or program as a result of the disapproval/closure, and
- The actively enrolled student did not receive credit or lost training time towards the completion of the program of education being pursued.

What We Determined

We have determined that your school closure or disapproval did not meet one or more of the above requirements under the Harry W. Colmery Veterans Educational Assistance Act of 2017.

Where Can I Find More Help

- If you feel you qualify for entitlement restoration please complete and return the Entitlement Restoration enclosure, which can be found at (https://www.benefits.va.gov/GIBILL/docs/EntitlmentRestoration.pdf).
- VA's GI Bill Comparison Tool (https://www.vets.gov/gi-bill-comparison-tool) can help you review and compare alternative schools.
- Student Veterans of America (http://studentveterans.org/) has a network of over 1,400 student chapters at colleges and universities and their staff can provide answers to your questions.
- Reach out to Veterans of Foreign Wars (https://www.vfw.org). They offer emergency assistance grants to students affected by school closures.
- Free lawyers and advice are available for students from Veterans Education Success. Visit their website at http://veteranseducationsuccess.org/ or email directly, help@VeteransEducationSuccess.org.
- The Department of Education has a page dedicated to school closures. Visit https://studentaid.ed.gov/sa/about/announcements/closed-school for more information.
- The American Legion (https://www.legion.org/serviceofficers) has service officers in every state that can provide answers to questions about education benefits, federal student loans and credit transferability.
- The State Approving Agencies (http://nasaa-vetseducation.com/Contacts.aspx) are working with schools to identify those that will accept transfers.

What If I Have Student Loans

If you are a GI Bill beneficiary who also has federal student loans, consider visiting the Department of Education's Federal Student Aid webpage (https://studentaid.ed.gov/sa/) for Closed School Discharge, which has information regarding loan forgiveness criteria for students whose schools close abruptly.

If You Have Questions or Need Assistance

If you have questions or need assistance, contact the Department of Veterans Affairs at 1-888-GI-BILL-1 (1-888-442-4551). If you use the Telecommunications Device for the Deaf (TDD), the Federal number is 711. See the "If You Need Help" enclosure for contact information.

We understand the extremely difficult situation this closure has caused, and wish to assist you as much as possible in continuing your educational goals.

Sincerely yours,

3

CSS XXX-XX-6789
Veter, J D

P. Stephens
Education Officer
22/ (VCE's initials)
Enclosure(s): If You Need Help

DEPARTMENT OF VETERANS AFFAIRS
VA Regional Office
PO Box 8888
Muskogee, OK 74402-8888

Current Date

In Reply Refer To: 351/22

JOHN D VETERAN
1 STREET
ANYTOWN, ANY STATE 12345

J D Veter
XXX-XX-6789

Dear Mr. Veteran:

We are sending you this letter because our records indicate you attended training at (Facility claimant attended) and received GI Bill benefits from the Department of Veterans Affairs (VA). This notice is to inform you that you may be eligible for restoration of entitlement under the Harry W. Colmery Veterans Educational Assistance Act of 2017 due to (Facility claimant attended) closure/disapproval on (Month, day, year).

What Does This Mean For My GI Bill Benefits

VA now has the authority to restore some or all GI Bill benefits used at an educational institution that will close/has closed or disapproved. Any restored entitlement may be used to pursue your education goals at another school or training facility. Specifically, no payment of educational assistance would be charged against an individual's entitlement to educational assistance under chapters 30, 32, 33, or 35 of title 38, or chapters 1606 or 1607 of title 10, or counted against the aggregate period for which an individual may receive educational assistance under two or more programs.

What You Should Do

In order to determine your eligibility for restoration of entitlement please complete the Education Benefit Entitlement Restoration Request Due To School Closure or Withdrawal enclosure and return the enclosure to our office.

Where to Send It

Please send this information to:

Muskogee Regional Processing Office
P.O. Box 8888
Muskogee, OK 74402-8888

Where Can I Find More Help

If you feel you qualify for entitlement restoration please complete and return the Entitlement Restoration enclosure, which can be found a (https://www.benefits.va.gov/GIBILL/docs/EntitlmentRestoration.pdf).

- VA's GI Bill Comparison Tool (https://www.vets.gov/gi-bill-comparison-tool) can help you review and compare alternative schools.
- Student Veterans of America (http://studentveterans.org/) has a network of over 1,400 student chapters at colleges and universities and their staff can provide answers to your questions.
- Reach out to Veterans of Foreign Wars (https://www.vfw.org). They offer emergency assistance grants to students affected by school closures.
- Free lawyers and advice are available for students from Veterans Education Success. Visit their website at http://veteranseducationsuccess.org/ or email directly, help@VeteransEducationSuccess.org.
- The Department of Education has a page dedicated to school closures. Visit https://studentaid.ed.gov/sa/about/announcements/closed-school for more information.
- The American Legion (https://www.legion.org/serviceofficers) has service officers in every state that can provide answers to questions about education benefits, federal student loans and credit transferability.
- The State Approving Agencies (http://nasaa-vetseducation.com/Contacts.aspx) are working with schools to identify those that will accept transfers.

What If I Have Student Loans

If you are a GI Bill beneficiary who also has federal student loans, consider visiting the Department of Education's Federal Student Aid webpage (https://studentaid.ed.gov/sa/) for Closed School Discharge, which has information regarding loan forgiveness criteria for students whose schools close abruptly.

Choosing the Right Career and Training

CareerScope® assesses your interests and aptitudes, gives career recommendations and helps you decide which courses or training programs you should focus on. To access CareerScope® please visit http://www.benefits.va.gov/gibill/careerscope.asp.

The GI Bill® Comparison tool allows you to compare estimated benefits by school. To access the tool please visit https://www.vets.gov/gi-bill-comparison-tool.

Career Counseling

The receipt of this letter means that you may be eligible for VA-provided professional career counseling services at any time during your eligibility period.

Please note: When considering the school(s) for which you would like to receive your educational training, we recommend that you research your perspective school using the GI Bill Comparison Tool and our "Factors to Consider When Choosing a School: A guide before using the G.I. Bill".

- GI Bill Comparison Tool: www.vets.gov/gi-bill-comparison-tool
- Factors to Choosing a School: A guide before using the GI Bill: www.benefits.va.gov/gibill/docs/factsheets/choosing_a_school.pdf

Pay particular attention to whether your prospective school(s) has articulation agreements in place, what the agreement involves, and how it applies to credit transferability should you wish to transfer to a different school at a later date.

If you have questions, particularly about articulation agreements, or would like more information about career counseling services, you may call VA to speak directly with a customer service representative at 1-800-827-1000.

Additionally, if you are within six months of discharge, you may be eligible for VA's professional career counseling. For more information, call 1-800-827-1000.

If You Have Questions or Need Assistance

Website	www.va.gov/
VA Forms	www.va.gov/vaforms
Frequently Asked Questions	https:\\gibill.custhelp.va.gov/app/answers/list
Submit a Question: *Include your full name and VA file number*	https:\\gibill.custhelp.va.gov/app/utils/login_form/redirect/ask
Mailing Address: *Include your full name and VA file number on the inside of mailed correspondence (not on envelope)*	See address at the top of this letter
Education Call Center	1-888-GI-BILL-1 (1-888-442-4551) (inside the U.S) 001-918-781-5678 (outside the U.S.)
TTY, Federal Relay	711
Veterans Crisis Line	1-800-273-8255 and press 1
VA Regional Office Location	www.va.gov/find-locations

4

CSS XXX-XX-6789
Veter, J D

GI Bill® Comparison Tool: *This tool allows you to get information on a school's value and, affordability; and to compare estimated benefits by school.*	www.vets.gov/gi-bill-comparison-tool

Sincerely yours,

Education Officer

Enclosure(s):

VA Form 22-0989: Education Benefit Entitlement Restoration Request Due To School Closure or Withdrawal

22/<VCEs initials>

Question 6f. How much VA funding did each DCEH campus (including those that have no yet closed) received in the past five academic years?

Response. Please see the excel spreadsheet below for DCEH school payments for chapter 33 benefits as of April 12, 2019. Please note the information provided is by fiscal year and not academic year.

			FY14			FY15		
Institution Status	Facility Code	Institution	Tuition and Fees Paid	Yellow Ribbon Paid	Total Paid	Tuition and Fees Paid	Yellow Ribbon Paid	Total Paid
Approved	319M4543	The Art Inst of Dallas						
	31017405	WESTERN STATE COLLEGE OF LAW AT ARGOSY UNIVERSITY						
	31020911	The Art Inst of Atlanta						
	31039843	The Art Inst of Austin						
	31040843	The Art Inst San Antonio						
	31048943	The Art Inst of Houston						
	31929246	The Art Inst of Virginia Beach						
	31940113	School of the Art Inst of Chicago	$1,393,127.87	$94,027.05	$1,487,154.92	$1,374,392.84	$320,910.19	$1,695,303.03
	31971110	The Art Inst Tampa						
Suspended	31904128	THE ART INSTITUTE OF LAS VEGAS						
Withdrawn	21005103	ARGOSY UNIVERSITY-PHOENIX ONLINE DIVISION	$639.24	$0.00	$639.24			
	21008742	ARGOSY UNIVERSITY-NASHVILLE	$8,265,157.95	$0.00	$8,265,157.95	$7,975,223.54	$21,650.68	$7,996,874.22
	21100238	ARGOSY UNIVERSITY-PHOENIX ONLINE DIVISION	$4,606.20	$0.00	$4,606.20	$1,803.60	$0.00	$1,803.60
	21405247	ARGOSY UNIVERSITY-SEATTLE	$8,386,595.35	$165,306.59	$8,551,901.94	$5,725,139.75	$192,355.65	$5,917,495.40
	21802005	THE ART INSTITUTE OF CALIFORNIA-ARGOSY UNIVERSITY LOS ANGELES	$8,880,761.73	$2,424,365.14	$11,305,126.87	$15,649,998.40	$1,987,946.25	$17,637,944.65
	21804405	THE ART INSTITUTE OF CALIFORNIA-ARGOSY UNIVERSITY-SILICON VALLEY	$2,965,899.30	$1,008,414.81	$3,974,314.11	$6,082,269.99	$768,038.54	$6,850,308.53
	31001523	ARGOSY UNIVERSITY-TWIN CITIES						
	31006603	ARGOSY UNIVERSITY						
	31009142	ARGOSY UNIVERSITY-NASHVILLE						
	31015106	ARGOSY UNIVERSITY-DENVER						
	31016405	Argosy University-Organe CA						
	31016505	ARGOSY UNIVERSITY-INLAND EMPIRE						
	31016605	Argosy University San Francisco Bay Area-Alameda CA						
	31016705	ARGOSY UNIVERSITY-SAN DIEGO				$1,683.00	$0.00	$1,683.00
	31016805	Argosy University-Los Angeles CA						
	31017005	The Art Inst of California San Diego						
	31017205	THE ART INSTITUTE OF CALIFORNIA-INLAND EMPIRE - A CAMPUS OF ARGOSY UNIV						
	31017705	The Art Institute of California-Hollywood CA						
	31017805	THE ART INSTITUTE OF CALIFORNIA-ARGOSY UNIVERSITY ORANGE COUNTY						
	31020811	Argosy University Atlanta						
	31034343	Argosy University-Dallas TX						
	31048813	ARGOSY UNIVERSITY-SCHAUMBURG						
	31048913	ARGOSY UNIVERSITY-CHICAGO						
	31057310	ARGOSY UNIVERSITY-SARASOTA						
	31058510	Argosy University-Tampa FL						
	31702364	Argosy University-Honolulu HI						
	31702467	Argosy University-American Samoa				$0.00	$0.00	$0.00
	31929346	Argosy University-Arlington VA						
	31940844	Argosy University Salt Lake City-Draper UT						
	34805538	The Art Inst of Pittsburgh Online						
	34905438	The Art Inst of Pittsburgh						
	34929447	THE ART INSTITUTE OF SEATTLE						

			FY16			FY17		
Institution Status	Facility Code	Institution	Tuition and Fees Paid	Yellow Ribbon Paid	Total Paid	Tuition and Fees Paid	Yellow Ribbon Paid	Total Paid
Approved	319M4543	The Art Inst of Dallas				$2,950.46	$0.00	$2,950.46
	31017405	WESTERN STATE COLLEGE OF LAW AT ARGOSY UNIVERSITY						
	31020911	The Art Inst of Atlanta						
	31039843	The Art Inst of Austin						
	31040843	The Art Inst San Antonio						
	31048943	The Art Inst of Houston						
	31929246	The Art Inst of Virginia Beach						
	31940113	School of the Art Inst of Chicago	$1,539,241.52	$215,693.81	$1,754,935.33	$1,707,572.89	$97,814.95	$1,805,387.84
	31971110	The Art Inst Tampa						
Suspended	31904128	THE ART INSTITUTE OF LAS VEGAS						
Withdrawn	21005103	ARGOSY UNIVERSITY-PHOENIX ONLINE DIVISION						
	21008742	ARGOSY UNIVERSITY-NASHVILLE	$6,390,886.27	$5,668.55	$6,396,554.82	$7,518,132.43	$0.00	$7,518,132.43
	21100238	ARGOSY UNIVERSITY-PHOENIX ONLINE DIVISION						
	21405247	ARGOSY UNIVERSITY-SEATTLE	$3,777,346.40	$0.00	$3,777,346.40	$252,820.00	$0.00	$252,820.00
	21802005	THE ART INSTITUTE OF CALIFORNIA-ARGOSY UNIVERSITY LOS ANGELES	$13,146,811.48	$1,725,974.32	$14,872,785.80	$3,604,580.66	$14,860.32	$3,619,440.98
	21804405	THE ART INSTITUTE OF CALIFORNIA-ARGOSY UNIVERSITY-SILICON VALLEY	$3,379,423.53	$509,824.15	$3,889,247.68	$1,034,446.00	$0.00	$1,034,446.00
	31001523	ARGOSY UNIVERSITY-TWIN CITIES				$16,804.80	$0.00	$16,804.80
	31006603	ARGOSY UNIVERSITY						
	31009142	ARGOSY UNIVERSITY-NASHVILLE				$0.00	$0.00	$0.00
	31015106	ARGOSY UNIVERSITY-DENVER						
	31016405	Argosy University-Organe CA						
	31016505	ARGOSY UNIVERSITY-INLAND EMPIRE						
	31016605	Argosy University San Francisco Bay Area-Alameda CA						
	31016705	ARGOSY UNIVERSITY-SAN DIEGO						
	31016805	Argosy University-Los Angeles CA						
	31017005	The Art Inst of California San Diego						
	31017205	THE ART INSTITUTE OF CALIFORNIA-INLAND EMPIRE - A CAMPUS OF ARGOSY UN						
	31017705	The Art Institute of California-Hollywood CA						
	31017805	THE ART INSTITUTE OF CALIFORNIA-ARGOSY UNIVERSITY ORANGE COUNTY						
	31020811	Argosy University Atlanta						
	31034343	Argosy University-Dallas TX						
	31048813	ARGOSY UNIVERSITY-SCHAUMBURG						
	31048913	ARGOSY UNIVERSITY-CHICAGO						
	31057310	ARGOSY UNIVERSITY-SARASOTA						
	31058510	Argosy University-Tampa FL	$7,960.00	$4,155.00	$12,115.00	$0.00	$0.00	$0.00
	31702364	Argosy University-Honolulu HI	$0.00	$698.39	$698.39			
	31702467	Argosy University-American Samoa	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	31929346	Argosy University-Arlington VA				$0.00	$0.00	$0.00
	31940844	Argosy University Salt Lake City-Draper UT						
	34805538	The Art Inst of Pittsburgh Online				$1,419.00	$0.00	$1,419.00
	34905438	The Art Inst of Pittsburgh						
	34929447	THE ART INSTITUTE OF SEATTLE						

