ACCOUNTABLE OR ABSENT?: EXAMINING VA LEADERSHIP UNDER THE BIDEN-HARRIS ADMINISTRATION

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BEFORE THE

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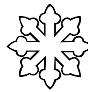

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ACCOUNTABLE OR ABSENT?: EXAMINING VA LEADERSHIP UNDER THE BIDEN-HARRIS ADMINISTRATION

TUESDAY, SEPTEMBER 10, 2024

COMMITTEE ON VETERANS' AFFAIRS,
U.S. HOUSE OF REPRESENTATIVES,
Washington, DC.

The committee met, pursuant to notice, at 11:16 p.m., in room 360, Cannon House Office Building, Hon. Mike Bost (chairman of the committee) presiding.

Present: Representatives Bost, Bergman, Mace, Rosendale, Self, Miller-Meeks, Murphy, Franklin, Van Orden, Luttrell, Ciscomani, Kiggans, Obernolte, Takano, Brownley, Levin, Pappas, Mrvan, Cherfilus-McCormick, McGarvey, Ramirez, Landsman, Budzinski, Kennedy, and Crow.

OPENING STATEMENT OF MIKE BOST, CHAIRMAN

The CHAIRMAN. The committee will come to order. Before we get started, I want to ask unanimous consent that Representative Obernolte and Representative Crow be able to sit at the dais and participate in questioning. Hearing no objections, so ordered.

Throughout this Congress, this committee has conducted rigorous oversight of the Biden-Harris administration management of U.S. Department of Veterans Affairs (VA). It is our bipartisan responsibility to make sure VA is properly serving veterans, period.

We have investigated leadership, mismanagement, misconduct, and ineffectiveness at medical centers across the country. This includes Aurora, Colorado; Hampton, Virginia; Loma Linda, California; Mountain Home, Tennessee; Buffalo, New York medical centers among others.

The committee has also examined allegations of individual misconduct, including sexual harassment, against senior leaders throughout the VA. As I said earlier this year, this behavior has no place at VA and I will always do my part as the chairman of this committee to put a stop to it.

One of the despicable examples for such misconduct are the recent sexual harassment and sexual assault allegations coming out of the Mountain Home, Tennessee VA Medical Center. Employees who work at this facility have outlined at least three different instances of alleged sexual harassment or sexual assault that occurred within the facility.

If this was not bad enough, the Mountain Home VA leadership allegedly knew about some of the allegations for nearly 6 months but never intervened.

Now, another example of misconduct is a coordinated decision by senior leaders to give Critical Skill Incentives (CSI) bonuses to nearly every VA central office executive. As chairman I have also encouraged whistleblowers to expose waste, fraud, and abuse of resources and violations of law and policy.

Whistleblowers know when the bureaucracy has lost its way. That is why my oversight team has spent hundreds of hours taking or talking to them and conducting oversight visits.

Now, unfortunately, we have seen a lot of mismanagement and misconduct, a lot of things that should not be happening, a lot of things that veterans and taxpayers expect us to end. It is these scandals, this is one—there is a complete lack of accountability within the VA.

We have seen this administration fail to effectively lead the Federal Government and, unfortunately, VA is no different. Senior leaders and managers in VA must be held responsible for employees they supervise and the work environment they create. Setting a positive example for employees on how to properly serve our veterans is not optional.

Time and time again, when VA leaders and management are inept, commit misconduct, or create hostile work environments, they are never held accountable. Instead, such leaders are left in place and collect a healthy paycheck until Congress, the Inspector General (IG), or the press find out.

Even then offenders usually get shuffled to another office to cause more problems while still collecting the same large paycheck. In one case, a medical center director was moved into a Veterans Health Administration (VHA) administrative position after being found to create a psychological and unsafe and dangerous workplace, but it gets better.

The VA later found this individual routinely engaged in inappropriate conduct that created a toxic work environment in the new office the leader was now moved to. I ask this administration to help me understand how moves like this make any shred of sense.

In another example, a facility director who mismanaged medical providers' clinical performance reviews, which could have led to poor veterans' care, was merely reassigned to a cushy VHA office. This lack of accountability is not fair to all the others hard-working VA employees, many of which are fellow veterans or those veterans who rely on VA for their care and benefits.

