May X, 2021

The Honorable John Yarmuth
Chairman, Committee on the Budget
Washington, DC 20515

The Honorable Jason Smith
Ranking Member, Committee on the Budget
Washington, DC 20515

Dear Chairman Yarmuth and Ranking Member Smith:

Pursuant to section 301(d) of the Congressional Budget Act of 1974, and clause 4(f), rule X of the Rules of the House of Representatives, and in response to your request, the Committee on Veterans' Affairs (the Committee) submits its Views and Estimates for fiscal year 2022 (FY 22).

The Committee awaits the complete FY 22 Department of Veterans Affairs (VA) budget proposal from the Biden Administration. The Administration has submitted an outline of its discretionary budget request, which proposes a total of $113.1 billion in funding, an increase of $8.5 billion (8.2%) over the FY 21 enacted level of $104.4 billion. The total FY 21 VA budget request was $240.2 billion, and VA received $243.2 billion in appropriations. VA's budget was significantly supplemented in FY 20 and FY 21 during the Coronavirus disease 2019 (COVID-19) pandemic, including $60 million in the Families First Coronavirus Response Act (Pub. L. 116-127); $19.6 billion in the Coronavirus Aid, Relief, and Economic Security (CARES) Act (Pub. L. 116-136); and, $17.1 billion in the American Rescue Plan (ARP) Act of 2021 (Pub. L. 117-2). VA experienced many operational and fiscal challenges related to its response to the pandemic, and while Congress has provided relief to enable VA to continue in its primary mission areas, the impact of the pandemic will complicate the budget picture for many years to come.

Despite operating in a challenging environment, VA will continue to serve a changing and increasingly diverse veteran population. Meeting the evolving needs of these veterans and providing the care and services they have earned will require that VA receive adequate appropriations in FY 22. Further, there are several areas where VA will need additional funding to implement critical programs and newly passed legislation, including legislation related to veterans' mental health and economic and education benefits.

Veterans Health Administration

Medical Care and Pandemic Response

The Biden Administration announced on April 9, 2021, that it would include $97.5 billion for the Medical Care account at Veterans Health Administration (VHA) in its FY 22 Discretionary Budget Request. This represents an 8.5% increase above the 2021 enacted level. The Committee is pleased to see the increase but will reserve further comment on its sufficiency until the larger budget request is released along with a greater level of detail on the request.

During the past year, despite the general chaos and poor management of the federal response to COVID-19 under the Trump Administration, VHA was able to use its experience in healthcare and emergency response in its pandemic approach.
Among other things, the Department quickly mobilized to expand inpatient beds and laboratory testing capacity; expanded the delivery of services via telehealth wherever possible; obtained temporary authorities that helped expedite hiring of medical personnel; restricted access to Community Living Centers and spinal cord injury units (which serve medically vulnerable veteran residents and patients); and established veteran, employee, and visitor screening processes at the entrances of all facilities. However, there were also several missteps with acquiring personal protective equipment (PPE), and VA's overall management of telework for non-medical staff was haphazard and may have unnecessarily exposed staff to COVID-19. It is clear that the response is by no means complete, and the Committee continues to closely monitor VHA's efforts, including COVID-19 vaccine distribution.

However, as the pandemic winds down, a detailed after-action review is necessary to fully appreciate lessons learned and understand possible future budgetary needs to ensure VHA is ready for the next pandemic. One vulnerability that was clearly exposed during the pandemic is the extent to which VHA can acquire necessary medical supplies and effectively monitor inventory levels of those supplies, including PPE. VA has multiple modernization initiatives underway, two of which relate to supply chain and inventory management. The shortcomings of VA's existing vendor contracts and inventory systems—which do not offer all the items VA facilities need and which rely heavily on manual data entry—have been made abundantly clear by the COVID-19 pandemic. The inability of VA's existing vendors to be able to fulfill orders for PPE led VA to search for other options for acquiring critical supplies. In the spring of 2020, VA entered into a partnership with the state of New Hampshire, its National Guard, and a private entrepreneur, through which the Department has procured cargo planeloads of PPE from across the globe. It is our understanding that VA obtained the vast majority of its PPE supplies through this arrangement during the pandemic. The failure of a coordinated federal response raises many questions about what this approach ultimately meant in terms of cost and lack of efficiency.

For inventory management, VHA has relied on its facilities to conduct manual counts of all PPE—down to individual gloves, by size—and report them to VHA Central Office daily.