			FY18			FYTD19		
Institution Status	Facility Code	Institution	Tuition and Fees Paid	Yellow Ribbon Paid	Total Paid	Tuition and Fees Paid	Yellow Ribbon Paid	Total Paid
Approved	319M4543	The Art Inst of Dallas	$6,416,369.54	$552,712.58	$6,969,082.12	$5,704,202.08	$0.00	$5,704,202.08
	31017405	WESTERN STATE COLLEGE OF LAW AT ARGOSY UNIVERSITY				$56,311.88	$7,937.06	$64,248.94
	31020911	The Art Inst of Atlanta	$567,552.44	$23,093.29	$590,645.73	$8,279,358.94	$0.00	$8,279,358.94
	31039843	The Art Inst of Austin	$8,610,902.38	$432,479.83	$9,043,382.21	$8,679,344.91	$0.00	$8,679,344.91
	31040843	The Art Inst San Antonio	$2,790,135.62	$375,200.05	$3,165,335.67	$8,459,044.72	$0.00	$8,459,044.72
	31048943	The Art Inst of Houston	$1,471,199.89	$188,553.16	$1,659,753.05	$3,646,475.70	$0.00	$3,646,475.70
	31929246	The Art Inst of Virginia Beach	$835,127.56	$287,359.56	$1,122,487.12	$5,381,446.61	$4,112.30	$5,385,558.91
	31940113	School of the Art Inst of Chicago	$1,530,879.23	$246,396.22	$1,777,275.45	$485,344.82	$186,060.80	$671,405.62
	31971110	The Art Inst Tampa	$5,085,545.72	$319,045.86	$5,404,591.58	$6,029,889.56	$0.00	$6,029,889.56
Suspended	31904128	THE ART INSTITUTE OF LAS VEGAS	$1,996,289.52	$216,048.31	$2,212,337.83	$3,672,054.94	$0.00	$3,672,054.94
Withdrawn	21005103	ARGOSY UNIVERSITY-PHOENIX ONLINE DIVISION						
	21008742	ARGOSY UNIVERSITY-NASHVILLE	$1,627,793.36	$0.00	$1,627,793.36			
	21100238	ARGOSY UNIVERSITY-PHOENIX ONLINE DIVISION						
	21405247	ARGOSY UNIVERSITY-SEATTLE	$0.00	$0.00	$0.00			
	21802005	THE ART INSTITUTE OF CALIFORNIA-ARGOSY UNIVERSITY LOS ANGELES				$13,468.00	$0.00	$13,468.00
	21804405	THE ART INSTITUTE OF CALIFORNIA-ARGOSY UNIVERSITY-SILICON VALLEY						
	31001523	ARGOSY UNIVERSITY-TWIN CITIES	$1,757,681.72	$16,933.28	$1,774,615.00	$680,761.55	$0.00	$680,761.55
	31006603	ARGOSY UNIVERSITY	$1,503,012.45	$0.00	$1,503,012.45	$5,435,921.24	$0.00	$5,435,921.24
	31009142	ARGOSY UNIVERSITY-NASHVILLE	$2,954,099.14	$0.00	$2,954,099.14	$128,565.60	$0.00	$128,565.60
	31015106	ARGOSY UNIVERSITY-DENVER	$799,716.35	$18,186.41	$817,902.76	$69,519.15	$0.00	$69,519.15
	31016405	Argosy University-Organe CA	$1,011,281.95	$40,905.99	$1,052,187.94	$1,277,122.02	$1,155.09	$1,278,277.11
	31016505	ARGOSY UNIVERSITY-INLAND EMPIRE	$1,042,495.64	$15,578.64	$1,058,074.28	$83,508.30	$0.00	$83,508.30
	31016605	Argosy University San Francisco Bay Area-Alameda CA	$1,008,444.30	$31,541.01	$1,039,985.31	$13,804.80	$0.00	$13,804.80
	31016705	ARGOSY UNIVERSITY-SAN DIEGO	$1,758,453.51	$52,013.90	$1,810,467.41	$233,173.14	$0.00	$233,173.14
	31016805	Argosy University-Los Angeles CA	$1,403,323.08	$13,108.64	$1,416,431.72	$724,372.32	$0.00	$724,372.32
	31017005	The Art Inst of California San Diego	$3,763,313.71	$1,247,307.93	$5,010,621.64	$19,550,479.28	$6,288.48	$19,556,767.76
	31017205	THE ART INSTITUTE OF CALIFORNIA-INLAND EMPIRE - A CAMPUS OF ARGOSY UN	$65,985.48	$9,461.26	$75,446.74	$217,415.88	$0.00	$217,415.88
	31017705	The Art Institute of California-Hollywood CA	$87,542.00	$0.00	$87,542.00	$1,795,530.42	$0.00	$1,795,530.42
	31017805	THE ART INSTITUTE OF CALIFORNIA-ARGOSY UNIVERSITY ORANGE COUNTY	$0.00	$1,547.33	$1,547.33	$156,197.90	$0.00	$156,197.90
	31020811	Argosy University Atlanta	$339,539.86	$0.00	$339,539.86	$870,687.12	$0.00	$870,687.12
	31034343	Argosy University-Dallas TX	$9,180.00	$0.00	$9,180.00	$1,758.00	$0.00	$1,758.00
	31048813	ARGOSY UNIVERSITY-SCHAUMBURG	$9,044.00	$0.00	$9,044.00	$4,500.00	$0.00	$4,500.00
	31048913	ARGOSY UNIVERSITY-CHICAGO	$96,188.67	$0.00	$96,188.67	$159,009.49	$0.00	$159,009.49
	31057310	ARGOSY UNIVERSITY-SARASOTA	$246,879.52	$7,833.00	$254,712.52	$0.00	$0.00	$0.00
	31058510	Argosy University-Tampa FL	$1,691,448.48	$42,735.02	$1,734,183.50	$1,181,580.16	$4,127.94	$1,185,708.10
	31702364	Argosy University-Honolulu HI	$12,539,073.88	$242,058.19	$12,781,132.07	$7,551,283.59	$23,393.32	$7,574,676.91
	31702467	Argosy University-American Samoa	$828,017.27	$0.00	$828,017.27	$409,170.91	$0.00	$409,170.91
	31929346	Argosy University-Arlington VA	$63,815.90	$0.00	$63,815.90	$131,811.15	$0.00	$131,811.15
	31940844	Argosy University Salt Lake City-Draper UT	$18,738.50	$0.00	$18,738.50	$11,025.00	$0.00	$11,025.00
	34805538	The Art Inst of Pittsburgh Online	$4,567,264.86	$15,608.50	$4,582,873.36	$6,977,565.31	$0.00	$6,977,565.31
	34905438	The Art Inst of Pittsburgh	$46,752.00	$730.50	$47,482.50	$530,380.60	$0.00	$530,380.60
	34929447	THE ART INSTITUTE OF SEATTLE	$7,246,428.13	$869,853.76	$8,116,281.89	$9,700,729.25	$0.00	$9,700,729.25

Question 6g. Describe how VA coordinated with SAAs, the U.S. Department of Education, or the DCEH to inform GI Bill recipients of their transfer and/or discharge options.

Response. VA informed GI Bill beneficiaries of actions taken by the Department of Education and DCEH on three occasions through email and social media accounts. The GI Bill Restoration Team has reached out to impacted individuals by letter to notify them and provide information on their options moving forward.

Additionally, VA coordinated with SAAs by supplying all relevant information received from the accreditor, the Department of Education, and the school itself within three business days of receipt.

Question 7. In November 2016, the Consumer Financial Protection Bureau (CFPB) issued "A snapshot of servicemember complaints" noting that veterans had reported "being targeted with aggressive solicitations by lenders to refinance" their home loan using a Department of Veterans Affairs (VA) product. Veterans also reported that solicitations were "potentially misleading." One year later, the CFPB and VA issued a joint Warning Order about aggressive and potentially misleading advertising of VA home loan refinances.

Most recently, the VA published an advanced notice of proposed rulemaking (ANPR) and a subsequent interim final rule on cash-out refinances on VA loans, in compliance with Section 309 of Public Law 115–174, the Economic Growth, Regulatory Relief, and Consumer Protection Act. Both documents indicated that potential lender abuses remain a substantial problem. That ANPR stated that "perhaps more than 50 percent of [VA] cash-out refinances remain vulnerable to predatory terms and conditions" and that "some lenders are pressuring veterans to increase artificially their home loan amounts when refinancing, without regard to the long-term costs to the veteran and without adequately advising the veteran of the veteran's loss of home equity."

Question 7a. What tools does VA currently have to ensure that all VA lenders are in compliance with VA regulations and policies?

Response. VA conducts post audits of closed loans to ensure that lenders comply with regulations and policies. VA's loan system automatically identifies and selects loans to review based on specific selection criteria and/or on a random sample basis. If a loan goes into default within the first 6 months after loan closing, VA reviews 100 percent of these cases to ensure that the lender followed VA policies and procedures. VA field staff can also request loans to review from lenders if there is an identified issue to examine based on data or findings from previous loan reviews. VACO staff also analyze program data for anomalies to identify which lenders to review to ensure compliance with program requirements.

Additionally, VA conducts onsite operational audits of lenders to test compliance with applicable laws, regulations, policies, and procedures that have direct material impact on the VA home loan benefit. These operational audits consist of: Quality Control of loan underwriting and closing; the Lender Appraisal Processing Program; Early Claims Loans; and Declined Loan reviews.

Question 7b. Does the VA have the oversight and enforcement authorities and resources it needs to hold lenders accountable and ensure that veteran homeowners aren't subject to predatory refinances?

Response. VA's oversight and enforcement authority are limited. For example, 38 United States Code (U.S.C.) § 3702 provides that certain lenders have authority to close loans on an automatic basis. It also provides that VA may, with 30-days' notice, require such lenders to begin submitting their loan packages for prior approval. The authority does not, however, expressly provide VA's authority to establish consequences, such as suspension from the program, for lenders, holders, or servicers who engage in predatory lending practices or dubious marketing practices.

Section 3710(g) provides a framework for establishing civil penalties against lenders who violate VA's underwriting rules and loan processing standards. Yet the authority is not necessarily broad enough to include conduct that falls outside the analysis of individual loan packages. By taking an expansive approach to address "novel lending products" and misleading solicitations, VA is at risk of facing legal challenges that could easily be avoided with additional statutory clarification. Another example is 38 U.S.C. § 3703(c)(1), a provision on which VA relies heavily to regulate the guaranteed loan program. This provision requires that VA-guaranteed loans be payable upon such terms and conditions as may be agreed upon by the parties (i.e., the Veteran and the lender), subject to the provisions of chapter 37 of title 38, U.S.C., and regulations issued by the Secretary. Although the provision can be given a broad interpretation, VA believes that more affirmative authority to promulgate rules could be extremely helpful when facing litigation challenges.

Please note that most lenders and loan servicers complete VA mortgage transactions in a responsible manner and VA does not want to impede benefits delivery to Veterans. VA generally guarantees 25 percent of the loan to help entice lenders to offer Veterans favorable loan terms (including a no down-payment mortgage and low interest rates), as part of Veterans' earned benefit entitlement. VA relies on private sector lenders to provide the earned benefit to Veterans through delegated authority and want to ensure that Veterans can continue to enjoy access to mortgage credit, while also holding unscrupulous lenders and servicers accountable.

Question 8. In April 2017, VA issued guidance for affordable loan modifications for VA-guaranteed loans in Circular 26–17–10. The guidance in this circular replaced options available under the VA Home Affordable Modification Program with the VA Affordable Modification Program (VAAM). But the circular also rescinded the guidance effective April 1, 2019, and, to date, VA has not issued an updated circular regarding the rescission date, putting affordable modifications for veterans at risk.

Other Federal mortgage insuring and guaranteeing agencies have adopted similar loan modification programs that have been or are proposed to be made permanent. The Federal Housing Administration has created a permanent FHA Home Affordable Modification Program (FHA-HAMP) to provide affordable modifications, while the United States Department of Agriculture (USDA) has proposed a new modification program for single-family loans.

Question 8a. Does VA intend to continue VAAM on a temporary or permanent basis? If not, why not?

Response. Circular 26–17–10 will expire, but the VA Affordable Modification (VAAM) will continue as is. VA will continue VAAM on a permanent basis. VAAM has now been included as a loss mitigation option in the VA Servicer's Handbook (VA Manual 26–4, Chapter 5: https://www.benefits.va.gov/WARMS/M26-4.asp).

Question 8b. If VA does not intend to renew VAAM, will VA create a new modification program to prevent avoidable and costly foreclosures?

Response. Please see response to question 8a.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. RICHARD BLUMENTHAL TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. In December 2018, the OIG published an audit to determine if VA and State Approving Agencies (SAAs) were effective in their review of education programs where Post-9/11 GI Bill beneficiaries were enrolled.

Question 1a. What actions has VBA taken, in coordination with the SAAs, to implement the OIG's recommendations?

Response. VA implemented a workgroup consisting of VA and SAA staff. The workgroup has met in-person and by teleconference numerous times to develop draft recommendations that will allow for implementation of the recommendations. VA worked closely with SAAs and schools to ensure Recommendation 3 was remedied, and it has been closed.

Question 1b. Please provide an update on the status of implementation of each of the OIG's recommendations

Response. Please see the attached most recent VBA update memo.

Department of Veterans Affairs

Memorandum

Date: April 2, 2019

From: Under Secretary for Benefits (20)

Subj: OIG Status Update — VA's Oversight of State Approving Agency Program Monitoring for Post-9/11 GI Bill Students [Report No. 16-00862-179]—VIEWS 00051039

To: Director, Operations Division, Office of Management and Administration (53B)

1. Attached is VBA's update on the OIG Report: VA's Oversight of State Approving Agency Program Monitoring for Post-9/11 GI Bill Students.

2. Questions may be referred to Christine Ras, Program Analyst, at (202) 461-9057.

Paul R. Lawrence, Ph.D.

Attachments

Attachment

VA's Oversight of State Approving Agency Program Monitoring for Post-9/11 GI Bill Students Report No. 16-00862-179, Issued December 3, 2018	
Recommendation 1:	**The Under Secretary for Benefits negotiates an amendment to State Approving Agency contracts to clarify requirements for program approvals and require, subject to the availability of resources, quarterly samples and reviews and evaluations of supporting documentation for State Approving Agency approvals to ensure approved programs meet Title 38 of the United States Code requirements.**
OIG Comment:	See below.
VA Response:	VBA's 9/6/18 Reply to Updated Draft: Concur. VBA will work to negotiate an amendment to the fiscal year (FY) 2020 State Approving Agency (SAA) contracts to clarify requirements for approvals. Beginning on October 1, 2018 (FY 2019), VBA will also develop and implement a quarterly sample review and evaluations of supporting documentation for SAAs to ensure approved programs meet Title 38 of the United States Code requirements. Target Completion Date: October 1, 2019 OIG's 12/3/18 Final Report Comment: VBA acknowledged in its response that several areas in the SAA oversight and monitoring processes needed improvement and provided acceptable action plans for Recommendations 1, 2, and 3. VBA's 1/18/19 Update: Discussions between VA and the National Association of State Approving Agencies will begin in February 2019. The quarterly sample review of supporting documentation for SAAs is being developed during the second quarter of FY 2019. Target Completion Date: October 1, 2019 OIG's 3/4/19 Comment: Please ensure your response contains documentation to verify the completion of the stated actions below. VBA's Current Status: Discussions between VA and the National Association of State Approving Agencies (NASAA) have begun. NASAA representatives have been designated to work closely with the Education Service work group. This collaborative effort will result in changes to clarify program approval requirements. Also, a quarterly sample review of approvals, to include supporting documentation for SAAs, is currently under development. Target Completion Date: October 1, 2019
Supporting Documentation:	*(embed attachment(s) here)*
Status:	Implementation of this recommendation is still in progress.

Recommendation 2:	**The Under Secretary for Benefits negotiates amendments to State Approving Agency contracts that, subject to available resources, require the State Approving Agencies to periodically reapprove programs and evaluate program changes and other operational changes, such as advertisement practices, that may affect a program's continued eligibility and compliance with Title 38 of the United States Code.**
OIG Comment:	See below.
VA Response:	VBA's 9/6/18 Reply to Updated Draft: Concur. VBA will work to negotiate an amendment to the FY 2020 SAA contracts to require the SAAs to periodically re-approve programs and evaluate program changes and other operational changes, such as advertisement practices, that may affect a program's continued eligibility and compliance with Title 38 of the United States Code. Target Completion Date: October 1, 2019 OIG's 12/3/18 Final Report Comment: VBA acknowledged in its response that several areas in the SAA oversight and monitoring processes needed improvement and provided acceptable action plans for Recommendations 1, 2, and 3. VBA's 1/18/19 Update: Starting in February 2019, discussions will begin between VA and the National Association of State Approving Agencies. VBA will work to negotiate an amendment to the FY 2020 SAA contracts to require periodic re-approval of programs, including but not limited to advertising practices. Target Completion Date: October 1, 2019 OIG's 3/4/19 Comment: Please ensure your response contains documentation to verify the completion of the stated actions below. VBA's Current Status: VBA began identifying the necessary requirements related to the periodic review and re-approval of programs, to include evaluating program changes and other operational changes such as advertising practices, by the SAAs. Discussions with NASAA related to the requirements have begun. VBA will continue to work to negotiate an amendment to the VA/SAA cooperative agreement for FY 2020. Target Completion Date: October 1, 2019

Supporting Documentation:	*(embed attachment(s) here)*
Status:	Implementation of this recommendation is still in progress.

Recommendation 3:	**The Under Secretary for Benefits refers schools identified during the audit with potentially erroneous, deceptive, or misleading advertising practices to the Federal Trade Commission for it to decide whether any further reviews or actions are needed.**
OIG Comment:	See below.
VA Response:	VBA's 9/6/18 Reply to Updated Draft: Concur. VBA will consult with the Federal Trade Commission (FTC) regarding the schools identified in the report and the advisability of formal referral under VA's memorandum of agreement with FTC. Target Completion Date: December 31, 2018 OIG's 12/3/18 Final Report Comment: VBA acknowledged in its response that several areas in the SAA oversight and monitoring processes needed improvement and provided acceptable action plans for Recommendations 1, 2, and 3. VBA's 1/18/19 Update: The OIG report highlighted 10 cases of potential deceptive practices. VBA reviewed the findings and has determined that four of the institutions do not require further review due to previously completed actions by the institution, VA, SAA, or FTC. The remaining six cases are currently being reviewed by a VBA work group to determine if further action is required. Upon completion of the review, cases requiring further action will be forwarded as appropriate. Target completion date: April 30, 2019. OIG's 3/4/19 Comment: Please ensure your response contains documentation to verify the completion of the stated actions below. VBA's Current Status: The ten cases identified in the OIG report have been thoroughly reviewed and all issues have been resolved. Please refer to the attached documents for a detailed summary of each case. VBA requests closure of this recommendation.
Supporting Documentation:	 Rec. 3 Executive Summary.pdf  OIG Recommendation 3 D

Status:	We request closure of this recommendation based on the information provided above.