I introduced the Restore Accountability Act of 2023 last year to prevent these bad apples from lingering around VA and collecting paychecks from the taxpayer. This legislation would restore the authorities in the 2017 Accountability Act and would allow VA to timely and appropriately discipline employees because right now under the Biden-Harris administration, watching, accountability, and oversight is nonexistent.

The lack of VA accountability is happening at VA. The lack of accountability that has happened at VA has completely lost control of its budgets and its Information Technology (IT) projects ballooning by tens of billions of dollars. That includes the Digital GI

Bill, financial management, business transformation, and the Electronic Health Records (EHR) system.

Poor leadership also includes bad management, poor judgment, and lack of transparency. We are seeing this all over VA.

Finally, we have the budget shortfalls. Mr. Jacobs has told us there is a nearly $3 billion hole in the disability compensation and education funding. The Biden-Harris administration is demanding Congress bail them out or veterans' benefit payments may be delayed.

My friend, Representative Mike Garcia, has introduced a supplemental bill, the Veterans Benefit Continuing and Accountability Supplemental Appropriation Act with strong accountability measures, and I proudly support and also am a co-sponsor of that legislation.

VA has no excuse for failing to budget for the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act, but we must hold the veterans harmless. Dr. Elnahal also tells us there will be a $12 billion hole in the healthcare funding next year, but VA stonewalls us when we try to get to the bottom of it.

We got a story that did not add up nearly 2 months ago, and VA refused to provide any more briefings before this hearing to further explain themselves. Now, either the VA estimates are completely unreliable or the administration presented a dishonest budget request in the spring.

We have to find out the truth and press for accountability so this never happens again. This is serious business and the veterans, the veterans' well-being is at stake.

With that, I would now like to recognize Ranking Member Takano for his opening comments.

OPENING STATEMENT OF MARK TAKANO, RANKING MEMBER

Mr. TAKANO. Well, thank you Mr. Chairman.

I want to at the beginning address the budget shortfall VA faces. When I got the PACT Act signed into law in 2022 I wanted VA to set ambitious goals. I wanted VA to outrun those goals to quickly get veterans into care and connected with the benefits that they are owed.

VA succeeded. One million disability, actually 1.1 million disability claims approved in 2 years, hundreds of thousands of new healthcare enrollees. The GI Bill and job training benefits are being used at unprecedented levels to further veterans' education and careers.

The budget shortfall is a product of VA's success in implementing the PACT Act. Congress knew VA would need more resources to implement the largest expansion of veterans' benefits in years. We made a commitment with the Cost of War Toxic Exposure Fund to provide those resources.

However, the unchecked growth of for-profit care has exploded over the last 2 years. This has severely impacted budget forecasts post-PACT Act.

When the Trump administration implemented new access standards in 2019, which further opened VA healthcare to privatization, I fear that this day would come. I support community care when

it is necessary for a veteran to receive timely and accessible care, but we have reached a fork in the road.

We have a choice of which way to proceed. In one direction we continue down the path we are on and VA crumbles under the enormous weight of for-profit healthcare. We enrich the private sector at the expense of the healthcare veterans know and love.

In the other direction we course correct and create an ecosystem in which resources for VA direct care and community care are balanced and seamlessly function to meet the needs of veterans. We have to invest in the staff and infrastructure VA needs to flourish into the future.

This is the more difficult path, but it is the one that we must take. Direct care is less expensive and more effective for veterans, and when I say direct care I mean VA care.

VA outperforms the private sector in terms of both quality of care and patient satisfaction. A strong VA is what veterans both need and want.

The continued unchecked growth of for-profit healthcare will eliminate choice, will eliminate choice for the millions of veterans who choose VA for their care because it will destroy VA care. There is no turning back from this fork in the road. We must choose now.

I want to work with VA to improve its budget estimates in the future so that we can avoid similar shortfalls and for the sake— and for all of us to take a realistic look at the true needs of the agency.