VHA is also requiring its facilities to maintain at least a 60-day supply of each item of PPE on site, which creates storage challenges, as facilities were previously only required to keep 14 days of supply on hand. VA is working toward establishing regional readiness centers to provide back-up stockpiles for VA medical centers. These depots are a key part of the Department's strategy to augment its just-in-time inventory system that failed to keep up with PPE demands in early 2020. Originally, VA planned for the regional readiness centers to be operational by July 2021. However, VA's plans have been delayed, and these readiness centers are now expected to be ready to help VA resilience in 2023.

An ongoing challenge for VA during the pandemic has been maintaining appropriate staff levels—especially as community spread began increasing. While many private hospitals and providers were laying off providers earlier this year because of a lack of business, VHA was able to not only leverage the funding provided in CARES to hire additional staff, but because of the public health emergency designation, onboard these new providers more quickly due to allowances by the Office of Personnel Management (OPM). VA officials have indicated a desire to explore keeping some of these allowances with OPM post-pandemic. Given the lengthy hiring and onboarding process, the Committee supports opportunities to streamline the process, but those efficiencies should not come at the price of not ensuring health care workers have been properly vetted. Moreover, if VHA intends to maintain increased staffing levels, it will likely need additional baseline funds to pay for staff salaries and other retention tools once emergency funding from CARES and ARP are exhausted.

Given the increased availability of COVID-19 vaccines, enrolled veterans have begun returning to VHA seeking care they delayed during the height of the pandemic. Unfortunately, because of deferring that care, the types of care and services needed will likely be more complex and costly. In addition, like most Americans, veterans are facing higher rates of unemployment due to the economic downturn related to the pandemic. As a result, veterans who previously were not enrolled in VHA may start seeking care and services at higher rates. We encourage VHA to use its existing hardship authority under 38 U.S.C. §1722 in the broadest possible matter to ensure that this cohort of veterans has access to high-quality health care. This is a particular concern for the Committee, as VHA's own data shows that the granting of hardships under 38 U.S.C §1722 fell significantly from a high of 5,100 in 2016 to just 2,490 in 2020. Funds from ARP should offset these costs for the current fiscal year; however, it is unclear what the burn rate for the nearly $15 billion in additional funds for VHA will be. To date, the Department has not provided the Committee any details regarding spend plans despite repeated requests for this information.

Workforce Vacancies

As of December 31, 2020, VA reported that it had 39,118 vacancies across the Department, 37,127 of which were within VHA. However, according to VA, only 8,969 (fewer

than 25%) of VHA's vacancies were considered "funded," meaning that the Department had budgeted for and received funding for them in FY 21. This is not to say that the remaining 28,159 vacancies at VHA are unnecessary. Indeed, VHA could strengthen its ability to deliver timely, accessible, high-quality health care—and lessen its reliance on community care—by adequately budgeting for its healthcare workforce and requesting the resources necessary to fill these longstanding vacancies. VA has been in the process of reviewing and revising its staffing models and determining appropriate staffing levels for VHA occupations for *years*. It is imperative that VA take additional steps to complete its years-long effort to validate all funded and unfunded positions and complete staffing models for each VHA occupation as soon as possible. The Committee must have a complete picture of VHA's true staffing needs, so that it can ensure the Department is adequately resourced in the future.

Mental Health

The Committee will continue to closely monitor the pandemic's possible implications for veterans' mental health and VA's mental health, substance use, and suicide prevention efforts. In 2020, two large veterans' mental health and suicide prevention legislative packages became law (the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act* and *the Veterans Comprehensive Prevention, Access to Care, and Treatment (COMPACT) Act*),[1] necessitating rigorous oversight. Given ongoing issues with timely veteran suicide data collection, analysis, and reporting from VA, the Committee also will work with VA and stakeholders to evaluate VA's use and dissemination of best practices in real-time veteran suicide surveillance. It will also examine VA's substance use and addiction treatment capacity and programming, with a focus on overlapping mental health issues. Overall, the Committee is pleased with the Administration's request for $542 million for suicide prevention and supports its use to increase the capacity of the Veterans Crisis Line. The Committee will also closely monitor and provide recommendations on VA's use of community providers and organizations to deliver mental health, substance use, and suicide prevention services to veterans, when VA cannot provide these services directly and when at-risk veterans are outside VA's reach. VA must ensure that such providers and organizations deliver culturally competent, evidence-based treatment.