Recommendation 4:	**The Under Secretary for Benefits revises and strengthens compliance surveys to improve the assessment of program eligibility and compliance survey quality reviews to include the review of supporting documentation and an independent assessment of the quality of the completed compliance surveys.**
OIG Comment:	See below.
VA Response:	VBA's 9/6/18 Reply to Updated Draft: Concur. VBA will update the compliance survey checklist to include additional program approval criteria to assess program eligibility. Quality reviews will be conducted at a national level by the Education Service Quality Assurance Team. Reviews will be conducted on a quarterly basis from a national random sampling and will include a review of supporting documentation of completed compliance surveys. Target Completion Date: December 31, 2018 OIG's 12/3/18 Final Report Comment: VBA's action plans for Recommendations 4, 5, and 6-related to strengthening compliance surveys, providing supporting documentation and independent assessment of completed compliance surveys; adding quality assurance metrics to annual SAA performance reviews; and assessing and addressing SAA funding-were not fully responsive and did not fulfill the intent of the recommendations. VBA needs to provide stronger program oversight by developing a system of controls that ensures education and training programs comply with Title 38 requirements, reduces improper payments, and better protects taxpayers' and students' interests. VBA's 1/18/19 Update: VBA is developing revisions to the compliance surveys to strengthen and improve assessment of program eligibility. This cannot be implemented until the contract with the SAA's is negotiated. In addition, a national quality review of completed compliance surveys will be conducted by the Education Service Quality Assurance Team to independently assess the quality and strength of compliance surveys. An evaluation guide and scorecard are being developed by VBA for testing and implementation by the end of June 2019. Target Completion Date: July 1, 2019 OIG's 3/4/19 Comment: Please ensure your response contains documentation to verify the completion of the stated actions below.

	VBA's Current Status: VBA is in the final stages of revising the draft evaluation guide and scorecard as well as the revisions to the compliance surveys to strengthen and improve assessment of program eligibility. A national quality review of completed compliance surveys and approvals will be conducted by the Education Service Quality Assurance Team. The quality reviews cannot be fully implemented until changes to the VA/SAA cooperative agreement are negotiated. Based on negotiations with the SAA contracts, Education Service is revising its target completion date to October 1, 2019. Target Completion Date: October 1, 2019
Supporting Documentation:	*(embed attachment(s) here)*
Status:	Implementation of this recommendation is still in progress.

Recommendation 5:	**The Under Secretary for Benefits negotiates an amendment to the State Approving Agency contracts to establish quality assurance metrics and ensure the Veterans Benefits Administration collects and uses quality assurance data from its reviews of the State Approving Agencies' approvals, monitoring, and compliance surveys in its annual evaluations of the State Approving Agencies.**
OIG Comment:	See below.
VA Response:	VBA's 9/6/18 Reply to Updated Draft: Concur in principle. Quality assurance metrics are already included in the SAA contracts, both for approvals and compliance, and the results are used in the annual evaluations of the performance of the SAA. VA negotiated language prior to the FY 2018 contract year that required the SAA contracts to be 100 percent compliant with applicable statutes and regulations. In the FY 2018 SAA contract, VA included specific language relevant to accurate program approval. In addition, VBA performs quality checks on the compliance work of VBA Education Compliance Survey Specialists and SAAs. OIG states on page 27 of the draft report: "Under the terms of the SAA contracts, the SAAs are required to submit accurate approval packages to the ELRs, which include a: - Completed application, - Catalog, - Decision letter, - Inspection report for nonaccredited courses, and - Administrative forms. The ELRs use checklists developed by VBA's SAA contract management team, the chief education liaison officers, and ELRs to perform administrative quality reviews of the approval packages. The ELRs use the applicable checklists based on the type of program to ensure that all required VA forms have been submitted and are complete. They also verify that all applicable policies are in the school catalog, such as attendance standards, student conduct, and standards of progress." VA currently has extensive policy regarding the review of the performance of the SAAs and has the authority under Title 38 U.S.C. 3674A to evaluate performance and determine whether contracts should be offered based on this

	performance. VA has successfully utilized this statute and has determined not to contract with an SAA rated as unsatisfactory when acceptable, mitigating circumstances were not present. VBA requests closure of this recommendation. OIG's 12/3/18 Final Report Comment: VBA's action plans for Recommendations 4, 5, and 6-related to strengthening compliance surveys, providing supporting documentation and independent assessment of completed compliance surveys; adding quality assurance metrics to annual SAA performance reviews; and assessing and addressing SAA funding-were not fully responsive and did not fulfill the intent of the recommendations. VBA needs to provide stronger program oversight by developing a system of controls that ensures education and training programs comply with Title 38 requirements, reduces improper payments, and better protects taxpayers' and students' interests. VBA's 1/18/19 Update: This recommendation is under review by an Education Service work group. This work group was established to strengthen program oversight by developing a system of controls to ensure education and training programs comply with Title 38 requirements, reduce improper payments, and better protect taxpayers' and students' interests. Target Completion Date: October 1, 2019 OIG's 3/4/19 Comment: Please ensure your response contains documentation to verify the completion of the stated actions below. VBA's Current Status: This recommendation is still under review by an Education Service work group. This work group was established to strengthen program oversight by developing a system of controls to ensure education and training programs comply with Title 38 requirements, reduce improper payments, and better protect taxpayers' and students' interests. The work group is finalizing the quality assurance metrics data to include quality reviews in the approval process and compliance surveys conducted by the SAAs within the VA/SAA cooperative agreement for FY 2020. Currently, the VA/SAA cooperative agreement does not include such a
	quality assurance metric, and a change must be negotiated. The target completion date remains October 1, 2019.
Supporting Documentation:	*(embed attachment(s) here)*
Status:	Implementation of this recommendation is still in progress.

Recommendation 6:	**The Under Secretary for Benefits assesses whether funding for State Approving Agencies is sufficient to ensure the adequate review, approval, and monitoring of programs, in conjunction with the establishment of a contract to update the State Approving Agency funding allocation model.**
OIG Comment:	See below.
VA Response:	VBA's 9/6/18 Reply to Updated Draft: Concur in principle. This recommendation duplicates work already in progress. The Harry W. Colmery Veterans Educational Assistance Act of 2017, also known as the "Forever G.I. Bill," increased funding for FY 2018 to $21 million, and it will further increase to $23 million for FY 2019 while also adding an annual cost of living allowance. In addition, the act allows VA to add up to $3 million annually from discretionary funds beginning in FY 2019. Furthermore, section 311 requires the Government Accountability Office (GAO) to carry out a study that includes an analysis of SAA funding. This study is in progress and VA will review GAO's final report to determine if changes are needed in the amount and/or distribution of SAA funding. VBA requests closure of this recommendation. OIG's 12/3/18 Final Report Comment: VBA's action plans for Recommendations 4, 5, and 6-related to strengthening compliance surveys, providing supporting documentation and independent assessment of completed compliance surveys; adding quality assurance metrics to annual SAA performance reviews; and assessing and addressing SAA funding-were not fully responsive and did not fulfill the intent of the recommendations. VBA needs to provide stronger program oversight by developing a system of controls that ensures education and training programs comply with Title 38 requirements, reduces improper payments, and better protects taxpayers' and students' interests. VBA's 1/18/19 Update: This recommendation is under review by an Education Service work group. VBA is reviewing GAO's final report (GAO-19-3) to determine if changes are needed in the amount and/or distribution of SAA funding. Target Completion Date: October 1, 2019 OIG's 3/4/19 Comment: Please ensure your response contains documentation to verify the completion of the stated actions below.

	VBA's Current Status: VA has secured contractor support to assist in reviewing the current calculations and formulas associated with the SAA funding allocation model. This recommendation remains under review by an Education Service work group. Once the allocation model has been reviewed and revised, VBA will determine if adjustments in the distribution among the SAAs are warranted, and if the total amount available for SAA contracts in statute is adequate. Target Completion Date: October 1, 2019
Supporting Documentation:	*(embed attachment(s) here)*
Status:	Implementation of this recommendation is still in progress.

Question 2. Do you agree that VBA has an administrative and financial responsibility to protect students' and taxpayers' interests by monitoring the SAA's performance effectively?

Response. Yes, VA agrees it has an administrative and financial responsibility to protect students' and taxpayers' interests by monitoring the SAA's performance effectively. Additionally, VA has a statutory responsibility, per 38 U.S.C. § 3674A to monitor SAA performance. VA does so by ensuring the terms of the annual cooperative agreement are met through review of SAA approval packages, compliance survey findings, and other deliverables. Once reviewed, VA will assign an annual rating and ensure that any deficiencies are mitigated. If deficiencies are not adequately addressed, VA may decide not to enter into a future agreement with the SAA to perform the work outlined in chapter 36 of title 38, U.S.C.

Question 3. What steps has VBA taken to improve their quality reviews of SAA program and modification approvals, as well as their evaluation of SAA decisions regarding a programs' eligibility and compliance with Federal laws?

Response. VA formed a workgroup consisting of VA and SAA staff that is drafting recommendations to ensure that quality reviews are performed on program approvals and compliance surveys. The compliance survey quality reviews are set to begin this month (April 2019). Additionally, VA is reviewing approval data to develop requirements of the documentation that SAAs will need to provide VA to substantiate that all approval requirements are met. This will be negotiated for inclusion in the FY 2020 SAA/VA agreement.

Question 4. What changes has VBA made to its compliance survey process since December 2018 to ensure programs are meeting the conditions necessary for approval?

Response. VA is in the final stages of revising compliance surveys to strengthen and improve assessment of program approval requirements. The revisions cannot be fully implemented until modifications to the VA/SAA cooperative agreement are negotiated. The target date for completion is October 1, 2019.

Question 5. Does the VA's budget request for FY 2020 account for improving VBA's oversight of SAA reviews of Post-9/11 GI Bill benefits?

Response. VA is working to improve and increase oversight of SAAs utilizing existing resources in the FY 2020 budget.

Question 6. Has VA awarded a Software Development and System Integration (SISD) contract?

Response. VA is committed to implementing sections 107 and 501 of the Colmery Act by December 2019. To that end, VA awarded a Software Development and Systems Integration contract to Accenture Federal Services (AFS) February 15, 2019. AFS will be responsible for delivering a complete IT solution to support sections 107 and 501.

Question 7. How can you ensure that IT modernization efforts in Education Services won't be sidelined by other IT projects, such as the Electronic Health Records Modernization?

Response. Modernization of Education Services efforts have their own dedicated resources and funding. IT architecture of Education systems is segmented and separate from the other IT efforts to minimize impact by other IT priorities. The efforts supporting modernization of Education IT solutions have regular and direct engagement with OIT senior leadership to ensure any conflicts are resolved.

Question 8. Is it correct to assume that all veterans who were underpaid have now been reimbursed? If not, about how many veterans are awaiting reimbursement?

Response. On December 8, 2018, VA installed the 2018 uncapped monthly housing allowance rates. All impacted students were updated to the correct MHA rate and if underpaid received a payment for the difference. Veterans who were overpaid were not held liable for any debts. Until the IT solution is in place on December 1, 2019, VA will pay students the current year uncapped rate. Upon implementation the IT solution will allow schools to accurately report all campus locations s where their students are attending the majority of their classes, so VA can process housing payments in accordance with sections 107 and 501

Question 9. Is VA on track to meet the May 31, 2019 deadline?

Response. VA is on track to meet the December 2019 deadline set by the Secretary in his November 29, 2018, announcement resetting the implementation of sections 107 and 501 of the Colmery Act.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MAZIE K. HIRONO TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. The Maui Minor Replacement CBOC project has been in progress for several years. The State Department of Education has offered land for the project and the Department of Veterans Affairs (VA) Central Office approved the land. My office was notified that a Memorandum of Understanding (MOU) would be executed in the second quarter of Fiscal Year 2019.

Question 1a. Has this MOU been completed?

Response. The draft Memorandum of Agreement (MOA) between the Veterans Affairs Pacific Island Health Care System (VAPIHCS) and the State of Hawaii Department of Education (HIDOE) was drafted and published for review by each of these agencies on August 30, 2018. There have been several reviews with key staff at various levels and with corporation consuls requesting clarifying points of interests that have been responded to over the course of the last 7 months. In the last month, HIDOE completed a final review with the State Attorney General's office in preparation for the final MOA sign off and to present to the State Board of Land and Natural Resources to consummate the property extended land lease.

Question 1b. If not, can you please explain the delay?

Response. Part of this delay can be attributed to the fact that this extended property land lease between the State and VAPIHCS is precedent setting. Dubbed "the Maui Doctrine," Federal funds and ultimately a permanent Federal facility will be designed, planned, constructed, and operated on State land and not Federal or purchased land owned by VAPIHCS. Legal sufficiency has been provided by VACO along with the State of Hawaii's respective legal counsels since both Federal (Maui Community Outpatient Clinic and Maui Vets Center) and state entities (Maui Office of Veterans Services) will be operating under the same roof. This MOA sets forth a structure in which both parties will work in a mutually beneficial manner to advance an educational and academic program with the purpose of providing voluntary internships and training primarily in health care disciplines to students at Maui High School. HIDOE, Maui High School, and VAPIHCS will have a shared responsibility for the academic enterprise.

Question 2. Compared to their nonveteran peers, women veterans have a higher rate of suicide than men. This difference in suicide rates suggests that strategies for preventing suicide among women veterans need to include consideration of gender-based risk factors.

Question 2a. Do you think that VA's suicide prevention and mental health efforts are adequately tailored to reach and treat women veterans?

Response. VA recognizes the urgent need to address the increasing rates of suicide among women Veterans and is committed to ensuring that appropriate services are available to meet the treatment needs of women Veterans who may be at risk for suicide. The Office of Mental Health and Suicide Prevention (OMHSP) has focused on developing trainings in gender-sensitive mental health approaches and implemented multiple initiatives to bolster mental health services for women Veterans, including those at risk for suicide.

Examples of innovative clinical training initiatives:

- The Women's Mental Health Mini-Residency is a 3-day training that covers a broad range of topics related to the treatment of women Veterans, such as understanding suicide risks in female patients and working with women whose mental health problems are influenced by hormonal changes.

• The STAIR (Skills Training in Affective and Interpersonal Regulation) training teaches clinicians to deliver a trauma treatment that focuses on strengthening emotion regulation and relationship skills. These areas of functioning are often disrupted in women who have experienced severe interpersonal traumas, such as sexual assault. Research suggests that emotion dysregulation is associated with suicidal ideation and behaviors.
• Parenting STAIR training teaches therapists to deliver a component of the STAIR treatment that is designed to help Veterans who have persistent trauma-related reactions that negatively impact their parenting and parent-child relationships.
• The Multidisciplinary Eating Disorder Treatment Team training aligns with the Joint Commission's rigorous standards for the outpatient treatment of eating disorders. Eating disorders are associated with increased risk for suicide attempts and death by suicide.
• The National Women's Mental Health Monthly Teleconference Series is a monthly clinical training designed to enhance knowledge of gender-tailored treatment approaches, including prescribing practices. Physiological changes across women's reproductive lifecycles can affect her mental health and suicide risk. For example, women who have premenstrual dysphoric disorder (PMDD) have a greater likelihood of having suicidal thoughts, plans, and attempts. Treating PMDD is different than treating depression. Only some antidepressants are effective for PMDD, and dosing only during the luteal phase (2nd half, after ovulation) of the menstrual cycle is effective. Proper recognition, diagnosis, and treatment of PMDD can substantially reduce suicide risk for this subset of women Veterans.

Examples of clinical programs and resources to enhance services for women Veterans:

• Studies have shown links between MST (Military Sexual Trauma) and suicidal ideation, suicide attempts, and death by suicide. VA's universal screening program, in which every Veteran seen for health care is asked about experiences of MST, is an important way of identifying individuals potentially at increased risk for suicide. VA's specialized MST-related services are key means of preventing suicide among at-risk women Veterans who have experienced MST.
• VA offers a continuum of care and a national network of Women's Mental Health Champions who disseminate information, facilitate consultations, and develop local resources.
• Specialty care programs target problems such as PTSD, substance use, depression, and MST—each of which has been associated with heightened suicide risk. Evidence-based therapies for conditions such as PTSD, including Prolonged Exposure and Cognitive Processing Therapy, have been shown to decrease suicidal ideation and are available at every VAMC.
• Additional VA suicide prevention and mental health resources for women Veterans include 24/7/365 immediate crisis intervention and support through the Veterans Crisis Line and Suicide Prevention Coordinators located at every VA facility and large community-based outpatient clinics.

Question 2b. Are you at all concerned the reported harassment and a sexist culture at VA is indirectly contributing to the elevated suicide risk by discouraging women veterans from seeking care?

Response. VA strives to create an environment in which all Veterans feel welcome and safe. VA also recognizes that harassment and sexism occur and can be disruptive to Veterans' access to care and overall patient experience.

As VA continues to promote respect for women Veterans, it has expanded efforts to address forms of harassment, including sexual harassment (e.g., lewd comments or gestures) and gender harassment (e.g., sexist remarks, being dismissive of a woman's military service). VA launched an End Harassment program at every medical center in the summer of 2017. This large-scale effort is designed to increased awareness, disseminate education, improve reporting, and promote a culture of accountability throughout VA. As part of this campaign, VA have launched messaging such as "it's not a compliment, it's harassment" directed primarily at educating male Veterans that these actions are harmful and unacceptable. Employees have received training to increase sensitivity to this issue and to ensure that any VA employee who witnesses harassment knows how to effectively intervene and respond. Culture change efforts continue as VA develops updated resources, training, and associated messaging.