The chairman has accused VA of running its budget into the ground. This shortfall cannot be blamed on mismanagement. This shortfall was caused by the quick increase in veterans now eligible for the benefits they have earned. VHA and Veterans Benefits Administration (VBA) are clearly and rightfully more focused on veteran outcomes than cost.

When we wrote the PACT Act, we gave the administration the authority to waive provisions that phased in eligibility. President Biden and Secretary McDonough agreed veterans had been waiting long enough and chose to exercise their authority to accelerate PACT Act eligibility for the hundreds of thousands of veterans who have been denied VA healthcare for decades.

I heard no objections from anybody from our side or the other side about this acceleration, both on day 1 on the bill signing and a year later when they accelerated the cohorts that could become eligible. Nobody objected. Nobody.

Now, we are hearing a lot of whining about the cost of that acceleration. Should VA not have implemented the PACT Act as quickly as it did? Should VA have stopped enrolling veterans or approving claims when they hit a certain number because that would put them over budget?

I fear my colleagues across the aisle are suggesting that we should break our promise and default on our debt to veterans because it just costs too much.

My priority as the ranking member of this committee is to ensure VA is where all eligible veterans choose to receive world class healthcare. That means fighting for the budget VA needs to grow its staff and address its aging infrastructure.

It also means extensive oversight of facilities and programs when issues arise, not just finger pointing and press releases. However, this is all part of the majority's long game to reduce VA to ruins, which is clearly laid out in Project 2025, as it was in the Heritage Foundation's budget blueprints in 2017 and 2021.

I will point to the poster behind me. The first step of this game plan is to tell veterans not to trust VA. My majority colleagues have spent almost all of their time in Congress this Congress, while they were in control of this Congress, wielding this committee's oversight authority to undermine confidence in VA instead of passing legislation to actually improve it.

They issue press releases that slam, bash, grill, and blast the Biden administration, or should I say the Biden-Harris administration, since for some reason they have only started recently adding the vice president to their attacks. How timely.

The second step is to starve VA of resources. As we know, due to the massive success of the PACT Act, more veterans than ever are now enrolled in VA healthcare. Because of the access standards put in place by the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act, VA needs to keep wait times for appointments low for veterans to receive their care at VA.

To push wait times down, VA needs to hire more clinical staff. To hire more clinical staff VA needs competitive salaries. To be more competitive in the market, VA needs the authority and the budget to pay clinicians what they deserve.

When VHA is spending at least a third of its budget, healthcare budget, on referring veterans' care into the private sector, those dollars end up in the pockets of providers who sometimes are earning as much as three times what VA employees earn.

Salary caps are driving clinicians away from VA, and when VA does not have the clinical staff needed to see patients wait times increase and then VA is forced to send even more care into the community.

VA's aging infrastructure also has a direct effect on wait times and VA is certainly put in the position of choosing between upgrading its facilities, opening new ones closer to where veterans live, or paying for private care. That cycle of resource starvation continues.

The third step in the Republican plan to destroy VA is to privatize more care. My colleagues are intent on opening the aperture to private care even more to continue the community care eligibility expansion started in the Trump era MISSION Act. Their solution is to always send veterans to the private sector and never to invest in VA employees or facilities.

Finally, the cycle restarts. Rinse and repeat. The majority continues its attacks and tells veterans not to trust VA.

As has been my concern while sitting through nearly an entire, Congress of oversight hearings led by the Republican majority I fear that we have different views of what accountability at VA is and should be.

My colleagues see accountability as the firing of any employee who is alleged to make a mistake, whether the facts are there to support the allegations or not. I submit we cannot fire our way to

success and every employee is afforded the constitutional right to due process. A show trial in this hearing room is not due process.

VA employees at all levels bear enormous responsibility for providing care and benefits to veterans, from housekeepers who ensure clean and sterile clinical environments, to the claims processors who help veterans receive their earned benefits, to the executives who steer some of the largest integrated health systems in the country, every employee plays a role in achieving VA's mission.

Accountability is about treating the challenges VA faces across the enterprise as opportunities.

Now, this is not to say that there are not instances of mismanagement or failure to meet the standards we require of those who care for our veterans. In those instances there are clear processes for investigating wrongdoing and carrying out proper disciplinary action.