Health Equity

Another special focus of the Committee will be examining how well veterans in traditionally underserved populations can access culturally appropriate mental health and suicide prevention services through VA. For women veterans, this includes addressing access to appropriate residential treatment programs, reproductive health, differences in suicide risk, and connections with experiences affecting the women veteran population such as military sexual trauma and intimate partner violence. This also includes ensuring all research regarding women

[1] Pub. L. 116-171 (2020) and Pub. L. 116-214 (2020).

veterans addresses high proportions of Black, Latinx, Native and Asian and Pacific Islander women veterans. The Committee also will continue to highlight the unique needs of and access to VA mental health care for minority veterans, LGBTQ veterans, and veterans living in rural and highly rural areas.

The Committee was pleased to see the Administration highlight racial disparities in its "skinny" budget. On almost all available metrics, minority veterans have lower life expectancies and higher prevalence of diseases than white veterans. The impact of COVID-19 on communities of color has exacerbated these existing disparities. In 2020, racial and ethnic minority veterans made up 22% of the total veteran population. VA projects that number to reach 35% by 2040. Among women veterans, more than 40% also belong to a racial or ethnic minority, and that proportion will surpass 50% by 2040. All veterans must have access to culturally competent healthcare from the very system charged with caring for them. The types of services, the competencies VA develops, and the manner of outreach it conducts must meet the unique needs of its patients. This is particularly true as VA works to establish relationships with tribal communities and increase access to care through partnerships with Indian Health Service (IHS), Urban Indian Organizations (UIO), and Tribal Health Programs (THP). This is crucially important as American Indians and Alaska Natives serve in the military at a higher rate than any other cohort yet are the least likely to use VA healthcare. VA should be the leading example in American healthcare of how to dynamically meet the needs of an increasingly diverse and intersectional patient population.

One enormous challenge VA faces in this effort is the preponderance of incomplete racial, ethnic, and LGBTQ data of enrolled VHA users. VHA must address the data and research gaps that have made health inequities among minority veterans so difficult to address. VA cannot confidently share with Congress any preliminary trends in outcomes and morbidity from COVID-19 among veterans. What data is available, through complete health records, indicates minority veterans were much more likely to survive hospitalization with COVID-19 than their civilian counterparts.

VA has provided race and ethnicity data related to the pandemic since July 2020, however by VA's own admission, these data are incomplete. Congress must be made aware of where disproportionate impacts or outcomes are experienced by veteran cohorts so we can better enable VA to protect and treat those veterans at heightened risk during this pandemic.[2] We need to know what early trends the largest integrated healthcare system in the United States is seeing in its patient data and what is needed to address any disparities.

Similar to the basic data collection challenges, VA has little data on the minority patient experience at VA. Outside of intermittent surveys, VA collects patient experience feedback

[2] House Veterans' Affairs Committee Subcommittee on Health, *Oversight Hearing: Achieving Health Equity for Americas' Minority Veterans* (Feb. 11. 2020) (https://veterans.house.gov/events/hearings/subcommittee-on-health-oversight-hearing-achieving-health-equity-for-americas-minority-veterans).

through patient advocates located in each of VA's 172 medical centers. Medical centers require at least one patient advocate available to respond to feedback and ensure that responses are recorded in the Patient Advocate Tracking System (PATS).[3] VA does not require patient advocates to submit race and ethnicity information in PATS. The Government Accountability Office (GAO) found that most do not unless it directly relates to the complaint. In 2017, the Office of Patient Advocacy created two codes that may specifically apply to issues affecting minority veterans: 1) discrimination concerns, and 2) diversity concerns. GAO interviewed 21 patient advocates—nine said they were not aware of those codes or had never used them. In response, "VA officials told [GAO] that they expected to see patient advocates use these codes more often in 2019 as a result of updates to their training curriculum."[4]

The pandemic has also illustrated the need to ensure VA is providing language inclusive written material, translation options on its websites, and multi-lingual personnel who answer hotlines and make appointments. For thousands of veterans and their caregivers, English is a second language. For older veterans, it is not uncommon that they lose their English proficiency. Effective communication, especially in the delivery of healthcare, is vital. VA must ensure it is able to communicate with those they care for. Additionally, VA must educate its workforce on the necessary cultural competencies for working with veterans in tribal and territorial communities and others whom VA has historically excluded.

Given the importance of health equity issues, the Committee would recommend robust funding so that VHA may begin to better address some of the challenges underscored above.

Long-Term Services and Supports

The Committee will assess VA's proposed funding for a broad array of Long-Term Services and Supports (LTSS) to determine whether veterans have access to the methods of care delivery that best suit their needs. Over the years, VA has relied primarily upon a network of institutional services, consisting of VA Community Living Centers (CLC), State Veterans Homes (SVH), and contracted community nursing homes; however, VA must do more to develop a robust network of home and community-based services to meet the growing demand for non-institutional care among its aging veteran population.