VA also continues to develop initiatives and strategies to facilitate women Veterans' access to gender-sensitive mental health care. Resources are now in place to improve women Veterans' ease and comfort navigating the health care system, and confidence in the competency of VA providers to address their specific needs. For

example, VA has recently established a national infrastructure of Women's Mental Health Champions who serve as a local point of contact for Women's Mental Health within each VA health care system. Champions disseminate information, facilitate consultations, and develop local resources in support of gender-sensitive mental health care. Every VA health care system also has a designated MST Coordinator who serves as the local point person for MST-related issues. Additionally, as detailed in response to Question 2a, extensive clinical training initiatives are in place to ensure that VA mental health providers have the expertise and specific competencies to address women Veterans' treatment needs.

Question 3. VA's Medical and Prosthetic Research helps improve veterans' health care by focusing on veteran-unique conditions. This research is especially vital to understand new and emerging issues and to assess how to care for a diversifying veteran population. Due to inflation, funding for VA research would need to be increased by $22 million over the 2019 baseline just to maintain current research levels. However, instead of investing in VA's research capacity, the President's Budget proposes a $17 million decrease in funding.

What areas of research is VA going to scale back to accommodate this decrease in funding? Please provide a justification for those decisions.

Response. The FY 2019 appropriation included a one-time addition of $27 million for collaboration with DOE on a big data science initiative and high capability computing. The $27 million provided for the DOE collaboration was provided to cover a 5-year period of availability through FY 2023. The remainder of the request for research in FY 2019 was $752 million (total $779 million). For FY 2020, VA requests to grow support for all other initiatives from $752 million to $762 million. That $10 million growth represents an overall program growth of 2 percent.

Question 4. Over three weeks ago I signed a letter with twelve of my colleagues to the Department of Education regarding the sudden closure of Argosy University that has affected an estimated 18,000 students nationwide—including 800 students in Hawaii, some of whom are veterans. In the letter we urged the Department of Education to work with the VA "to ensure that accurate information is being provided to GI Bill beneficiaries regarding students' remaining benefits, including housing, and their options to have their benefits restored" before the school closed.

Question 4a. In the wake of Argosy's collapse, has the Department of Education taken any steps to coordinate with the VA on this issue?

Response. The Department of Education has coordinated with VA on its actions via teleconference, as well as updates to its Federal Student Aid (FSA) Web site located here: https://studentaid.ed.gov/sa/about/announcements/dream-center#motion-for-closure.

Question 4b. If so, then can you elaborate on how the Departments have coordinated?

Response. VA was invited to multiple teleconferences and received numerous emails outlining the steps that the Department of Education has and is taking regarding Argosy University. VA has taken steps to inform students via social media and through the GI Bill Comparison Tool as new information has been shared.

Question 4c. If not, how does VA plan to make sure that student veterans affected by Argosy's closure in Hawaii and elsewhere have the resources they need?

Response. As stated in the previous responses, VA is working closely with the Department of Education to provide information and assistance to GI Bill beneficiaries. In addition, the 5-day letter that VA sent to students upon notice that an institution has closed also provides contact information and resources.

Question 5. Generally speaking what resources does the VA make available for student veterans affected by school closures?

Response. VA has the authority, provided by section 109 of the Harry W. Colmery Veterans Educational Assistance Act of 2017, to restore entitlement to qualifying beneficiaries. The specific details and process for entitlement restoration due to school closures can be found online at https://www.benefits.va.gov/gibill/fgib/restoration.asp.

VA provides the following information in its letters to students:

Where Can I Find More Help

- If you feel you qualify for entitlement restoration please complete and return the Entitlement Restoration enclosure, which can be found at (https://www.benefits.va.gov/GIBILL/docs/EntitlmentRestoration.pdf).
- VA's GI Bill Comparison Tool (https://www.vets.gov/gi-bill-comparison-tool) can help you review and compare alternative schools.
- Student Veterans of America (http://studentveterans.org/) has a network of over 1,400 student chapters at colleges and universities and their staff can provide answers to your questions.
- Reach out to Veterans of Foreign Wars (https://www.vfw.org). They offer emergency assistance grants to students affected by school closures.
- Free lawyers and advice are available for students from Veterans Education Success. Visit their website at http://veteranseducationsuccess.org/ or email directly, help@VeteransEducationSuccess.org.
- The Department of Education has a page dedicated to school closures. Visit https://studentaid.ed.gov/sa/about/announcements/closed-school for more information.
- The American Legion (https://www.legion.org/serviceofficers) has service officers in every state that can provide answers to questions about education benefits, federal student loans and credit transferability.
- The State Approving Agencies (http://nasaa-vetseducation.com/Contacts.aspx) are working with schools to identify those that will accept transfers.

Question 6. I have received information that the VA has updated its online tools and resources and notified student veterans who were affected.

Question 6a. Can you provide further information about what steps the Department has taken?

Response. VA has ensured restoration information on the GI Bill Web site was up to date: https://www.benefits.va.gov/gibill/fgib/restoration.asp. Additionally, VA posted announcements and regular updates to the GI Bill Web site—https://www.benefits.va.gov/GIBILL/news.asp—and the GI Bill Facebook page—https://www.facebook.com/gibillEducation/.

Question 7. I have also received information that the VA has identified 716 GI Bill beneficiaries who were attending schools that closed.

Question 7a. Is this number still accurate, or have more beneficiaries been identified?

Response. The identification of "716 students" corresponds to the Department of Education's notification revoking Argosy University's approval for Federal Student Aid, on February 27, 2019, and that number did not include VA students enrolled at the Art Institute campuses that also subsequently closed. The number of impacted students identified following the closure of the Argosy University and Art Institute campuses, on March 8, 2019, is 1,782, which includes the 716 individuals identified previously.

Question 7b. If more have been identified, which campuses did they attend and in which states?

Response. As indicated in our previous response, 1,782 students were identified after the schools closed. Please see accompanying pdf document below for campus and state information.

Argosy University/Dream Center Closures

Institution	City	State	Number of Students
Argosy University – American Samoa	Pago Pago	AS	40
Argosy University - Phoenix ATS Chandler	Chandler	AZ	0
Argosy University - Phoenix	Phoenix	AZ	285
Argosy University - San Francisco Bay Area	Alameda	CA	4
Argosy University – Orange CA	Orange	CA	46
Argosy University - The Art Institute of California - Hollywood	North Hollywood	CA	140
Argosy University - Ai Hollywood (The Shed)	North Hollywood	CA	0
Argosy University - Los Angeles	Los Angeles	CA	31
Argosy University - The Art Institute of California - San Diego	San Diego	CA	275
Argosy University - Tampa	Tampa	FL	76
Argosy University - Atlanta	Atlanta	GA	72
Argosy University - Clay National Guard Center	Marietta	GA	0
Argosy University - Hilo Campus	Hilo	HI	0
Argosy University - Hawaii	Honolulu	HI	194
Argosy University - Maui Campus	Wailuku	HI	0
Argosy University - Chicago	Chicago	IL	19
Argosy University - Twin Cities	Eagan	MN	30
The Art Institute of Pittsburgh	Pittsburgh	PA	20
The Art Institute of Pittsburgh -Online Division	Pittsburgh	PA	363
Argosy University - Dallas	Dallas	TX	4
Argosy University - Salt Lake City	Draper	UT	4
Argosy University - UT National Guard Base, SLC	Salt Lake City	UT	0
Argosy University - Washington D.C. Area	Arlington	VA	32
Argosy University - Seattle	Seattle	WA	0
The Art Institute of Seattle	Seattle	WA	147
Total			**1,782**

Question 8. I have received information that the VA has been coordinating with state approving agencies. What kind of coordination, if any, has there been with the state approving agency in Hawaii?

Response. VA does not have a signed cooperative agreement with the state of Hawaii and, therefore, VA is acting as the SAA for that state. VA has taken withdrawal actions as necessary for the state of Hawaii and Veterans in that state have been provided all relevant information.

Question 9. Last Congress this Committee worked to pass the Forever GI Bill, which expanded access to educational opportunities for student veterans, servicemembers, families, and survivors, and changed how housing allowances are calculated for these students. However, we have seen challenges to implementation, which have resulted in students receiving inaccurate or delayed payments. The Department's Inspector General recently concluded that even as VA missed implementation deadlines there was no accountable official overseeing these changes.

Question 9a. Since these challenges have been identified, what steps has the VA taken to notify students who were affected, and what resources has VA provided for these students?

Response. Immediately following the Secretary's November 2018 announcement on resetting implementation, VA notified schools, Veterans Service Organizations, and other stakeholders on its efforts moving forward. This included an email notification to almost one million GI Bill beneficiaries on November 28, 2018 and December 4, 2018 and multiple social media posts. VA also held seven online webinars for Veterans throughout December 2018 and January 2019 to provide additional details and resources.

Question 9b. What more does VA plan to do to address this issue for students going forward?

Response. VA will continue to regularly update students through social media, targeted email notifications, and webinars regarding the implementation of sections 107 and 501. In April 2019, VA began to host a series of Roundtable Discussions with schools and stakeholders on implementation and will follow these sessions with updates on its Web site and social media.

Question 10. The VA Office of Health Equity was established in 2012 to advance health equity and reduce health disparities for disadvantaged veterans. Part of the goal when establishing the office was to conceptualize and release a blueprint for achieving these ends, which it did with the March 2016 release of the VHA Health Equity Action Plan (HEAP).

Question 10a. Since the introduction of HEAP, has the VA achieved any of the deliverables outlined in the plan?

Response. The HEAP describes many activities that the Office of Health Equity should do on an ongoing basis and a few activities that have discrete deliverables. In general, the Office of Health Equity is involved with most of the indicated ongoing activities and has produced many of the specific deliverables.

Question 10b. If so, which?

Response. The HEAP is organized around 5 focus areas: Awareness, Leadership, Health system and life experience, Cultural and linguistic competency, and Data, research, and evaluation.

Awareness: As planned in the HEAP, the Office of Health Equity leads a Health Equity Coalition, has developed many partnerships for implementing the HEAP, and presents data on disparities (monthly fact sheets and quarterly cyber seminars). Specific goals to develop a communication plan and initiate 5 partnerships and 2 projects have been completed.

Leadership: As planned in the HEAP, the Office of Health Equity reviews all VHA policies and directives, promotes a culture of dialog about equity, coordinates resources to support the HEAP, and directly funds health equity projects. Specific goals to include Health Equity Coalition members on the National Leadership Council and support VAMCs to participate in Health Equity Impact assessments have been achieved.

Health system and life experience: As planned in the HEAP, the Office of Health Equity tracks many measures of access and quality, identifies disparities, supports interventions to reduce disparities, and promotes understanding of Veterans' life experiences, decisionmaking, and social determinants of health. Specific goals to report on and disseminate findings on disparities have been completed.

Cultural and linguistic competency: As planned in the HEAP, the Office of Health Equity shares information and supports training on cultural competency, unconscious bias, and Culturally and Linguistically Appropriate Services (CLAS). Specific goals to support rollout of the VA Talent Management System's Cultural Competency Module and Clinical Look at Unconscious Bias training have been completed.

Data, research, and evaluation: As planned in the HEAP, the Office of Health Equity monitors and tracks disparities, fills information gaps on disparities, promotes data sharing, and develops tools and dashboards to increase equity. Specific goals to develop standards for disparities reporting and to report on disparities among Veterans have been achieved in the first National Veteran Health Equity Report.

Question 11. The majority of the deliverables in HEAP rely on an understanding of what populations are experiencing disparities, yet the most recently available data outlining race/ethnicity, gender, age, geography, and mental health status among veterans receiving care is from 2013.

Response. The 2013 data are the most recent VHA data that the Office of Health Equity has reported to the public. Within VHA, working with VHA Central Office, VISN, and VAMC partners to reduce disparities, much more recent data are used. A second National Veteran Health Equity Report is planned for release in 2019 and will report on 2017 data.

Question 11a. How does the Department intend to address disparities in health care provision and outcomes without understanding what disparities actually exist?

Response. Identifying disparities in health care provision and outcomes is at the core of efficient quality improvement. The Office of Health Equity is working with VHA Central Office, VISN, and VAMC partners to develop an Equity Guided Improvement Strategy (EGIS) that identifies measures and populations with the largest quality deficits and thereby allows facilities to target quality improvement toward these specific Veteran groups with specific conditions. EGIS also allows the application of optimal interventions for these specific Veteran groups with specific conditions.

Question 11b. Do you believe that the Office of Health Equity can credibly fulfill their mission without updated, relevant data?

Response. Yes, the Office of Health Equity is fulfilling its mission because we currently have access to updated, relevant data that allows identification of disparities in health care processes and outcomes for many Veteran groups. For some Veteran groups, such as Lesbian, Gay, Bisexual and Transgender (LGBT) and disabled Veterans, systematic identification is limited in VHA data. The Office of Health Equity is involved in activities to improve data on these groups through use of and data linkage with non-VHA data.

Question 11c. If not, please provide a plan for updating the data.

Response. As VHA modernizes to the new EHR system, the Office of Health Equity will work to ensure that data needed to identify disparities for different Veteran groups is available.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOE MANCHIN III TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. Secretary Wilkie, in your testimony we discussed my concern with investment in infrastructure and construction projects, especially in rural States like West Virginia. I used the Rural Mobile Unit (RMU) in Clarksburg as an example. According to our recent RFI, a replacement RMU is the only true long term solution costing $600k.

Question 1a. This RMU is the only VA facility for many of our rural Veterans. Will you make this RMU replacement a priority in your 2020 budget?

Response. The Office of Rural Health (ORH) does not currently have an enterprise wide funding program for Rural Mobile Units (RMU). ORH ceased funding RMUs in 2014 after VHA suspended mobile medical unit acquisitions in the wake of an unfavorable audit by the VA Office of the Inspector General (VAOIG–13–03213–152). Although the suspension has since been lifted, ORH's FY 2020 funding is completely committed to other programs. However, we will revisit the funding opportunities for RMUs in FY 2021.

Question 2. I'm concerned that as we are investing in community care, we will leave rural facilities in WV behind.

Question 2a. What are you doing to decrease the project backlog and making sure that our VA facilities in rural communities are not waiting in a never-ending list of projects?

Response. In order to be fair, equitable, and transparent, VISN 5 takes a multifaceted approach to the distribution of construction funding each fiscal year:

- High Cost High Tech (HCHT) equipment funding and procurement are often on rigid timelines. This equipment has a direct impact on patient care and access. As such, the HCHT equipment site prep projects are funded off the top of the VISN construction allocation.
- Each facility in VISN 5 submits business cases for their top five projects each fiscal year. Each facility then scores the other facility business cases against a list of criteria. This yields a prioritized list of all the VISN–5 projects submitted. Those projects that fall above the cumulative budget line get funded that fiscal year; the others are subject to the availability of funding. This process is transparent and gains the consensus of all the facilities.
- A portion of the overall construction appropriation is distributed to each facility for station level projects. The distribution is prorated, based on each facility's Facility Condition Assessment (FCA) backlog. Each facility determines how the station level funds are spent, based on locally identified priorities.

Each facility in VISN 5 gets their HCHT site prep funded, each facility gets a fair shot at getting their top 5 projects funded, and each facility receives an allowance to spend at their discretion on local priorities.

Question 3. As of today, there were 138 open positions posted on USAJOBS for the VA in West Virginia. Our CBOC in Petersburg especially is having a hard time recruiting and retaining staff.

Question 3a. Do you have some type of vacancy action plan for rural communities who have a hard time competing with neighboring States?

Response. VA implements targeted solution-driven approaches to increase the overall care to 2.8 million Veterans living in rural communities who rely on VA health care. VA remains fully engaged in a fiercely competitive clinical recruitment market and has employed a multi-faceted strategy to attract qualified candidates for rural facilities including the following:

- Expanding the ability of all clinicians to practice at the full extent of their licenses;
- Increased maximum physician salaries;
- Utilization of recruitment/relocation and retention (3R) incentives and the Education Debt Reduction Program (EDRP);
- Targeted Nation-wide recruitment advertising and marketing;
- Expanding opportunities for telemedicine providers;
- DOD/VA effort to recruit transitioning Servicemembers; and
- Exhibiting regularly at key health care conference and job fairs.

Question 4. Mr. Secretary, you know that the opioid epidemic is my number one issue. The VHA in WV is treating over 1,300 Veterans for opioid use disorder I want assurances that when Veterans go outside of the VA under these new access standards, we have rock-solid agreements and oversight with non-VA care providers that ensures over-prescription of opioids will not occur. I know we have the formulary and other safeguards to prevent against abuse now.

Are there ways that we can improve these safeguards and coordination given your commitment to increased access to care in the community?

Response. Section 131 of the VA MISSION Act requires VA to ensure that all community providers are furnished a copy of and certify that they have reviewed the evidence-based guidelines for prescribing opioids set forth by VA's Opioid Safety Initiative. It further requires VA to implement a process to ensure that VA submits to community providers the available and relevant medical history of the Veteran and a list of all medications prescribed to the Veteran as known by VA. Community providers must submit medical records, including records of any opioid prescriptions to VA in the timeframe and format specified by VA. VA must report annually on the compliance of covered health care providers with the requirements of this section. If VA determines that the opioid prescribing practices of a community provider, when treating covered Veterans, meet certain conditions, VA must take appropriate action to ensure the safety of all Veterans receiving care from the provider. Finally, VA must ensure any network contracts include language authorizing the contractors to take similarly appropriate action. All Community care providers will follow the same opioid prescribing practices as VA providers.

Question 5. With respect to the access standards and community care. My biggest concern is that the VA is not adequately preparing communities for these new access standards.

Question 5a. What are you doing to investigate whether communities, especially rural communities like in my State, are prepared for more Veterans coming to them from the VA?