VA has a host of challenges, as does any organization of its size, and when issues are brought to this committee's attention we take them seriously. We spend a substantial amount of time on oversight of VA facilities, which is justified and warranted.

However, as I pointed out earlier, as I stated earlier, the amount of VA's budget supporting for-profit healthcare has risen significantly, with the VA on track to spend almost three times as much on community care as it now did before Trump's MISSION Act was implemented.

Yet, the Republican majority has not dedicated a single oversight hearing to for-profit healthcare since they have held the gavel, not a single hearing, oversight hearing on for-profit healthcare since they have held the gavel.

Instead, my Republican colleagues have pushed back and thwarted every attempt at greater accountability for for-profit healthcare. At a time when more veterans get their care from non-VA providers than ever before, it is dangerous for us not to extend our focus on access, patient safety, and accountability to taxpayer-funded care received outside VA.

The Government Accountability Office and Inspector General have sounded the alarm in report after report, but this Congress has stood idly by and sent more dollars out to these for-profit healthcare systems without even asking if veterans are getting adequate or timely care and if this is a good return on the taxpayers' investment.

Today, my colleagues are using VA's budget shortfall and other challenges to chip away at the public's faith in the agency. They will not be satisfied until it is merely a shell that pays the bills and nothing more. In other words, they want to voucherize VA healthcare.

We are going to spend this hearing, like we have all the others, with loud, screaming demands for people's heads and where does that leave us? No meaningful change and no solutions from this committee for veterans.

I am going to use this hearing to meet my congressional responsibility, which is to gather information and to use it to develop and improve policies that strengthen VA so that it can—so that it remains the best place for veterans to receive care and it is what they are owed.

Thank you and I yield back.

The CHAIRMAN. Thank you, Mr. Takano.

With that, we want to recognize, we want to now turn to our witnesses' testimonies. Testifying before us today we have Hon. Michael J. Missal, Inspector General of the Department of Veterans Affairs.

From the VA we have Under Secretary Shereef Elnahal and Under Secretary for Benefits Joshua Jacobs and Mr. Edward Murray, acting assistant secretary for management and the Chief Financial Officer (CFO).

Will the witnesses please rise and stand and raise your right hand? Do you solemnly swear that the testimony you are about to provide is the truth, the whole truth, and nothing but the truth? Thank you. You may have your seats. Let the record reflect that the witnesses answered in the affirmative.

[Witnesses sworn.]

The CHAIRMAN. Mr. Missal, you are recognized for 5 minutes to provide your opening testimony. Thank you for being here.

STATEMENT OF MICHAEL MISSAL

Mr. MISSAL. Thank you. Chairman Bost, Ranking Member Takano and members of the committee, the Office of Inspector General (OIG) is committed to conducting oversight work that improves the lives of veterans and their families and ensures that VA is a good steward of financial resources.

For VA to be as successful as possible it must hold its leaders and staff at every level accountable for their actions.

My written statement provides details on the foundational elements of accountability that we have identified as a result of our work. Our staff routinely finds breakdowns in leadership, governance, processes, staffing and other infrastructure, IT systems, and quality assurance programs that erode accountability.

These breakdowns impede VA's efforts to make certain that all patients receive timely, high quality healthcare and that all veterans and other eligible beneficiaries are afforded the compensation and services they are owed.

Some of the most concerning examples are found in medical centers. We recently issued a number of reports on the VA medical centers in Hampton, Virginia and Aurora, Colorado. They serve as case studies on how veterans care is affected when leaders fail to uphold a culture of accountability dedicated to patient safety and zero harm.

The Hampton reports highlight avoidable delays in cancer treatment, failures to conduct quality reviews, and substandard surgical care. The Aurora reports identified leadership failures that created a psychologically unsafe environment that resulted in significant turnover of clinical leaders.

In a system is large as VHA, we recognize that mistakes happen. The real test is how VHA leaders at the facility, Veterans Integrated Service Network (VISN), and Central Office levels respond to these mistakes and aggressively work to prevent them from recurring.

When leaders act with urgency and transparency and hold themselves and their staff accountable to identified failures, the system can improve for the veterans it serves.