Moreover, given the impact COVID-19 has had on long-term care facilities nationwide, serious re-evaluations of this industry and the extent to which these facilities offer high-quality, safe care to residents need to occur and lessons need to be learned from VA's CLCs. As of early 2021, there have been no widespread outbreaks of COVID-19 in any of VA's 134 CLCs, largely

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[3] An electronic system used to describe and track the resolution of veterans' feedback across VA medical centers.

[4] Government Accountability Office, *VA Health Care: Opportunities Exist for VA to Better Identify and Address Racial and Ethnic Disparities* (GAO-20-83) (Dec. 11, 2019).

because of VA's extensive expertise in geriatrics, infection control, and emergency response. VA has a role in monitoring the quality of care and patient safety at SVHs, along with supporting the cost of care for veteran residents, along with SVH construction, renovation, and maintenance. This raises questions about whether VA's current oversight authority is sufficient and whether additional funding should be dedicated to expanding the reach of VA's expertise in this area.

Furthermore, following the expansion of the Program of Comprehensive Assistance for Family Caregivers (PCAFC) in October 2020 to the first cohort of pre-9/11 veterans and their caregivers, VA has indicated this program may not be adequately funded. The Committee has long been skeptical of VA's budgetary assumptions around expansion of this program and preliminary data regarding new applicants seem to bear out those concerns. Without proper funding, pre-9/11 veterans and their caregivers may once again face exclusion. Aside from these budgetary concerns, the Committee will also closely monitor VA's implementation of the numerous changes it made to the program through regulation, as VA attempts to standardize the program and expand it to the second cohort of pre-9/11 veterans and their caregivers.

Community Care

It is the Committee's understanding that the majority of the $8.5 billion above the previously enacted level that the Administration plans to request for VHA for FY 22 will be directed to community care. This will be in addition to the more than $6.1 billion in supplemental funding for VA community care that was already provided through the Families First Coronavirus Response Act (Pub. L. 116-127), the CARES Act (Pub. L. 116-136), and the ARP Act of 2021 (Pub. L. 117-2). Given these significant, un-planned increases in VA's community care budget, the Committee has serious concerns about the reliability of VA's community care budget estimates, and about VA's increasing reliance on care in the community.

Under the Trump Administration, eligibility for care in the community was significantly expanded through VA regulations, designating access standards for the Veterans Community Care Program (VCCP), as mandated by the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 (P.L. 115-182). As we have learned from implementing previous iterations of community care programs, including the Veterans Choice Program, roughly 18 months are needed to fully understand utilization and costs associated with that care. While VCCP has now been in place for more than 21 months, there are a number of factors this time around that suggest the program is still maturing and we still may not have a comprehensive picture of utilization or costs to date. For example, early in the pandemic, community providers limited access to care, and veterans (like most Americans) largely put off routine care in 2020. Furthermore, VA took a long time to award contracts in the various regions across the country (region 6 remains unawarded) to develop Community Care Networks (CCN), using older, more expensive contracting vehicles to obtain care when VCCP implementation began in June of 2019.

Aside from the financial implications, the Committee remains broadly concerned about VA's increasing reliance on care in the community—which was a trend that began well before the pandemic. During the 2014 wait-time scandal, expanding veterans' "choice" via increasing access to care in the community was seen as a cure-all to long wait times. However, the Committee has conducted several oversight hearings in recent years that have highlighted the lengthy bureaucratic process to get community care—GAO's most recent report on the subject showed that VA had established an appointment scheduling process that allows up to 19 days for staff at VHA medical facilities to simply schedule veterans' community care appointments, which may not occur until well after they are scheduled.[5] According to VHA's own data on veterans' actual wait times, veterans waited on average 34.6 days to receive care in the community during the first quarter of fiscal year 2021, with 22.3 of those days accounted for by the administratively burdensome appointment scheduling process VA established.

It is important to preserve and strengthen VA's direct care system. Not only is care in VA more culturally competent, numerous studies have shown the quality of VA care to be equal to, if not better than, the care delivered in the private sector in several important metrics. It is anticipated through VA's own market assessments and subsequent Asset and Infrastructure Review Commission that recommendations will be made to expand VA's direct care system in some regions of the country to help address demand for care and services.