Response. Providers joining the Community Care Network (CCN) are required to take training in the unique needs and cultural aspects of the Veteran population. Additionally, VHA works closely with CCN Third Party Administrators (TPA) to assist them in understanding the network adequacy requirements and how that applies to the Veteran population. Part of evaluating network adequacy includes factoring in an equitable allotment of Veteran patients into the community provider's practice. This is done through close collaboration with the TPA and utilizing both internal metrics as well as industry standard calculations.

For both Primary Care and Mental Health there are many sites that are presently meeting wait time standards. These sites will be able to retain Veterans and not need to send them to the community for care. VA's goal is to achieve and sustain 100 percent in both categories.

See data summary below.

As of 4/23/19	% of sites with less than 20 days avg. wait for new patients
MH	98.58%

As of 4/23/19	% of sites with less than 20 days avg. wait for new patients
PC	57.5%

VA continues to work to strengthen direct care delivery. The Office of Veterans Access to Care is partnering with several VHA program offices to lead the ICEP initiative. This includes facilities in rural sites. The main goals of ICEP are the following:

- Ensure accuracy of labor mapping, person class code, and Primary Care Management Module data;
- Ensure sustainment plan for maintaining continued accuracy for the data in sub-bullet one;
- Balance supply and demand by using present resources and full care teams more efficiently by maximizing individual providers capacity for direct patient care; and
- Partner with workforce development to hire additional staff where applicable.

MISSION Act section 401 also helps to prepare facilities for access standards:

- Section 401 of the MISSION Act requires VA to identify and develop plans to address underserved facilities. Some of the facilities VA identified as underserved are rural facilities. In collaboration with VISN Directors, VA is developing a program leveraging system-wide resources to support improvement in facilities designated as underserved.
- Some of these resources particularly used in rural facilities include maximizing hiring incentives to attract and retain providers to these areas by offering the following:
  - Recruitment, Retention, and Relocation awards;
  - Education Debt Reduction Program offering student loan reimbursement to employees with qualifying loans;
  - Compressed/flexible work schedules; and
  - Retirement waivers that offset the required salary offset to reemploy retired staff members on a temporary basis.
- Difficulties hiring providers in rural areas are also addressed by the following:
  - Maximizing current resources and capacity;
  - Leveraging interagency relationships;
  - Using Mobile Medical Units;
  - Offering training opportunities such as the national consultative program, academic detailing programs, as well as continuing education opportunities and scholarship programs; and
  - Using direct hiring authority.
- Additionally, many rural facilities identified as underserved leverage technology and telehealth strategies such as the following:
  - Increasing the use of VA Video Connect;
  - Establishing/expanding Clinical Resource Hubs;
  - Using Store and Forward Telehealth where clinical health data is retrieved by a VA provider at another VA location for clinical evaluation and follow up; and
  - Establishing/expanding ATLAS (Advancing Telehealth through Local Access Stations).

Additionally, VA is enhancing Same Day Primary Care and Mental Health services and leveraging virtual care modalities to provide Veterans convenience while increasing access. Proposed budgets in FY 2020 and FY 2021 further support the Clinical Contact Centers for virtual care. Currently, nearly half of all VISNs have licensed independent practitioners, expanding access to care by addressing patient needs via telephone or video appointment. These services are especially useful for Veterans in rural communities.

Question 5b. Will you be communicating to Veterans if you deem certain communities unprepared to accept Veterans as patients?

Response. At the time of scheduling, if a community provider is unable to accept Veterans within the metrics defined by the CCN contract, the Veteran is given the opportunity to select another provider. The inability for a provider to accept a patient within the metrics negatively impacts the third-party administrator's (TPA) performance and is reflected in a percentage decrease in payment to the TPA. Network adequacy is monitored monthly to identify gaps. When gaps are identified, the

TPA is required to submit a plan outlining how they intend to resolve the issue and bring the network into compliance.

Question 6. I applaud the VA for investing in alternative pain management prevention programs, such as acupuncture, chiropractic services, Tai Chi, and Yoga. In West Virginia, these programs are growing in demand but don't seem to be widely implemented at all the VAMCs.

Question 6a. What are your plans for growing these potentially life-saving programs so all Veterans have access to them?

Response. As a preliminary point of clarification, we generally now use the terms "complementary" or "integrative" to describe this category of therapies rather than "alternative." This is to make completely clear that we do not endorse using these therapies to the exclusion of evidence-based conventional approaches, but rather in addition to and in support of these.[1]

VHA requires that all VA facilities have at least one evidence-based psychological/behavioral therapy available at the facility as part of the integrated and interdisciplinary pain management teams at each facility. This mandate was established as part of VA's implementation of CARA. The teams also include access to physical medicine and rehabilitation providers and integrated access to assessment of opioid use disorder, if clinically indicated with access to providers skilled in addiction medicine who provide evidence-based treatment.

Substantial progress has been made in building infrastructure to support increased access to Complementary and Integrative Health (CIH) services for Veterans with pain and other conditions. On May 19, 2017, VHA Directive 1137 "Provision of Complementary and Integrative Health" was approved, establishing internal policy regarding the provision of CIH approaches. The current list of approved CIH approaches covered by the Veterans Medical Benefits package includes acupuncture, meditation, yoga, tai chi/qi gong, biofeedback, hypnosis, guided imagery, and massage as covered benefits if appropriate as part of the Veterans care plan. Chiropractic care was previously approved for use at VA in 2004 so was not included in this list but its use across VA continues to increase. Chiropractic care has been shown to correlate with decreased opioid use in Veteran and general populations, and currently over 110 VA facilities operate on-station chiropractic clinics.

The availability of CIH approaches in VA has also continued to grow as the infrastructure (including policy, qualifications standards, tracking/coding/billing mechanisms, position descriptions, etc.) has been developed to support the ability to deliver, manage, and track these services. Most notable is the recently approved qualification standard for massage therapists, which will allow licensed and certified massage therapists to be hired across VHA for the first time, and a qualification standard for licensed acupuncturist which was approved in February 2018 and which will greatly improve in-house delivery of acupuncture. In FY 2018 there were 181,961 total acupuncture encounters (a 20 percent increase from FY 2017) and 131,547 unique Veterans receiving acupuncture (a 60 percent increase from FY 2017) across the enterprise.

In addition, VHA has trained over 2,400 battlefield acupuncture (BFA) providers and has 78 active BFA instructors. BFA is a limited acupuncture protocol applied just to the ears designed to relieve acute and chronic pain. Standards have also been developed for facilities to use in identifying staff properly trained to deliver each of the CIH approaches, and CIH Skills Training programs are being developed to increase capacity of VA staff to deliver these in the future.

Additionally, CIH champions from facilities across the country have been identified and included on VISN Pain Management Committees to support inclusion of CIH approaches as a routine part of pain management. This group meets monthly with the Office of Patient Centered Care and Cultural Transformation/10NE (OPCC&CT) Integrative Health Coordinating Center to discuss VISN level best practices and concerns and to gain new information related to CIH to take back to their VISNs. The Integrative Health Coordinating Center is also working closely with VHA Office of Community Care to develop standards and protocols for the delivery of CIH services in the community where necessary.

Section 933 of the CARA legislation requires demonstration projects on integrating the delivery of CIH services with other health care services provided by VA for Veterans with mental health conditions, chronic pain, and other chronic conditions. Rather than just adding these approaches into primary care, CIH approaches are delivered through a Whole Health System. This approach improves access and reduces the burden on primary care. Whole Health is an approach to health care

[1] For the same reason, the National Center for Complementary and Alternative Medicine at NIH has now changed its name to "National Center for Complementary and Integrative Health."

that empowers and equips people to take charge of their health, well-being, and to live their life to the fullest, and is the primary delivery vehicle through which Veterans can access CIH services.

The Whole Health System includes three components: 1) Empower: The Pathway—in partnership with peers, empowers Veterans to explore mission, aspiration, and purpose and begin personal health planning; 2) Equip: Well-being Programs equip Veterans with self-care tools, skill-building, and support. Services may include proactive CIH approaches such as yoga, tai chi, or mindfulness; and 3) Treat: Whole Health Clinical Care—in VA, the community, or both, clinicians are trained in Whole Health and incorporate CIH approaches based on the Veteran's personalized health plan. VA staff has been working with Veterans around the country to bring elements of this Whole Health approach to life. In conjunction with the CARA legislation, VA began implementation of the full Whole Health System in 18 Flagship Facilities in the beginning of FY 2018, the first wave of facilities in the national deployment of Whole Health. Flagship facility implementation of the Whole Health System will proceed over a 3-year period (FY 2018–FY 2020) and is supported by a well-proven collaborative model which drives large scale organizational change.

The Whole Health approach is well-integrated with the VA Opioid Safety Initiative (OSI) and the National Pain Program's Stepped Care Model, both of which emphasize redesigning pain care with a focus on non-pharmacological approaches, self-care, skill building, and support. Preliminary data shows a decrease in opioid prescription costs among Veterans with two or more Whole Health encounters; we continue to focus on the mitigation of opioid overuse as a priority goal for the Whole health initiative.

An important delivery strategy is making Whole Health and CIH for pain and other conditions available via telehealth, and we have made significant progress in this area. In FY 2017, 770 Whole Health/CIH Encounters were offered to 160 unique Veterans at 9 VAMCs across VHA; In FY 2018, 4,354 Whole Health/CIH encounters have been offered to 1,004 unique Veterans via Telehealth at approximately 26 VAMCs across VHA. We continue to see significant growth in utilization of Whole Health via telehealth in FY 2019 to date as well.

In addition, the VA Whole Health Education Program provides education and skills-based practice on Whole Health and CIH approaches; to date over 20,000 VA staff have participated in one or more Whole Health education offerings. One example of the many educational opportunities is Whole Health for Pain and Suffering: this 2-day course teaches evidence-informed, safe, and effective non-pharmaceutical approaches to pain care. Participants learn how mind-body approaches and self-management can support coping and wellbeing for people with pain, including acupuncture, dietary supplements, and manual therapies. Clinician self-care, burnout prevention, and enhancing resilience are also emphasized. To date 1,274 VA staff have completed the Whole Health for Pain and Suffering course, with an additional 704 projected to attend through the end of FY 2019.

Along with identifying the challenges and successes of CIH implementation at VA facilities, our research partners from VA HSR&D continue to examine many patient-reported health outcomes, clinical outcomes, and Veteran satisfaction measures in their comprehensive study of the flagship sites. We will be able to better understand the health outcomes as well as cost impact upon conclusion of their evaluation efforts. VA plans to continue to expand Veteran access to complementary and integrative approaches for pain through all our successful strategies to date, including infrastructure development, hiring of CIH providers, telehealth, community care coordination, education, and research.

One specific example, in 2018, the Office of Patient Centered Care & Cultural Transformation adopted the Institute for Healthcare Improvement (IHI) Learning Collaborative model and launched the first Learning Collaborative for the 18 Whole Health flagship facilities to support the delivery and implementation of the Whole Health System. To further support national deployment, The Whole Health Learning Collaborative Two: Driving Cultural Transformation begins in the spring of 2019 and will support 36 more facilities in continuing to accelerate Whole Health delivery and innovation across VA. On March 12, 2019, guidance via the Office of the Deputy Under Secretary for Health for Operations and Management was distributed requesting that each VISN identify two additional sites to help further Whole Health deployment in their VISN. Teams from each of the participating sites will join three face-to-face meetings during the 18-month collaborative, as well as monthly calls and virtual meetings as part of this Learning Collaborative process.

Telehealth modalities are continuing to grow to facilitate a smoother Provider and Veteran experience of Whole Health and CIH. The most recent innovation is the VA Video Connect modality which is popular among both group and one-on-one TeleWholeHealth encounters such as Tele-Coaching, Tele-Facilitated Groups, and

TeleWholeHealth Clinical Care encounters. With this modality, Veterans can access their Health Coach or Provider from anywhere they have an internet connection. The provider and Veteran enter a virtual medical room where they can complete the encounter.

We are also planning for continued growth in our education program, which is critical to expanding access to CIH services for pain. We have trained 60 VA clinical faculty across the country to date to teach the Whole Health curriculum as a means to scale implementation. This coming year, we will train an additional 40 field-based faculty to continue this expansion. In addition, we anticipate continued increase in the hiring of CIH providers across VA to provide pain treatment options. For example, we expect on-station chiropractic clinics at a minimum of 50 percent of all VAMCs in each VISN by December 2021.

VA is also committed to expanding its research efforts in the area of CIH and Whole Health for pain. In 2016, VA HSR&D held a state-of-the-art Conference on non-pharmacological approaches to chronic pain. This conference convened VA researchers and clinical experts to identify which CIH and other non-pharmacological approaches had sufficient evidence to be provided across the system and which require further research. Based on the findings of this conference, the VA Office and Research and Development will continue to support research on the use of this type of approaches for the management of pain conditions.

Question 6b. What other alternative pain-treatments do you think could be effective in preventing opioid addiction?

Response. VA's approach to preventing opioid addiction in patients with chronic pain has been to promote safer, more effective pain care that minimizes reliance on opioid medication for treatment of both acute and chronic, non-end-of-life pain conditions. Instead, VA's approach relies on non-opioid pharmacological and non-pharmacological pain treatment modalities that have greater safety and long-term benefits than opioid pain medication.

The VA/DOD Clinical Practice Guideline on Opioid Therapy for Chronic Pain, updated in 2017, makes the following recommendations to prevent opioid addiction for patients with chronic non-end-of-life pain:

- "We recommend against initiation of long-term opioid therapy for chronic pain.
- We recommend alternatives to opioid therapy such as self-management strategies and other non-pharmacological treatments.
- When pharmacologic therapies are used, we recommend non-opioids over opioids.
- We recommend alternatives to opioids for mild-to-moderate acute pain.
- We suggest use of multimodal pain care including non-opioid medications as indicated when opioids are used for acute pain.
- If take-home opioids are prescribed, we recommend that immediate-release opioids are used at the lowest effective dose with opioid therapy reassessment no later than 3–5 days to determine if adjustments or continuing opioid therapy is indicated."

The full clinical practice guideline is available at this Web site: https://www.healthquality.va.gov/guidelines/Pain/cot/.

In November 2016, VA held a state-of-the-art conference titled "Non-Pharmacological Approaches to Chronic Musculoskeletal Pain Management" to obtain expert consensus on evidence-based treatment modalities to guide policy recommendations. The attached summary report was published in the Journal of General Internal Medicine in 2018, by Kligler et al. Categorized under the three groups of psychological/behavioral therapies, exercise/movement therapies, and manual therapies, the following recommendations were made to be implemented across the VHA system as part of pain care:

- Cognitive behavioral therapy;
- Acceptance and commitment therapy;
- Mindfulness-based stress reduction;
- Exercise therapy;
- Tai Chi;
- Yoga;
- Acupuncture;
- Manipulation; and
- Massage.

The complementary and integrative health modalities are outlined above in the response to Question 6a. Regarding behavioral/psychological therapies, VHA has rolled out a national treatment manual to administer cognitive behavioral therapy for chronic pain (CBT-CP) with 12 standardized session modules. This was then

adapted to a brief CBT-CP protocol suitable for mental health providers embedded within Primary Care, with 30-minute sessions for 4–6 appointments.

Clinical Policy Recommendations from the VHA State-of-the-Art Conference on Non-Pharmacological Approaches to Chronic Musculoskeletal Pain

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As a large national healthcare system, Veterans Health Administration (VHA) is ideally suited to build on its work to date and develop a safe, evidence-based, and comprehensive approach to the care of chronic musculoskeletal pain conditions that de-emphasizes opioid use and emphasizes non-pharmacological strategies. The VHA Office of Health Services Research and Development (HSR&D) held a state-of-the-art (SOTA) conference titled "Non-pharmacological Approaches to Chronic Musculoskeletal Pain Management" in November 2016. Goals of the conference were (1) to establish consensus on the current state of evidence regarding non-pharmacological approaches to chronic musculoskeletal pain to inform VHA policy in this area and (2) to begin to identify priorities for the future VHA research agenda. Workgroups were established and asked to reach consensus recommendations on clinical and research priorities for the following treatment strategies: psychological/behavioral therapies, exercise/movement therapies, manual therapies, and models for delivering multimodal pain care. Participants in the SOTA identified nine non-pharmacological therapies with sufficient evidence to be implemented across the VHA system as part of pain care. Participants further recommended that effective integration of these non-pharmacological approaches across the VHA and especially into VHA primary care, pain care, and mental health settings should be a priority, and that these treatments should be offered early in the course of pain treatment and delivered in a team-based, multimodal treatment setting concurrently with active self-care and self-management approaches. In addition, we recommend that VHA leadership and policy makers systematically address the barriers to implementation of these approaches by expanding opportunities for clinician and veteran education on the effectiveness of these strategies; supporting and funding further research to determine optimal dosage, duration, sequencing, combination, and frequency of treatment; emphasizing multimodal care with rigorous evaluation grounded in team-based approaches to test integrated models of delivery and stepped-care approaches; and working to address socioeconomic and cultural barriers to veterans' access to non-pharmacological approaches.

KEY WORDS: veterans; chronic pain; psychological therapies; complementary and alternative medicine; self-management.

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INTRODUCTION

In the 1990s, chronic pain (defined as pain lasting 90 days or more) began to be considered a disease that warranted aggressive and urgent treatment, and opioids became standard treatment for both acute and chronic pain. By 2015, opioid overuse and misuse was widely recognized as a major threat to health and well-being in the USA.[1–4] High-quality evidence has demonstrated the effectiveness of non-pharmacological therapies for chronic pain.[2, 5] There is strong evidence that physical, psychological, emotional, and social factors can significantly affect the course of chronic pain.[6]

The Veterans Health Administration (VHA) has made significant progress in reducing opioid prescribing and increasing the focus on non-pharmacological approaches.[7] The Stepped Care Model (SCM),[8, 9] a veteran-centered, interdisciplinary, multimodal approach in which most pain problems are managed in primary care with support from pain specialty teams and which emphasizes self-management,[10] provides the foundation for this effort. The passage of the Comprehensive Addiction Recovery Act (CARA),[11] in July 2016, which mandates access to interdisciplinary pain care teams at all facilities to include behavioral therapy, physical medicine rehabilitation, and addiction therapy, as well as an expansion of complementary and integrative health (CIH) services system-wide, is providing additional momentum to this effort within VHA.