We have also recently testified and published reports on quality assurance weaknesses within VBA that affected both beneficiaries and VA's stewardship of taxpayer dollars.

Other recent oversight work has spotlighted how leadership failures led to the improper award of $10.8 million in critical skills incentives to nearly every VHA and VBA senior executive working in VA Central Office.

Next week, OIG staff will testify on the pause of the Program Integrity Tool (PIT), which has led to significant financial consequences for VHA and challenges to uncovering fraud, waste, and abuse.

When I testified before this committee last year, I discussed the OIG's goal to continue to provide the department with the information and recommendations to not only improve the services, programs, and operations, but also to enhance accountability.

Our auditors, healthcare inspectors, and investigators, both criminal and administrative, are conducting the most impactful work possible to achieve this goal.

Our findings and recommendations are typically a roadmap for other facilities and offices across VA to assess their own risk and help prevent or correct similar problems or deficiencies that have gone undetected or unaddressed.

We recognize that changing the culture of a massive organization takes time and sustained effort. We have certainly seen engaged VA leaders who are trying to enact change and who are responsive to our findings and recommendations.

We have also found that the vast majority of frontline staff are dedicated to providing high quality care and benefits. However, more can be done to ensure that every individual at the VA understands their role and responsibility in meeting the VA's mission.

Such understanding empowers leaders and all staff to take ownership of and responsibility for their decisions and actions. This will help achieve a culture of accountability.

Chairman Bost, Ranking Member Takano, and members of the committee, I am happy to answer any questions you may have.

[THE PREPARED STATEMENT OF MICHAEL MISSAL APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Missal.

Under Secretary Elnahal, yes, Elnahal, you are now recognized for 5 minutes.

STATEMENT OF SHEREEF ELNAHAL

Dr. ELNAHAL. Thank you, Mr. Chairman, Mr. Ranking Member, members of the committee, for the opportunity to testify before you today. I am proud to represent the more than 400,000 dedicated employees in VA's healthcare system.

Together we continue to make historic gains on behalf of veterans. VA is primarily and most importantly accountable for achieving the best health outcomes possible for veterans while being maximally transparent with our stakeholders.

I will start with our accountability to the veteran. Since the historic expansion of benefits under the PACT Act, our commitment has been to enroll as many veterans as we possibly can into VA healthcare because we know that the VA is the best and most affordable healthcare option for veterans and for many other reasons, but most importantly a veteran enrolled in VA healthcare reduces their risk for suicide.

That is why beginning March 5th we made new groups of veterans eligible for VA healthcare years earlier than required by the law, including every veteran deployed to a post-911 mission, regardless of their conditions or service-connection.

Any toxic-exposed veteran exposed abroad or at home also qualifies for direct enrollment. We have also held thousands of outreach events over the 2 years since the PACT Act to meet veterans where they are.

At our second VetFest event this year in Fayetteville, North Carolina, we met Vietnam veteran Danny Cox. Danny came to learn more about toxic exposure screenings and healthcare eligibility.

Years ago Danny's service did not qualify him for VA care and he did not have high expectations. He was, quote, " over the moon" to learn that thanks to the PACT Act he is now eligible to enroll.

Danny tells us that not only does he appreciate that his healthcare team knows veterans but that this is going to help his family financially. He now tells every veteran he can to contact their local VA.

We have enrolled veterans like Danny at historic levels. Since President Biden signed the PACT Act, more than 740,000 veterans have enrolled in VA healthcare, 33 percent more than the 2 years before the law was signed.

Further, nearly 900,000 veterans saw an increase in their priority group reducing their out-of-pocket costs and in many cases allowing them more care options like long-term care and dental care.

We are also delivering more appointments to veterans than ever before. We are on track to exceed last year's record and deliver over 130 million appointments by the end of this month.

Further, we are exceeding previous records in pharmacy and prosthetics with almost 5 percent more prescriptions and 10 percent more prosthetics delivered this year than last.

To prepare for this record-breaking volume of needed care to veterans, we embarked on a historic hiring effort. Despite industry headwinds in recruitment and retention, last year our workforce grew at rates not seen in the last 15 years.

This includes increases in critical occupations such as physicians, nurses, medical support assistants, food service workers, and housekeeping aides. We primarily grew in essential frontline jobs for veterans.