Veterans Benefits Administration

Homelessness

While the Committee recognizes VA's overall success in reducing veteran homelessness, data compiled during the 2020 Department of Housing and Urban Development (HUD) Point-in-Time (PIT) count is alarming, as it revealed a pre-pandemic rise in veteran homelessness and does not account for the potential increase in housing insecurity caused by COVID-19 economic conditions and strain. Progress towards decreasing veteran homelessness has stalled the past two years; the 2019 PIT count showed only a 2.1% decrease from 2018 levels after a general trend of more significant year-over-year declines. Although a federal eviction moratorium and renter protections remain in place, the Committee is concerned that housing instability is a persistent issue for veterans and their families that may continue to grow throughout the pandemic and beyond, absent a strong, sustainable response and strategy.

The CARES Act and ARP appropriated additional funding and made it possible for VA to obligate those additional funds over previously authorized levels to support its programs for homeless veterans. During this time, VA also waived certain program and policy requirements to

[5] Government Accountability Office, *Veterans Community Care Program: Improvements Needed to Help Ensure Timely Access to Care* (GAO-20-640) (Sept. 28, 2020).

provide flexibility in its pandemic response to account for veteran safety and needs, including allowing grantees to use Supportive Services for Veteran Families (SSVF) funds to move veterans into hotel/motel accommodations; hiring health care navigators to help those placed in hotels access health and behavioral health service; assisting veterans enrolled in Housing and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH) during the slowdown in Public Housing Authority operations; and expanding prevention services to address an anticipated wave of evictions. VA indicated to the Committee that as of January 29, 2021, the SSVF program had provided over 23,000 hotel/motel placements since the beginning of the pandemic.

Additionally, VA waived payment limits for facility costs and per diem rates for the Grant and Per Diem (GPD) program. VA also authorized funding for the Healthcare for Homeless Veterans (HCHV) program to be used to provide shelter for veterans experiencing homelessness, including in hotel/motel rooms and for supportive services. VA rapidly expanded its telehealth and virtual care offerings for case managers and homeless veterans and provided over 28,000 mobile phones to VAMC homeless programs to distribute to veterans.

Still, increasing the housing supply and ensuring access to wraparound services like mental health care and employment resources through case managers remain fundamental to preventing and ending veteran homelessness. The 2020 PIT count data indicates VA's efforts to combat housing insecurity were falling short before the pandemic. The extent of the effects of COVID-19 on factors that may drive veterans into homelessness, such as job and income loss, housing instability, and mental and emotional health, remain difficult to forecast. Swift and proper implementation of the resource enhancements and expansions for homeless veterans provided in the *Johnny Isakson and David P. Roe Veterans Healthcare and Benefits Improvement Act*[6] is critical. The Committee looks forward to seeing data related to the program and policy waivers the VA instituted for its various homeless support programs to determine if there is evidence that this flexibility improves outcomes for veterans.

Initial data indicates the COVID-19 pandemic is disproportionately affecting minority veterans. Black veterans experienced higher unemployment rates than white veterans throughout 2020. Women veterans are also experiencing compounded stress due to increased mental, financial, and familial responsibilities. Throughout the pandemic, minority veterans reported a higher level of need across categories including financial assistance, housing, food, and childcare. The Committee will continue to strongly encourage the VA to prioritize equity in its policies and the provision of homeless programs and services.

[6] Pub. L. 116-315 (2020).

Education

Though the Committee has worked closely with VA to address concerns with the processing of GI Bill benefits and delivery of other education and transition assistance resources, issues with implementation remain that require attention and resources. The *Isakson and Roe Veterans Healthcare and Benefits Improvement Act* mandated a number of significant changes to the provision of VA educational assistance benefits.

In response to the COVID-19 pandemic, VA instituted temporary measures to provide flexibility for student veterans to ensure they can utilize and preserve their earned benefits in the event of school closure or other circumstances that prevent the continuation of their studies. Existing programs were also expanded and enhanced, including the Edith Nourse Rogers STEM Scholarship, the Fry Scholarship, and the Veteran Employment for Technology Education Courses (VET TEC). The ARP authorized the Veteran Rapid Retraining Assistance Program (VRRAP) for $386 million to provide training for high-demand occupations to up to 17,250 veterans who are unemployed as a result of the pandemic and are ineligible for GI Bill or Veteran Readiness and Employment (VR&E) benefits. The Committee will oversee implementation of this and other key provisions of recently enacted legislation to ensure VA is delivering adequate and timely resources to veterans throughout the pandemic.