The VHA is ideally suited to build on its work to date and develop a safe, evidence-based, and comprehensive approach to the care of chronic musculoskeletal pain conditions which if effective can serve as a model for other large health systems. To this end, the VHA Office of Health Services Research and Development (HSR&D) held a state-of-the-art (SOTA) conference titled "Non-pharmacological Approaches to Chronic Musculoskeletal Pain Management" in November 2016. The

conference invited VHA and non-VHA pain experts to review the literature and respond to assigned questions in preparation for the SOTA.. Workgroups were established and asked to reach consensus recommendations on clinical and research priorities for the following treatment strategies:

- Psychological/behavioral therapies
- Exercise/movement therapies
- Manual therapies
- Models for delivering multimodal pain care

The workgroups were intentionally structured around treatment approaches rather than professions. For example, the evidence for physical therapy is addressed in both the exercise and the manual therapies sections rather than evaluating evidence for physical therapy as a discipline. Similarly, we reviewed the evidence for manipulation, which can be delivered by chiropractors, osteopaths, physicians, or physical therapists, choosing to focus on the approach rather than a specific discipline.

Goals of the conference were (1) to establish consensus on the current state of evidence regarding non-pharmacological approaches to chronic musculoskeletal pain to inform VHA policy and (2) to begin to identify priorities for the future VHA research agenda. This paper, which focuses on the first goal, summarizes the clinical policy recommendations from each of the four workgroups.

Relevance to Non-VHA Audiences

Although the task of the SOTA participants was to develop recommendations specifically for VHA policy makers and researchers, the group included experts from outside the VHA, including from the Department of Defense, the National Institutes of Health, major insurers including Kaiser Permanente, and leading academic institutions. Because the VHA is one of the largest integrated health systems in the USA, policy and implementation decisions resulting from the SOTA have potential impact for other large health systems and insurers as they address the challenges of reducing opioid utilization and incorporating evidence-based non-pharmacological approaches to pain into the standard of care. Because the VHA also has the ability to collect large scale clinical outcome data, the policy decisions informed by this meeting will ultimately contribute significantly to the evidence regarding the effectiveness of these approaches in a real-world setting, which again will have potential implications for the rest of American medicine.

WORKGROUP RECOMMENDATIONS

Each of the workgroups was asked to address the following questions.

1. Which treatment strategies have sufficient evidence of effectiveness to support implementation into clinical practice and which are promising but in need of further research to establish their effectiveness?
2. What are the most important challenges or barriers to implementation of the effective approaches?

The therapeutic approaches to chronic pain which have sufficient evidence to be implemented into VHA care are summarized here. These are not meant to be comprehensive summaries of the published evidence, but rather highlights of the evidence discussed at the SOTA and a summary of workgroup conclusions.

Although most of the medical literature addresses the effectiveness of specific therapies applied individually, in practice, therapies are most often delivered in combination. All workgroups addressed the need for awareness of the distinction between relatively "passive" therapies such as massage, and relatively "active" ones such as exercise or CBT. The importance of self-efficacy and patient activation as important factors in treating chronic pain[12] and promoting self-care and the need for a coordinated approach which includes an activation component—as opposed to a simple menu of therapies—was a recurring theme across all of the workgroups.

Psychological/Behavioral Therapies

Cognitive Behavioral Therapy (CBT). CBT is a psychotherapy which highlights the central role and interaction between cognitive, behavioral, and emotional factors in the experience of chronic pain. The effectiveness of CBT in assisting those with chronic pain has been demonstrated in many randomized controlled trials (RCTs) across various populations. A 2012 Cochrane review[13] that included 4788 participants found that CBT for chronic pain, compared with usual treatment and wait list controls, had moderate size effects on mood and catastrophizing and small effects on pain and disability at treatment conclusion.

For specific conditions such as low back pain (LBP), a 2007 meta-analysis concluded that CBT was superior to wait list controls in reducing post-treatment pain intensity but not depression.[14] A recent review of RCTs that included 3359 participants with non-specific LBP found that CBT yielded moderate to large effects for pain and disability in both the short and long term versus guideline-based active treatments.[15] In addition, CBT interventions for orofacial pain,[16] fibromyalgia,[17] and rheumatoid arthritis[18] have all shown small but robust effects that are comparable to or better than other treatments used for the disorders. Furthermore, analysis of VHA's Cognitive Behavioral for Chronic Pain (CBT-CP) evidence-based psychotherapy initiative found statistically significant improvements for veterans across physical and emotional domains with a large effect size in pain catastrophizing and moderate effects for improvements in pain-related distress, interference, and physical health.[19] The recently revised ACP guidelines on LBP include a strong recommendation that CBT should be offered as a first-line treatment for chronic LBP.[2]

Acceptance and Commitment Therapy (ACT). ACT is a form of cognitive behavioral therapy that helps those with chronic pain to become more comfortable and remain in contact with

pain-related emotions, thoughts, and sensations that may be unpleasant. Hann and McCracken's 2014 systematic review on chronic pain found that ACT enhanced mostly physical function and decreased distress compared to inactive treatments.[20] A second systematic review and meta-analysis of ACT for chronic pain found small effect sizes for reduced pain intensity and depression (.37, .32, respectively), and concluded that ACT (as well as mindfulness based stress reduction) had small to moderate effects on mental and physical health, and that these options were not superior to CBT but a potentially good alternative.[21] Results examining ACT processes (i.e., acceptance of pain, values-based action) in the context of interdisciplinary treatment revealed uniformly medium or larger effect sizes for improvements across domains including for pain, physical performance, depression, and pain-related anxiety.[22]

Mindfulness-Based Stress Reduction (MBSR). MBSR, a mind-body/meditation approach focused on increasing awareness and acceptance of experiences, also has sufficient evidence to support its use as a standard psychological/behavioral treatment for chronic pain. Chiesa and Serretti[23] reviewed both randomized and non-randomized controlled trials of MBSR for chronic pain and concluded that while MBSR did not demonstrate greater efficacy compared to other active treatments, it had favorable non-specific effects in reduction of pain intensity and depression compared to wait list controls. In a randomized clinical trial in 2016, Cherkin et al. found that MBSR was as effective as CBT, and more effective than usual care, in producing clinically meaningful improvement with back pain and associated functional limitations as well as pain bothersomeness.[24] The new ACP guidelines on LBP include a strong recommendation that MBSR should be offered as a first-line treatment for chronic LBP.[2]

Other Promising Psychological/Behavioral Approaches

A number of other therapies in this category were evaluated by the workgroup. Hypnosis, biofeedback, and meditation strategies other than MBSR were found to be promising but in need of further effectiveness research for pain.

EXERCISE/MOVEMENT THERAPIES

Exercise Therapy

Exercise is recognized as a key component in the management of musculoskeletal pain. This section focused on evidence regarding specific exercise therapies delivered for the most part by physical therapists rather than on general "physical exercise." Exercise has been found to result in mild to moderate improvements in pain and function in OA of the hip and knee, and the effects may be sustained for up to 6 months.[25, 26] In knee OA adherence to exercise has been positively correlated with improvements in pain and function and may be more important than the intensity and amount of exercise.[27] Guidelines such as those from the American College of Rheumatology (ACR) strongly recommend both aerobic and resistance exercise in the management of osteoarthritis (OA).[28]

While the effect size is small, there is evidence supporting the use of exercise for LBP; a wide range of exercise strategies can be effective including stretching and muscle strengthening.[29] There is also evidence that exercise programs initiated after a course of treatment for back pain can reduce recurrences.[30] While strength/resistance and coordination/stabilization exercise programs are also effective for reducing pain among patients with chronic LBP,[31] questions remain as to the optimal type, duration, and frequency of exercise. There is some data that suggest that core stability exercises, that strengthen and stabilize the trunk, result in better pain relief and back specific function in the short term. However, in the longer term, there does not appear to be a difference in outcome when compared to general exercise.[32] The ACP guidelines on LBP include a strong recommendation that motor control exercise should be offered as a first-line treatment for chronic LBP.[2] Given that adverse events are uncommon and of limited severity,[33] the potential benefits of exercise are sufficient to recommend exercise as a core component of pain management.

Yoga. Yoga uses breathing, movement, and meditation techniques to increase health and well-being and reduce pain. It is generally offered in groups and requires ongoing practice to yield meaningful benefit. The VHA Evidence Synthesis Program review[34] found potential benefit of yoga in the management of chronic LBP. A 2013 review found evidence for the benefits of yoga in the short-term as well as long-term effects in management of LBP.[35] Yoga has been found to be equivalent to both physical therapy[36] and to non-yoga exercise for LBP [37] and has specifically shown a benefit in veterans with chronic LBP when compared to usual care.[38] The ACP guidelines on LBP include a strong recommendation that yoga should be offered as a first-line treatment for chronic LBP.[2] Despite occasional non-severe and temporary worsening of pain reported in some studies, yoga appears to be as safe as usual care or exercise,[39] and is a relatively low cost self-care activity that can be done alone or in group settings.[40]

Tai Chi. Tai Chi uses sequences of slow, controlled movements to improve both mental and physical well-being. The VHA Evidence-based Synthesis Program[41] found a potential positive effect of Tai Chi on chronic pain and OA, with a larger effect size on pain reduction than that seen with NSAIDs and systemic corticosteroids.[42] A 2009 meta-analysis concluded that the effects of Tai Chi on OA pain were mostly short-term and seen immediately after treatment.[43] A more recent meta-analysis, however, found that long-term use of Tai Chi (12–20 weeks) appears to be more effective than short-term Tai Chi (6–10 weeks) in improving chronic OA pain. [44] Tai Chi has also shown small positive effects on

overall physical health and satisfaction with general health in patients with OA.[41] The recent ACP guidelines support the use of Tai Chi as first-line treatment for chronic LBP,[2] and the 2012 ACR guidelines conditionally recommend Tai Chi for patients with OA of the knee.[28] Tai Chi is a relatively low cost and safe intervention that can be done alone, in group settings, or via telehealth.

Other Promising Exercise/Movement Approaches

Aquatic exercise also appears promising as a treatment option for hip and knee OA. There is moderate quality evidence that aquatic exercise produces small but clinically significant reductions in pain and function,[45] with an effect comparable to that of land based exercise.[46] Costs and limited facilities pose challenges to making aquatic exercise widely available in VHA.

MANUAL THERAPIES

Manipulation

Manipulation delivers passive motion to a joint at a high velocity over a small distance, ideally resulting in increased range of motion and decreased pain. Manipulation is typically provided by chiropractors, osteopaths, and physical therapists. A systematic review of 13 clinical practice guidelines on non-invasive management of LBP reported that most high-quality guidelines recommended manipulation/manual therapy for chronic LBP and that manipulation may be beneficial for lumbar disc herniation with radiculopathy.[47] A comparative effectiveness review of non-invasive treatments for LBP found evidence for effectiveness of manipulation for chronic LBP,[48] and the 2017 ACP guideline on low back pain recommended manipulation for chronic LBP.[2]

Manipulation can also be effective for most common types of chronic mechanical neck pain, especially in combination with exercise.[49] A recent systematic review found evidence to support the effectiveness of manipulation for degenerative cervical radiculopathy.[50] A Cochrane review on manipulation for neck pain found evidence of effectiveness for thoracic spine manipulation and that cervical manipulation may provide better pain relief and functional improvement than certain medications at immediate/intermediate/long-term follow-up.[51] There is limited evidence that manipulation/mobilization may be effective for other conditions, including non-specific shoulder pain and ankle sprains.[52]

Acupuncture

Acupuncture uses fine needles inserted through the skin at specific points, as well as other manual techniques, to treat disease and promote health and well-being. A meta-analysis published in 2012 which combined data from over 19,000 subjects found acupuncture to be more effective than both usual care and placebo for musculoskeletal pain, headache, and OA pain.[53] A 2016 meta-analysis concluded that in trials for the neck, lower back and shoulder pain, knee OA pain, and headache/migraine, 50–90% of the benefit of acupuncture is sustained at 12 months.[54] A Cochrane review of 27 studies including participants with mixed duration neck pain found evidence that acupuncture provides better short-term pain relief than sham acupuncture or inactive treatment.[55] Another Cochrane review of 9 trials reported that acupuncture improves pain and stiffness compared to no treatment or standard treatment in patients with fibromyalgia.[56] Finally, a VHA evidence synthesis also reported positive effects for acupuncture on mixed chronic pain conditions.[57]

The recent guidelines from the ACP found evidence for the effectiveness of acupuncture for chronic LBP and made a strong recommendation that acupuncture be offered as one of several non-pharmacological first-line treatment options.[2] The 2012 ACR guidelines on osteoarthritis conditionally recommend the use of acupuncture for treatment of knee OA.[28]

Massage

Massage therapy is defined as the manipulation of body tissues through a variety of techniques and can be delivered by a wide range of practitioners including licensed massage therapists, physical therapists, chiropractors, acupuncturists, and physicians. A Cochrane review of 25 trials of mixed duration LBP found evidence of short-term functional improvement with massage when compared with inactive controls.[58] The recent VHA evidence synthesis report of 21 high-quality systematic reviews similarly found evidence of potential benefits for massage for musculoskeletal pain including the shoulder, back, and neck complaints.[59] For neck pain, a Cochrane review of 15 trials of mixed duration mechanical neck disorders reported evidence of immediate and/or short-term effectiveness in pain and tenderness when massage was used as a stand-alone treatment.[60] There is also some evidence that massage may be effective for lateral epicondylitis and plantar fasciitis.[61] The recent ACP comparative effectiveness review identified evidence that massage was effective for chronic LBP and included a strong recommendation that it be considered as one of the first-line treatment options.[2]

Given the diversity of massage techniques ranging from acupressure to myofascial release to Swedish style, important unresolved questions for VHA implementation of massage for pain are which techniques work best for which type of pain, and what are the optimal dose, frequency, and duration of treatment.

MODELS FOR DELIVERING MULTIMODAL PAIN CARE

Multimodal pain care encompasses physical, behavioral, and integrated medical approaches with the primary goal of reducing pain-related functional impairment and disability.

Numerous studies demonstrate the effectiveness of this approach; the workgroup chose to focus their discussion on the studies specific to VHA as the most relevant evidence for their recommendations.

Given the multifactorial contributors to chronic pain, a multimodal approach, and particularly one which includes strategies with the potential to increase self-efficacy and patient activation, is clearly desirable. This approach is also consistent with the current standard-of-care in the VHA through the Stepped Care Model, which shows promise in clinical trials to date.[62, 63] Findings from several rigorously conducted clinical trials in VHA settings provide examples of multimodal pain care delivery at the primary care and self-management level within the SCM and suggest that multimodal care results in clinically relevant improvements in functioning for veterans with chronic musculoskeletal pain.[64, 65, 66]

An important point in designing this type of care delivery system is the role of the care manager: all of these trials have included ongoing monitoring by a care manager (nurse, psychologist, pharmacist, or social worker) with telephone-based follow-up when monitoring indicated worsening pain-related symptoms or insufficient treatment response. These care managers focused on helping patients build core behavioral and cognitive skills for pain self-care and often helped patients to establish explicit goals for increasing physical activity and to address barriers to change. A major challenge is how to assist the VHA primary care clinician in providing broad access to multimodal care that is cost-effective and acceptable to veterans; care managers can play a critical role in making this approach feasible and sustainable across VHA settings.

To leverage resources, VHA has greatly expanded telehealth options and seeks to expand non-traditional care delivery approaches. Kroenke et al.,[65] for example, used automated symptom monitoring to prioritize care manager contacts with patients. Another VHA trial by Heapy et al[67] found improvements in pain-related outcomes (including satisfaction with care) from interactive voice response (IVR)-based self-management for chronic back pain on par with CBT delivered in individual, in-person sessions. In addition, adherence to care was better with IVR delivered, weekly feedback in conjunction with a self-guided, pain self-management manual. Adopting such an approach across the VHA could significantly reduce staffing burden and ensure fidelity to evidence-based delivery while optimally tailoring feedback to individual patients' needs. While these technology-aided approaches would require an upfront investment in resources to build the needed infrastructure—and while there are certainly information technology challenges as well as real limitations to telehealth as compared to in-person care—the potential scalability may result in better uptake and sustainability across the VHA.

Although the strength and consistency of findings suggest readiness for implementation, an important gap in the studies to date is the fact that integrative treatment approaches (e.g., acupuncture, chiropractic care, yoga) have not been systematically evaluated in combination with the multimodal treatment components described above. An additional issue that will need to be addressed for broader implementation of these models is veteran engagement. Only a small proportion of individuals deemed eligible for clinical trials of multimodal care elect to participate, suggesting the need to better communicate the benefits and lower risks of such biopsychosocial approaches and enhancing opportunities and motivation for patients to connect with clinicians to refer to such programs. This is one of the central challenges of this effort—how do we promote self-care approaches and healthy behaviors? How do we move from the patient as the passive recipient of care to the patient as active participant, taking charge of his or her own health?