Protecting veterans from predatory institutions that prioritize profit over education has long been a priority of this Committee. The *Isakson Roe* bill strengthens oversight of educational providers and requires VA to work with State Approving Agencies (SAA) to develop risk-based surveys that can be used to identify and analyze bad actors. It also closed the 90/10 loophole through which for-profit institutions used GI Bill funds to circumvent the cap on federal funds the schools would otherwise face. Further, VA is now required to analyze whether schools facing legal or punitive actions from the government should be cut off from GI Bill money. VA must begin holding schools accountable for deceptive marketing and predatory practices and provide easily accessible, comprehensive information to veterans as they choose an institution for their studies.

Modernizing VA IT infrastructure to centralize GI Bill claims processing and improve customer service is still in its nascent stage despite this being an ongoing need for many years. In mid-March 2021, VA awarded a $458 million contract to support VA digital transformation for GI Bill claim processing. Prior attempts to update these systems resulted in glitches that caused further processing delays and frustration for users. The Committee will closely monitor VA progress towards developing and implementing a modern IT system, ensuring that veterans are not adversely affected throughout the process.

Transition

Expanding the role of VA in the Transition Assistance Program (TAP) to make it a more effective resource remains a high priority of this Committee. The COVID-19 pandemic presented new challenges to transitioning servicemembers and the execution of TAP. The *National Defense Authorization Act of 2020 (FY 20 NDAA)*[7] and *Isakson Roe* mandated a number of improvements to TAP and other transition resources. These bills require TAP to take a more personalized approach in its services by providing one-on-one counseling and specific career-oriented tracks that suit a servicemember's post-separation plans. Additionally, VA is now required to make grants to eligible organizations for the provision of transition assistance.

A better understanding of the effectiveness of TAP is fundamental to informing changes that will produce positive post-separation outcomes for servicemembers. *Isakson Roe* requires VA to enter an agreement with an independent entity with experience in adult education to report on the efficacy of TAP. VA must also conduct a five-year study of TAP on cohorts who have separated from the Armed Forces. To have a more comprehensive view of outcomes, VA and the Department of Labor (DOL) are now granted access to certain information reported by employers to states' new hire directories in order to track employment of veterans. The Committee will continue to monitor success of the Solid Start program and VA efforts to proactively engage with veterans after their military separation.

Despite authorizing many improvements to TAP, the Committee has concerns about VA's commitment to implementing those changes in accordance with Congressional intent. For instance, the *FY 20 NDAA* authorized the Department of Defense, VA, and DOL to jointly conduct a pilot program on a one-stop online application (app) to assist servicemembers and veterans participating in TAP. VA indicated in April 2021 that they have not created this app and the Committee is worried the agency may delay implementation of other key provisions of the law as well.

Claims and Compensation & Pension Exams

The COVID-19 pandemic forced VHA to pause in-person compensation and pension exams for almost two months in the spring of 2020. VA made this decision in an effort to reduce the spread of COVID-19 among the veteran population. The steps taken to reduce the spread of the virus are commendable. However, pausing in-person examinations led to an increase in the compensation and pension inventory, which has more than doubled from 144,000 in March 2020 to 352,154 by April 2021.

The increased compensation and pension exam inventory contributes to an increase in the number of backlogged claims. The claims backlog—claims awaiting adjudication for more than

[7] Pub. L. 116-92 (2019).

125 days—has increased from 77,000 in January 2020 to 202,222 as of April 2021. VA anticipates an increase in the number disability compensation claims for three new Agent Orange presumptive conditions—including bladder cancer, hypothyroidism, and Parkinsons-like symptoms. The Committee supports VA's request for $40.3 million in discretionary funds to hire 334 new benefits claims processors to support the influx of new disability claims and prevent an increase in the currently outstanding 202,000 claims. The Committee expects the new processors and funds that support overtime in FY 22 will reduce both the disability claims backlog and the compensation and pension exam inventory.

National Cemetery Administration

The National Cemetery Administration (NCA) has the important role of honoring the legacy of America's veterans in perpetuity. This responsibility comes with many opportunities to incorporate the diversity of veterans and their evolving communities.

To that end, in December 2020, Congress passed legislation requiring an expansion of burial benefits.[8] This expansion includes: extending transportation services to state veterans cemeteries, extending VA's requirements for outer burial receptacles to cemeteries, authorizing VA to replace existing VA-furnished headstones to add inscriptions for deceased spouses and eligible dependent children, and allowing for inscriptions on headstones furnished by the VA if the spouse or eligible dependent child predeceases the veteran. The legislation also makes counties eligible to apply for Veterans Cemetery Grants and authorizes NCA to furnish an urn or a commemorative plaque in lieu of a headstone or marker to eligible individuals whose cremated remains are not interred in a cemetery. These programs will help to ensure more inclusive and thoughtful programs for veterans and their families across the country and in territories.