DISCUSSION: FACILITATORS AND BARRIERS TO POLICY IMPLEMENTATION

As the findings of the workgroups demonstrate, recent high-quality clinical guidelines and clinical trials highlight the importance of taking a broader perspective and emphasize the need to start with non-pharmacological treatments for chronic musculoskeletal pain. However, expecting clinicians to adopt these new guidelines and trial findings in the absence of system support and adequate resources (at all levels) is unrealistic, and there remain many barriers to implementation of these approaches both inside and outside the VHA system.

Barriers identified by the workgroups included out of pocket costs due to limited reimbursement for some of the non-pharmacological approaches, primary care provider time constraints, and challenges in engaging and motivating patients to become active participants in their care, which is necessary for the effectiveness of many of the non-pharmacological approaches. Inadequate collaboration and communication between providers from different disciplines resulting in multimodal care that is not integrated and interdisciplinary, but rather provided in "silos"; and access for veterans in rural and other underserved areas were also identified as significant barriers. Allocation of adequate resources to support access to the wide range of therapies discussed here when there are many other competing priorities for those resources poses a difficult challenge for the system and may slow full implementation of these recommendations.

Education—of providers, patients, and other key stakeholders—was identified as a major barrier that needs to be addressed in moving this approach to pain care forward. A lack of providers with expertise in behavioral interventions for chronic pain (including pain psychologists) and other pain specialty providers is a significant issue, as is uneven access across the health care system to providers trained in CIH approaches. Lack of adequate knowledge and familiarity with these therapies among patients, frontline clinicians, and other key stakeholders also needs to be addressed with a national education campaign with clear messaging about the benefits of non-pharmacological interventions.

Proposed strategies to maximize effectiveness of implementation included using technology such as apps and wrist-worn monitoring devices to enhance access and monitor outcomes, enhancing understanding of the process of change in treatment and treatment mediators to improve patient outcomes, implementing motivational interviewing approaches to enhance patient engagement and activation, and exploring group and peer-led interventions.

The workgroups also identified a need for further research to support effective implementation; these recommendations are presented in the article by Becker et al. in this supplement.

CONCLUSION AND POLICY RECOMMENDATIONS

Participants in the VHA HSR&D SOTA on non-pharmacological approaches to the management of chronic musculoskeletal pain recommend that the following therapies be implemented across the VHA system as part of pain care:

1. Cognitive behavioral therapy
2. Acceptance and commitment therapy
3. Mindfulness-based stress reduction
4. Exercise therapy
5. Tai Chi
6. Yoga
7. Acupuncture
8. Manipulation
9. Massage

Integration of these non-pharmacological approaches into primary care, pain care, and mental health settings should be a policy priority, and these treatments should be offered early in the course of pain treatment. Multimodal care which incorporates approaches designed to engage and activate patients and to build self-management skills and which utilizes care managers and telehealth strategies should be the standard of care for chronic pain. In addition, we recommend that VHA leadership and policy makers systematically address the barriers to implementation of these approaches by expanding opportunities for clinician and veteran education on the effectiveness of these strategies; supporting and funding further research to determine optimal dosage, duration, sequencing, combination and frequency of treatment; and working to address socioeconomic and cultural barriers to veterans' access to non-pharmacological approaches. To better evaluate the impact of these approaches, investment in more effective strategies for tracking the use of psychological, behavioral, and mind-body therapies in VHA clinical settings is also critical. Implementation of these recommendations has the potential to make the VHA a national model for improving care for chronic musculoskeletal pain.

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Question 7. How will the initiatives in the President's new Executive Order creating a roadmap for suicide prevention, issuing community grants, and increasing mental health research be funded?

Response. Task Force roles and leads for the lines of effort (enabling support, state and local action to include grant structure, and the research strategy) and grant structure are in the process of being determined. Role determinations and associated kick-off meetings will occur in May 2019.

Question 7a. We're all waiting on the FCC to issue a report on the feasibility of a 3-digit "N11" number from legislation we passed last year. Have you been given any update from the FCC on the status of creating a 3-digit suicide hotline number for Veterans?

Response. Per the timeline included in the signed legislation, the Federal Communications Commission (FCC) has until August 2019 to submit the final report to Congress. This report will include responses by the Veterans Crisis Line (VCL), the Substance Abuse and Mental Health Services Administration (SAMHSA), and requested organizations such as the North American Numbering Council (NANC). VCL has submitted the original report to FCC on January 28, 2019, and the secondary NANC request on March 22, 2019. James Wright, VCL Chief of Staff, presented to NANC at FCC on March 28, 2019, to share a summary of both responses by VCL. Upon completion of the meeting, NANC requested additional information (3 points of interest) that VCL is currently completing. After receiving all requested information, NANC will submit their technical report to FCC for inclusion in the final report. The National Suicide Hotline Improvement Act of 2018 does not mandate the creation of a 3-digit code for Veterans or community services. The Act specifically calls for FCC to study the feasibility of designating a 3-digit dialing code, including recommendations on the number, costs associated with designation, and logistics to include infrastructure and operation needs.

Question 7b. How quickly can this be implemented?

Response. VCL does not have information regarding the actual creation of a 3-digit code, as the legislation does not mandate that outcome. Depending on the FCC final report, recommendations will be included on potential impact of such a designation. Additional steps post report would need to be taken to move toward implementation if a 3-digit code expansion was feasible, including expansion requirement with state vs. national guidelines, along with financial, marketing, training, and infrastructure needs.

Question 8. The Vocational Rehabilitation and Employment (VR&E) program is a good news story that a lot of folks do not hear about often. A key focus of mine in the Senate has been working to reduce the Veterans unemployment rate has and the VR&E program is a big player in our successes. The latest VA data shows that from 2016 to 2018, the number of VRE participants fell from 173,000 to 164,000 a decrease of more than 5%.

Question 8a. Given how important this program is to disabled Veterans, why are fewer using this service?

Response. In 2018, Vocational Rehabilitation and Employment (VR&E) program participants achieved over 15,000 positive outcomes while participants decreased by 5 percent. VR&E Service attributes the decrease to due to a combination of the following factors:

- Applicants found eligible for the VR&E program are not reporting to their initial orientation and, therefore, not entering a plan of services; and
- The number of Veterans successfully exiting the program have increased each year (positive outcomes). Positive Outcomes were introduced as a performance measure fourth quarter FY 2015 (July 1, 2015), and were fully implemented effective FY 2016 (October 1, 2015). Year-over-year results and increases are as follows:

FY	Positive Outcomes	% Δ
2016	14,351	NA
2017	15,528	+8.20%
2018	15,998	+3.03%

With the number of new plans remaining stagnant and despite the steady mix of eligible and entitled applicants, more Veterans are exiting the program than entering. However, VR&E continues to work on plans to hire to additional Vocational Rehabilitation Counselors (VRC) to reach a Veteran-to-Counselor ratio of 125 to 1 or below, implement a new case management system, and use other technological solutions to keep Veterans engaged throughout the lifecycle of their program partici-

pation (remote entitlement, VA Video Connect (tele-counseling), appointment reminders, etc.). These changes are expected to increase the number of participants. With the number of new plans remaining stagnant and despite the steady mix of eligible and entitled applicants, more Veterans are exiting the program than entering. VR&E is embarking on a multiyear modernization effort that will serve as the solution to improve participation of Veterans in the program. These efforts will address Veteran's understanding of the program through outreach and the administrative burden counselors have in the field.

VR&E will expand outreach through social media, engagement with VSOs at conferences, expanding briefings at TAP, and through Vet Success on Campus Counselors at Institutes of Higher Learning. This will aid in decreasing the 66% of discontinuances the Service has due to Veteran's misunderstanding of what the VR&E program does. As for administrative burden, VR&E Service research discovered over 60 percent of a counselor's day is spent in administrative tasks and functions. Modernization initiatives such as the new case management system, an electronic virtual assistant that will provide 24/7 scheduling and administrative support to counselors and Veterans, and e-invoicing will dramatically decrease that administrative burden. This will increase the ability of counselors to have direct-facing veteran services and increased capability to follow up with Veteran clients. Those services are essential to Veterans persistently participating in the program.

Question 8b. Have you instituted new policies or taken any actions that would have led to decreased usage?

Response. No, VA's VR&E program has not instituted any new policies or taken any actions that would have led to decreased usage. To the contrary, over the past several years VR&E has taken several actions to meet Servicemembers and Veterans where they are and in the manner they wish to be met. These actions, coupled with legislative changes, were expected to increase participation in the VR&E program. These actions include the following:

- In accordance with Public Law 114–223, section 254, Veteran-to-Counselor ratio should not exceed 125 to 1. VA's VR&E Program began the process of reducing the average Veteran-to-Counselor ratio to 125 to 1 or below through the hiring of 169 VRCs. This will help improve service to Veterans with service-connected disabilities and employment barriers, as well as help provide them with expanded services to improve their ability to transition to the civilian workforce.
- The placement of 145 VRCs on 71 military installations across the Nation provides outreach and rehabilitation services to Servicemembers and their families prior to discharge from active duty service.
- The placement of 87 VRCs on 104 college campuses across the Nation provides outreach and rehabilitation services to Servicemembers, Veterans, and their dependents.
- On September 29, 2018, the VA Expiring Authorities Act of 2018, Public Law 115–251, section 126, made permanent the authority to provide VR&E benefits and services to Servicemembers who are awaiting discharge due to a severe illness or injury incurred during active duty service.
- VR&E expanded its Tele-counseling policy to allow its use during all aspects of the rehabilitation process. This practice allows VR&E VRCs to meet virtually with a VR&E participant via an application that can be used on a computer or smart device. This practice saves travel time for the participant and allows for greater access to the program.

VR&E continues to increase awareness and share information on VR&E benefits and services. VR&E reviews and updates all VR&E fact sheets and Web sites each year as needed as well as promotes, monthly, all the marketing material that is available online. VR&E promotes the online marketing materials in a variety of ways, including by email, social media, outreach events, and conference calls with VR&E's field staff. They have developed an overview whiteboard video which was distributed to the field offices. The video provides an overview of VR&E's benefits and the types of assistance available and is a tool for the VRCs to promote the VR&E program. VR&E has also provided numerous trainings on how to promote early intervention into VR&E to active duty members on the military installations. Last, VR&E is changing the performance standards for the VRCs on military installations to focus more on ensuring Servicemembers are entering the VR&E program.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. KYRSTEN SINEMA TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. Can I count on your support to ensure the VA takes steps to make family members aware of benefits available to their loved ones?

Response. Yes. VA continues to proactively conduct outreach to the families of Servicemembers and Veterans through face-to-face interactions, social media, and email correspondence. VA's outreach services include attendance at various types of national and local events, stakeholder presentations, and collaboration efforts with other Federal and state agencies, Veterans Service Organizations, private partners, and non-profit organizations such as the Tragedy Assistance Program for Survivors. VA works to promote information on benefits and services available to family members and proactively disseminates information in the same manner as its recent VA Benefits Bulletin newsletter sent on April 5, 2019, to over 5.5 million recipients with specific information pertaining to a VA Survivors and Burial Benefits Kit.

Question 2. What is your long term plan to be able to fully staff the VA with the adequate number of medical professionals and retain them long term to serve those that served us?

Response. VHA's workforce challenges mirror those of the health care industry as a whole. There is a national shortage of health care professionals, especially for physicians and nurses. The American Association of Colleges of Nursing, Association of American Medical Colleges, and other national health care organizations have written about this workforce shortage at length. VHA remains fully engaged in a fiercely competitive clinical recruitment market. VHA has been successful in increasing the number of clinical providers including hard-to-recruit-and-retain physicians such as psychiatrists.

While there are many approaches to projecting staffing of medical professionals and support staff across large health care systems at the national level, forecasting at the local level remains challenging due a multitude of factors. Nationally, Veteran enrollment is projected to grow by 1.6 percent from 2017 to 2026 even though the Veteran population is declining. The VHA workforce has consistently grown by approximately 3 percent annually over the last 5 years. Integration of existing resources with community care as well as the expansion of telehealth capabilities will be a critical driver in assessing future resource requirements.

In FY 2018, VHA formally stood-up the VHA Manpower Management Office (MMO). VHA has an aggressive schedule for establishing manpower capabilities, which includes establishing staffing models for all functional areas; benchmarking staffing, quality, and access at similar health care systems; developing predictive recruitment models; and identifying facilities in danger of low staffing levels.

VHA staffing plans account for normal rates of workforce turnover, retirement, and growth, and the expectation that there will always be vacant positions. VHA is taking several key steps to attract qualified candidates, including the following:

- Mental Health and other targeted hiring initiatives;
- increased maximum physician salaries;
- utilization of 3R incentives and the Education Debt Reduction Program (EDRP);
- targeted Nation-wide recruitment advertising and marketing;
- "Take A Closer Look at VA" trainee outreach recruitment program;
- expanding opportunities for telemedicine providers;
- DOD/VA effort to recruit transitioning Servicemembers; and
- exhibiting regularly at key health care conferences and job fairs.

The MISSION Act also provides additional authority that VA will leverage for recruitment and retention of medical professionals, including the following:

- Awarding 50 scholarships per year for people enrolled in a medical or dental school;
- increasing the maximum award amount for the Education Debt Reduction Program (EDRP),
- expanding program eligibility to additional mental health providers;
- offering recent medical school graduates loan repayment opportunities in exchange for service in VAMCs through the Specialty Education Loan Repayment Program (SELRP);
- initiating a pilot scholarship program targeted toward Veterans for medical school education; and
- increased the overall sums authorized for VA bonus awards and funding 3Rs.

VA recently achieved our goal of adding 1,000 more mental health providers to serve Veterans, adding 1,045 more mental health providers as of January 31, 2019. VA made this commitment in June 2017 as part of VA's #1 clinical priority to eliminate Veteran suicide and used a wide variety of strategies to recruit and retain the

mental health workforce. This included VA's first-ever virtual trainee hiring fair, which resulted in 74 mental health trainees accepting job offers. The second trainee hiring event is currently underway and will connect current VA psychology trainees with available positions at VHA facilities using the non-competitive hiring process. Building a clinical trainee pipeline of qualified health care professionals is crucial to future VA recruitment and sustainment efforts.

Each year, VHA hires more employees than it loses to replace turnover and keep up with the growth in demand for services. VHA turnover rates compare favorably with the health care industry, including for those occupations identified as mission critical. In FY 2018, VHA's annual turnover rate for full-time and part-time employees was 9.5 percent, which compares well to the health care industry turnover rate of 20–30 percent.

The best indicators of adequate staffing levels are Veteran access to care and health care outcomes, and VHA continues to make substantial progress on these measures. As identified by external research and studies, in general, Veterans are receiving the same or better care at VAMCs as patients at non-VA hospitals.

Question 3. Mr. Secretary, are you aware of the recent United States Digital Service findings on the issues surrounding the new software to determine eligibility under the MISSION Act?

Response. Yes.

Question 3a. What steps is the VA taking in response to the USDS study?

Response. The United States Digital Service (USDS) identified several key points and recommendations that OIT could use to enable a better product development effort for MISSION Act and more specifically for the Decision Support Tool (DST). OIT and VHA are using USDS's recommendations to improve DST and other MISSION Act IT needs.

A P P E N D I X

JOINT STATEMENT OF THE CO-AUTHORS OF THE *INDEPENDENT BUDGET*

CHAIRMAN ISAKSON, RANKING MEMBER TESTER, AND MEMBERS OF THE COMMITTEE, The co-authors of *The Independent Budget* (*IB*)—DAV (Disabled American Veterans), Paralyzed Veterans of America (PVA), and Veterans of Foreign Wars (VFW)—are pleased to present our views regarding the President's funding request for the Department of Veterans Affairs (VA) for Fiscal Year (FY) 2020, including advance appropriations for FY 2021.

Last month, prior to the Administration's budget request, the *IB* released our comprehensive VA budget recommendations for all discretionary programs for FY 2020, as well as advance appropriations recommendations for medical care accounts for FY 2021.[1] The recommendations also include funding to implement the VA MISSION Act of 2018 (P.L. 115–182) and other reform efforts. The *IB* believes that Congress must continue vigorous oversight of VA to ensure an accurate assessment of its true needs. Our own FY 2020 estimates affirm that these needs continue to grow.

After reviewing the Administration's budget request for VA and comparing it to the *IB* recommendations, particularly in light of the requirements of the VA MISSION Act, we believe that the request falls short of meeting the needs of veterans seeking care through VA. Although the budget request provides a seven percent increase in the level of discretionary funding, when factoring in VA's own estimates of the cost of implementing the VA MISSION Act, the shift of $5.5 billion from mandatory to discretionary funding from the Choice program, and the increased cost for providing medical care due to inflation and other factors, VA will not have sufficient resources to meet the health care needs of America's veterans.

The Administration's request of $84 billion for Medical Care is $4 billion less than the *IB* estimates is necessary to fully meet the demand by veterans for health care during the fiscal year. For FY 2020, the *IB* recommends approximately $88.1 billion in total medical care funding and approximately $90.8 billion for FY 2021. This recommendation reflects the necessary adjustments to the baseline for all Medical Care program funding in the preceding fiscal year, and assumes the Choice program is fully replaced at the beginning of FY 2020 by the Veterans Community Care Program (VCCP).

For FY 2020, the *IB* recommends $56.1 billion for VA Medical Services. This recommendation is a reflection of multiple components including the current services estimate, the increase in patient workload, and additional medical care program costs. The current services estimate reflects the impact of projected uncontrollable inflation on the cost to provide services to veterans currently using the system. This estimate also assumes a 2.1 percent increase for pay and benefits across the board for all VA employees in FY 2020.

[1] The full *IB* budget report addressing all aspects of discretionary funding for VA can be downloaded at www.independentbudget.org.

Our estimate of growth in patient workload is based on a projected increase of approximately 90,000 new unique patients. These patients include priority group 1–8 veterans and covered non-veterans. We estimate the cost of these new unique patients to be approximately $1.3 billion.

The *IB* believes that there are additional projected medical program funding needs for VA. Those costs total over $1.2 billion. Specifically, we believe there is a real need for funding to address an array of issues in VA's Long-Term Services and Supports (LTSS) program, including the shortfall in non-institutional services due to the unremitting waitlist for home and community-based services; to provide additional centralized prosthetics funding (based on actual expenditures and projections from the VA's Prosthetics and Sensory Aids Service); funding to expand and improve services for women veterans; funding to support the recently approved authority for reproductive services, to include in vitro fertilization (IVF); and initial funding to implement extending comprehensive caregiver support services to severely injured veterans of all eras.

The Administration's request for VA Medical Services of $51.4 billion is approximately $4.7 billion below the *IB* recommendation. To better understand the shortfall, it should be noted that the *IB* does not include anticipated receipts from VA's Medical Care Collections Fund in its recommendation. Although the Administration's request reflects an apparent increase of three percent, the *IB* believes that when taking into account the increased cost to maintain current services and anticipated increases in workload, as well as increased costs inside VA due to the VA MISSION Act that apparent increase will ultimately result in a shortfall.

Of great concern to our organizations and members, the Administration's budget request makes clear that VA will fail to meet the VA MISSION Act's very clear timetable for expanding its comprehensive caregiver support program to severely injured WWII, Korean, and Vietnam War veterans and their family caregivers. These men and women have waited nearly a decade for equal treatment and it is simply unacceptable to ask them to wait longer.

The VA Caregiver Support Program currently uses the IT system known as the Caregiver Application Tracker (CAT), which was rapidly developed due to time constraints on implementing the program and was not designed to manage a high volume of information as is required today. We are aware VA has requested a reprogramming of nearly $96 million in Medical Care funding to the IT Systems account, which includes just over $4 million to continue development and stabilization of CAT, while in its FY 2020 budget submission, VA is requesting $2.6 million to update the Caregivers Tool (CareT) to support the first phase of expansion. As this Committee is aware, VA notified Congress in April 2017 that CareT, which at that time was expected to fully automate the application and stipend delivery process for the program, experienced significant delays associated with external dependencies and lost prioritization among competing projects. As a result, a new contract had to be drafted to continue work pushing the delivery of CareT out one year to June 2018.

We are deeply troubled at VA's apparent lack of commitment to accomplish this IT task correctly and on time and that these funding requests appear to uncaringly prioritize caregiver expansion behind that of the VCCP. Moreover, the delay in certifying the IT infrastructure for expansion of the caregiver program until at least 2020 raises troubling concerns about VA's ability to fully deploy the significant IT infrastructure needed to properly implement the more expansive VCCP in a shorter timeframe.

In terms of funding, the Administration included $150 million to expand VA's comprehensive caregiver program. This figure is over $100 million less than the *IB* recommendation of $253 million to fully implement phase one of the caregiver expansion in FY 2020. The *IB*'s recommendation is based on the Congressional Budget Office estimate for preparing the program, including increased staffing and IT needs, and the beginning of the first phase of expansion.

For Medical Community Care, the *IB* recommends $18.1 billion for FY 2020, which includes the growth in current services, estimated spending under the Choice program, and additional obligations under the VA MISSION Act of $3.7 billion. The Administration's FY 2020 request for $15.3 billion in discretionary funding appears to be a $5.9 billion increase in funding for Community Care. However, VA has indicated that $5.5 billion of that increase merely represents shifting $5.5 billion that would otherwise be necessary to pay for the Choice program, from mandatory funding. Considering that VA estimated the VA MISSION Act will require $2.6 billion in new funding for expanded access based on new access standards, expanded transplant care, and $271 million for urgent care, there appears to be a significant shortfall for VA community care programs.

Furthermore, during VA's budget briefing on March 11, VHA officials stated that there would be no Medical Community Care funding required to implement the new wait time access standards, that VA would be able to fully meet those standards within VA facilities; therefore, not one veteran would get VCCP eligibility due solely to the wait time standard. However, VA has also stated that the current median wait time for primary care is 21 days, which would mean that approximately half of all veterans seeking primary care appointments today have a greater than 20 day wait time. Yet, VA's budget request assumes that they would achieve 100 percent compliance with the wait time standard through greater efficiency and an approximate 30 percent increase in VA primary care providers. We have serious doubts about whether this is realistic given the national shortage of primary care providers and the time needed to recruit, hire, and onboard new employees; and certainly, whether it is achievable by the first day of the next fiscal year, just over six months from today.

The Administration's FY 2020 request for VA's construction programs of $1.8 billion dollars is a 44 percent reduction from FY 2019 funding levels, and a disappointing retreat in funding to maintain VA's aging infrastructure. For major construction in FY 2019, VA requested and Congress appropriated a significant increase in funding for major construction projects—an approximate $700 million increase. While these funds will allow VA to begin construction on key projects, many other previously funded sites still lack the funding for completion. Some of these projects have been on hold or in the design and development phase for years. Additionally, there are outstanding seismic corrections that must be addressed. Thus, the *IB* recommended $2.78 billion in major construction, nearly $1 billion more than VA's total construction request.

To ensure that VA funding keeps pace with all current and future minor construction needs, the *IB* recommends that Congress appropriate an additional $761 million for minor construction projects. It is important to invest heavily in minor construction because these are the types of projects that can be completed faster and have a more immediate impact on services for veterans. Previously, these changes fell under facilities similar to Non-Recurring Maintenance (NRM), but the *IB* recommends these specific modifications be under a different authority to ensure their priority.

In addition, the Administration's FY 2020 Medical Facilities request of $6.1 billion, which includes critical NRM to ensure VA facilities have the space to provide care, is a $660 million cut compared to FY 2019 levels. The *IB* recommends $6.6 billion for FY 2020. This includes nearly $400 million for NRM and leases, which provides funding to address VA research NRM needs. VA uses major and minor leases in lieu of facility construction to address access needs and space gaps to quickly respond to health care advances, and adopt changing technology in order to provide state-of-the-art health care to veterans when a lease is better aligned with the Department's overall capital strategy.

The Administration's request of $762 million for Medical and Prosthetic Research is nearly $80 million below the *IB* recommendation of $840 million. The request represents a 2 percent cut, at a time when medical research inflation is estimated to be 2.8 percent. The VA Medical and Prosthetic Research program is widely acknowledged as a success, with direct and significant contributions to improved care for veterans and an elevated standard of care for all Americans. This research program is also an important tool in VA's recruitment and retention of health care professionals and clinician-scientists to serve our Nation's veterans. This reduction would diminish VA's ability to provide the most advance treatments available to injured and ill veterans in the future, one of VA's core missions.

Overall, the *IB* believes that the Administration's FY 2020 budget request for VA will neither allow the Department to fully and faithfully implement the VA MISSION Act, nor will it fully meet the rising demand by veterans for care within VA hospitals and clinics. The *IB* veterans services organizations (IBVSOs) are left with significant questions regarding both the assumptions on which the request was made and how the VA intends to meet the requirements of not only the VA MISSION Act, but also other requirements to provide the health care, benefits, and services that veterans have earned. Below are some of the questions about VA's budget request that have not been answered.

- At its March 11 budget briefing, VA officials stated that the FY 2020 budget request was predicated on a carryover of approximately $3 billion from FY 2019 appropriations, but offered no details or further explanation. Exactly, how much "carryover" is assumed in the FY 2020 budget request and how did VA determine less than halfway through FY 2019 that such a large amount of funding could not be used to meet veterans' health care needs? What are the specific dollar amounts

being carried over and from what specific accounts, and into what accounts and for what purposes will this carryover funding be used in FY 2020?

• As discussed above, VA officials indicated that there would be zero new dollars necessary for the Medical Community Care account as a result of the new wait time access standards proposed because VA assumes it will be able to meet those standards 100 percent of the time within VA facilities. VA indicated it will do this through workload recapture, greater efficiency, and a 30 percent increase in the total number of VA primary care providers. What new initiatives will VA undertake and what are the specific increases in productivity that each will achieve? What are VA's detailed plans and projections for increasing primary care providers by 30 percent, and how will these new providers be in place at the beginning of FY 2020?

• What factors did VA consider in reaching its decision to cut research spending for the emerging field of genomics research in FY 2020 by 2 percent at a time when medical research inflation is estimated to be 2.8 percent?

• In the full budget documents made available on March 18, the Veterans Benefits Administration budget request seeks appropriations to support the exact same level of FTE for FY 2020 as it does in FY 2019. However, the Direct Labor estimate for the Disability Compensation program shows a decrease of 51 FTE in FY 2020. This small decrease in claims processors occurs at a time that the VA budget is projecting that number of pending claims for disability compensation will rise to over 450,000 by the end of FY 2020, almost a 50 percent increase in just the past three years. Why is VA requesting fewer claims processing staff in FY 2020 when its own data shows that the number of pending claims is rising dramatically?

• VA budget documents state that the Vocational Rehabilitation and Employment (VRE) program will meet and sustain the congressionally-mandated goal of 1:125 counselor-to-client ratio. However, the latest data in the VA budget document also shows that from 2016 to 2018, the number of VRE participants fell from 173,606 to 164,355, more than a five percent decrease. During that same period, VRE's caseload also dropped from 137,097 to 125,513, an 8.4 percent decline. It would appear that VRE is able to meet the 1:125 goal by serving fewer veterans. Given how important and beneficial the VRE program is to disabled veterans—providing many of them with the ability to increase their economic independence—why are fewer veterans taking advantage of this program? Has VRE instituted any new policies or practices that have deterred disabled veterans from seeking VRE services and what actions is VRE taking to increase awareness about the availability and benefits of VRE services?

Last, the IBVSOs strongly oppose four legislative proposals included in the budget that would reduce benefits to disabled veterans that were earned through their service:

1. *Round-Down of the Computation of the Cost of Living Adjustment (COLA) for Service-Connected Compensation and Dependency and Indemnity Compensation (DIC) for Five Years:*

   In 1990, Congress, in an omnibus reconciliation act, mandated veterans' and survivors' benefit payments be rounded down to the next lower whole dollar. While this policy was initially limited to a few years, Congress continued it until 2014. While not significant at the onset, the overwhelming effect of twenty-four years of round-down resulted in veterans and their beneficiaries losing billions of dollars.

   In the Administration's proposed budget for FY 2019, the Administration sought legislation to round-down the computation of COLA for ten years. This would have cost beneficiaries $34.1 million in 2019, $749.2 million for five years, and $3.11 billion over ten years.

   The Administration's proposed budget for FY 2020, is seeking to round-down COLA computations from 2020 to 2024. The cumulative effect of this proposal levies a tax on disabled veterans and their survivors, costing them money each year. When multiplied by the number of disabled veterans and DIC recipients, millions of dollars are siphoned from these deserving individuals annually. All told, the government estimates that it would cost beneficiaries $34 million in 2020 and $637 million for five years and $2 billion over ten years.

   Veterans and their survivors rely on their compensation for essential purchases such as food, transportation, rent, and utilities. Any COLA round-down will negatively impact the quality of life for our Nation's disabled veterans and their families, and we oppose this and any similar effort. The Federal budget should not seek financial savings at the expense of benefits earned by disabled veterans and their families.

2. Clarify Evidentiary Threshold for Ordering VA Examinations:

This proposal would increase the evidentiary threshold at which VA, under its duty to assist obligation in 38 U.S.C. § 5103A, is required to request a medical examination for compensation claims. Section 5103A(d)(2) requires VA to "treat an examination or opinion as being necessary to make a decision on a claim" if the evidence of record, "taking into consideration all information and lay or medical evidence . . . (A) contains competent evidence that the claimant has a current disability, or persistent or recurrent symptoms of disability; and (B) indicates that the disability or symptoms may be associated with the claimant's active military, naval, or air service; but (C) does not contain sufficient medical evidence for the Secretary to make a decision on the claim."

The Court of Appeals for Veterans Claims (CAVC), in *McLendon* v. *Nicholson*, 20 Vet. App. 79 (2006), determined that in disability compensation claims, VA must provide a VA medical examination when there is:

- Competent evidence of a current disability or persistent or recurrent symptoms of a disability, and
- Evidence establishing that an event, injury, or disease occurred in service or establishing certain diseases manifesting during an applicable presumptive period for which the claimant qualifies, and
- An indication that the disability or persistent or recurrent symptoms of a disability may be associated with the veteran's service or with another service-connected disability, but,
- Insufficient competent medical evidence on file for the secretary to make a decision on the claim. It notes that the requirement of (3) is a low threshold.

We oppose this proposal as it would be inherently detrimental to the VA claims process for all veterans. The Administration asserts the holdings by the CAVC, specifically in *McLendon* v. *Nicholson*, are inconsistent and too low a bar when compared to 38 U.S.C. § 5103A(d)(2). However, that is not correct. As noted above, the statutory requirements for a VA examination are consistent with the CAVC's holding. The Administration's proposed legislation would intentionally raise the bar of the VA's Duty to Assist and allow the VA to hold veterans to a much higher threshold and result in fewer examinations with more claim denials. This would lead to more Higher Level Review requests, supplemental claims, and appeals directly to the Board of Veterans' Appeals. Ultimately, this will result in an increased number of veterans never receiving the benefits they earned.

The Administration's proposal would reduce anticipated disability compensation to veterans by $233 million in 2020, $1.3 billion over five years, and $2.8 billion over ten years. We strongly oppose this attempt to limit the due process rights of veterans, particularly when the result will be billions of dollars in lost disability compensation for those who were injured or made ill in service.

3. VA Schedule for Rating Disability (VASRD) Effective Dates:

VA seeks to amend 38 U.S.C. § 1155 so that when VASRD is readjusted, such changes would apply to any new or pending claims and may include action to decrease an existing evaluation. Under section 1155, "The Secretary shall from time to time readjust this schedule of ratings in accordance with experience. However, in no event shall such a readjustment in the rating schedule cause a veteran's disability rating in effect on the effective date of the readjustment to be reduced unless an improvement in the veteran's disability is shown to have occurred."

Currently, if a diagnostic code rating criteria changes, the veteran can only be granted an increased evaluation under the old rating criteria up to the date of the change to the new rating criteria. The new rating criteria must be applied from the date of the change. The Administration's proposal would eliminate a veteran's ability to receive an increased evaluation up to the date of the change and only apply the new criteria.

This proposal would have a negative impact on veterans and would clearly be in contrast to 38 CFR § 3.103, which states, "Proceedings before VA are ex parte in nature, and it is the obligation of VA to assist a claimant in developing the facts pertinent to the claim and to render a decision which grants every benefit that can be supported in law while protecting the interests of the Government."

The Administration's proposed budget does not show any estimate of budgetary savings based on this legislative proposal and mentions only that it would make it easier for VA rating personnel to make decisions on veterans' claims. However, this proposal will eliminate any potential increased evaluations prior

to the change of the rating criteria; thereby, lowering the earned benefit for affected disabled veterans. We oppose this proposal as it will have negative consequences on veterans.

4. Elimination of Payment of Benefits to the Estates of Deceased Nehmer Class Members and to the Survivors of Certain Class Members:

VA seeks to amend 38 U.S.C. § 1116 to eliminate payment of benefits to survivors and estates of deceased Nehmer class members. If a Nehmer class member, per 38 CFR § 3.816, entitled to retroactive benefits dies prior to receiving such payment, VA is required to pay any unpaid retroactive benefits to the surviving spouse or subsequent family members. This proposed legislation would deny veterans' survivors and families' benefits that would have otherwise been due to their deceased veteran family member as a result of exposure to these toxic chemicals while in service. It is outrageous that the Administration would deny compensation payments due to a surviving spouse. We adamantly oppose this or any similar proposal that may be offered.

The IBVSOs do support one of VA's legislative proposals regarding VA approved Medical Foster Homes (MFH). This proposal would require the VA to pay for service-connected veterans to reside in VA approved MFHs.

MFHs provide an alternative to long-stay nursing home (NH) care at a much lower cost. The program has already proven to be safe, preferable to veterans, highly veteran-centric, and half the cost to VA compared to NH care. Aligning patient choice with optimal locus of care results in more veterans receiving long-term care in a preferred setting, with substantial reductions in costs to VA. This proposal would require VA to include MFH in the program of extended care services for the provision of care in MFHs for veterans who would otherwise encumber VA with the higher cost of care in NHs.

Many more service-connected veterans referred to or residing in NHs would choose MFH if VA paid the costs for MFH. Instead, they presently defer to NH care due to VA having payment authority to cover NH, while not having payment authority for MFH. As a result of this gap in authority, VA pays more than twice as much for the long-term NH care for many veterans than it would if VA was granted the proposed authority to pay for MFH. This proposal would give veterans in need of NH level care greater choice and ability to reside in a more home-like, safe environment, continue to have VA oversight and monitoring of their care, and preferably age in place in a VA-approved MFH rather than a NH. The proposal does not create authority to cover veterans who reside in assisted living facilities.

MFH promotes veteran-centered care for those service-connected veterans who would otherwise be in a nursing home at VA expense, by honoring their choice of setting without financial penalty for choosing MFH.

Thank you for the opportunity to submit our views on the Administration's budget request for VA. We firmly believe that unless Congress acts to substantially increase VA's funding for FY 2020, veterans will be forced to wait longer for care, whether they seek care at VA or in the community, leaving unfulfilled the promises made to veterans in the VA MISSION Act.

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