Along with the expansion of these programs, the Committee wants to ensure that VA continues efforts to replace headstones of prisoners of war in Fort Sam Houston National Cemetery and Fort Douglas National Cemetery that feature swastikas and inscriptions honoring Adolf Hitler. The presence of the headstones remains disturbing and though the Department has agreed to take immediate steps to swiftly replace these headstones, the Committee wants to make clear that the process of removing and replacing these relics remains a priority. The Committee supports resources to continue NCA's efforts to provide legacy programs such as its digital legacy program and its continued mission to support national, state, and local veterans cemeteries.

Departmental Administration

Electronic Health Record Modernization

[8] *Johnny Isakson and David P. Roe, M.D., Veterans Health Care and Benefits Improvement Act*, Pub. L. 116-315 (2020).

VA's deployment of its new Electronic Health Record (EHR) system has encountered numerous delays and a significant number of ongoing issues must be resolved before VA deploys the program to future sites. EHRM went live with its first initial operating capability (IOC) site, Mann-Grandstaff VA Medical Center in Spokane, Washington, on October 24, 2020 with a reduced capability set—labeled Capability Set 1.1—with the full capabilities to be delivered at a later date, once COVID-19 restrictions are eased so as to allow necessary staff to be on premises. However, since the initial deployment, Committee staff have heard concerns regarding the implementation of Cerner Millennium as well as the new standardized workflows.

Between January 25-26, 2021, Acting Under Secretary for Health, Dr. Richard Stone, visited Mann-Grandstaff to meet with frontline VA employees and gain firsthand knowledge of the issues that had been identified, including declines in productivity and morale, and frustration with various aspects of the system that are perceived to not be working correctly. Committee staff have been tracking these concerns. While a loss of productivity is to be expected with any major IT upgrade, it is not clear whether VA is measuring this productivity loss against productivity levels before the COVID-19 pandemic or against levels just prior to the go-live, which was during the pandemic.

In February 2021, GAO released a report recommending that VA delay all future deployments until critical and high severity test findings have been resolved.[9] On March 17, 2021, VA Secretary Denis McDonough announced that he was directing a strategic review of the program, including a contract review, following the initial review he conducted upon taking office. At an April 14, 2021 hearing, Acting Deputy Secretary, Dr. Clancy, pledged to halt all further deployments until the strategic review is completed and its findings are implemented.[10]

While the Committee supports fully funding the EHRM program at appropriate levels, it is critical that the Administration provide additional information to Congress regarding the state of the program, including potential schedule shifts and budgetary impacts. The discretionary budget proposal includes $2.7 billion for EHRM but lacks detail to allow the Committee to understand how this positions the program to succeed in the coming year. The Committee looks forward to the report from VA's strategic review as well as the full budget proposal, which will allow the Committee to better assess whether the proposal is adequate.

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[9] Government Accountability Office, *VA Has Made Progress in Preparing for New System, but Subsequent Test Findings Will Need to Be Addressed* (GAO-21-224) (Feb. 11, 2021).

[10] House Veterans' Affairs Committee Subcommittee on Technology Modernization, *Hearing on Strategic Review: Evaluating Concerns About the Ongoing Implementation of the Electronic Health Record Modernization Program* (Apr.14, 2020) (https://veterans.house.gov/events/hearings/strategic-review-evaluating-concerns-about-the-ongoing-implementation-of-the-electronic-health-record-modernization-programs).

Information Technology Funding

The overall budget for the Office of Information and Technology (OIT) has remained relatively static over the last several years, with $4.8 billion requested for FY 22 to pilot application transformation efforts, support cloud modernization, deliver efficient information technology services, and enhance customer service experience. The $4.8 billion represents a decrease from the $4.921 enacted FY 21 funding. The Committee has not received a detailed accounting of FY 21 funding, including an explanation regarding the source of funds (regular appropriations, supplemental, or repurposed funds) and how the application of those funds impacts the budget picture for OIT.

With a decrease in funding, OIT faces an ambitious set of goals—including enterprise needs, both maintenance and upgrades, as well as managing VA's more than $1 billion in technology deficit. VA and OIT are also managing several ongoing complex modernization projects, such as EHRM, Financial Management Business Transformation (FMBT), Defense Medical Logistics Standard Support (DMLSS), and LogiCole, all of which are projected to take at least a decade to implement. These projects have required significant investment in IT equipment and infrastructure.

Owing to the size of the technology debt and number of modernization projects, the Committee recommends that VA conduct a strategic review of all IT modernization projects to determine if VA is on track, poised to meet specified goals, and if IT funding is sufficient to meet short and long-term need. OIT also needs to determine if, and where, modernization efforts may be "colliding", resulting in inefficiencies such duplicate purchases or upgrades with insufficient capacity for multiple systems. OIT also needs to determine what projects and programs exist outside of the formal purview of the Chief Information Officer (e.g. "shadow IT").

Despite numerous requests, VA has not provided Congress with a prioritized list of unfunded (or underfunded) IT modernization projects. In 2020, VA released its plan for a 4-year department-wide technical refresh program.[11] The document outlined a 4-year plan between FY 20 – FY 23 to eliminate VA's technical debt and identified a budget request of $473 million specifically aimed at this goal. While the Committee agrees with the need to update VA's aged, and sometimes obsolete, technology, VA has failed to follow up and inform the Committee of the status of the refresh program or furnish the Committee with an updated plan. It also failed to outline how items are paid for after the 4-year period—a deficiency noted last year but still not corrected. Likewise, the Committee has not seen a follow-up to the FY 20 goal of transitioning to the Enterprise Cloud Solution (VAEC). While the Committee supports robust OIT funding, such funding must be supported by strong justification, proper requirements development, and absolute transparency—including reporting and management requirements. As budgetary outlays are made, VA must provide clarification as to where funding is being spent and if strategic goals are being met.

[11] Department of Veterans Affairs, Office of Information and Technology, *VA OIT Infrastructure: ITOP/EHRM Infrastructure Alignment FY20-FY22* (Oct. 31, 2019).

Many of the problems identified by the Committee in its FY 21 budgetary views and estimates continue. VA also seems to suffer from a lack of consistent leadership and a clear, articulated, strategic vision. In addition to leadership challenges, there has been slow growth in highly skilled staff at OIT, leaving VA heavily dependent on contractor support and detailed staff from other programs.

Strengthening VA Workforce Diversity, Equity and Inclusion

VA has recognized that delivering a world-class customer experience is very dependent on high levels of employee engagement by empowering and enabling a diverse workforce. However, over the last few years, there have been persistent signals that VA can and should do more to address employee discrimination. In FY 20, VA reported that it received over 2,800 complaints of equal employment discrimination. It was particularly worrying to see increases since 2016 in the number of complaints of discrimination based on disability and pregnancy, as well as persistently large numbers of complaints of racial, color, gender, and age discrimination. As the institution charged with caring for our increasingly diverse veteran population, it is critical that VA welcomes all veterans who walk through its doors—regardless of race, gender, sexuality, or gender identity.

In VA's most recent Equal Employment Opportunity (EEO) program report, VA identified several concerning trends among specific employee groups indicating that barriers exist, including:

- Hispanic workers are underrepresented in the VA workforce, hired at a lower rate, and have a higher involuntary separation rate when compared to relevant labor forces.

- Most minorities and women are underrepresented in VA's most senior job roles—from GS-11 to the Senior Executive Service (SES). For example, according to VA data, Black or African American females comprise almost 17% of the VA workforce but only about 3% of GS-15 positions and 6% of VA's SES positions. By comparison, white males comprise only 23% of the VA workforce but make up nearly 40% of GS-15 positions and 50% of SES positions.

- VA has not met its goals for achieving its targets for persons with disabilities or targeted disabilities in senior positions. Only 10% and 1.4% of VA's GS-11 to SES positions are held by persons with disabilities and targeted disabilities, respectively, falling short of goals of 12% and 2%, respectively.

To quickly lay the groundwork toward sustainable solutions, the Committee believes VA should dedicate resources to the following actions to immediately bolster efforts to improve diversity, equity, and inclusion across VA, including: 1) conducting increased number of barrier analyses and implement corrective action plans; 2) increasing the number of site visits conducted

at VA facilities across the nation, including Technical Assistance Reviews; and, 3) strengthening work with employees and stakeholders.

VA faces many challenges ahead and, as noted above, there are several areas that the Committee would urge the Department focus on. Congress has provided VA with many tools and resources, but there is still much work left to be done. As the veteran population changes, and as its mission evolves, VA must continually adapt its approach. The Committee stands ready to assist VA in these efforts, so that we may continue to meet our obligation to those who have served. The Committee appreciates your strong support of programs and benefits for veterans and looks forward to working with you to effectively resource VA in FY 22.

Sincerely,

Mark Takano
Chairman