Hiring more than 60,000 healthcare workers was the right decision to ensure we had the capacity to serve the needs of veterans, not knowing what the PACT Act would bring in terms of new demand.

We also placed an emphasis on improving clinical productivity holding a series of what we called access sprints earlier this year.

In over just a couple of months, our teams across the Nation made it easier and faster for veterans to access VA care by offering night clinics, weekend clinics, increasing the number of veterans scheduled into appointment slots in daily clinics, and we continue to see the impact today with wait times in the direct care system down for our foundational services of primary care and mental health year-over-year, despite veterans' historic demand for VA care.

Further, we are leveraging every modality of care that we possibly can to open VA's doors wider to get care with us. Since the start of the pandemic we have seen telehealth episodes triple, our clinical resource hubs, home-based primary care, e-consults are also up, and I am happy to report that all VISNs now have a tele-emergency care service.

Finally, our most important report card includes what veterans tell us about their care and, of course, care quality and outcomes. Last week we were proud to announce that VA hospitals outperformed non-VA in the most recent Centers for Medicare & Medicaid Serivces (CMS) star ratings for overall hospital quality for the second year in a row and patient satisfaction for the ninth quarter in a row. Most importantly, veteran trust stands at 92 percent for outpatient care, which is an all-time high.

None of these achievements would be possible without the dedicated work of our leaders, but with any organization of our size we do not always get it right. When we do not, we must ensure that the issues are resolved and that we institute changes so that these things never happen again and that includes at times taking accountable actions to remove leadership.

As we have communicated through the last year, despite these changes to exceed the most aggressive expectations, we have delivered all-time records for VA care and the growth in services to veterans has resulted in a need for additional funds.

I look forward to continuing our work with you to improve quality access and veteran trust because there is nothing that is more important.

Chairman Bost, Ranking Member Takano, members of the committee thank you again for the opportunity to speak with you today.

The CHAIRMAN. Thank you, Under Secretary Elnahal.

Under Secretary Jacobs, you are now recognized for 5 minutes.

STATEMENT OF JOSHUA JACOBS

Mr. JACOBS. Good morning, Chairman Bost, Ranking Member Takano, and members of the committee. Thank you for the opportunity to appear before you today.

Over the last 3 years, the more than 34,000 dedicated Veterans Benefits Administration employees, over half of whom are veterans, have vigorously worked to deliver more benefits to more veterans, family members, and survivors more quickly than at any other time in our history.

In fact, VBA and its hard-working employees have been performing at an incredibly high level enabling VA to embark on the largest expansion of veteran benefits in a generation.

After 2 years of robust implementation of the PACT Act.

In the 2 years since the PACT Act was signed into law, VA has delivered PACT Act benefits to 1.2 million veterans and survivors, which equates to a 75 percent grant rate and more than $7 billion in PACT Act-related benefits.

We were able to deliver these long-overdue benefits because of the authorities and generous resources provided by Congress, as well as our decision to make all presumptives effective the day the bill was signed into law rather than over several years, to start processing all PACT Act claims on January 1st, 2023 instead of waiting 18 to 24 months for regulations because of the planning, coordination, and months of hard work that went into PACT Act implementation and ultimately because of the talented and mission-focused VBA colleagues who helped deliver on the promise of a grateful nation.

Today, more veterans are receiving their earned benefits than ever before. In Fiscal Year 2023, VA delivered $163 billion in earned benefits, including $150 billion in compensation and pension benefits to over 6 million veterans and survivors.

We also processed approximately 2 million claims, surpassing the previous all-time record set in 2022 by 17 percent. In this Fiscal Year we are outpacing last year's record-breaking rate by nearly 30 percent and are projected to complete 2.5 million compensation and pension claims this fiscal year.

These results and the progress we have made across our education, home loan, insurance, and pension services, are a result of a highly motivated and talented workforce. To keep up with the record number of claims received since the PACT Act, VBA has grown its workforce by 35 percent since October 1st, 2022.

We have also achieved an attrition rate lower than the 6-year average. VBA's incredible workforce has exceeded our own aggressive performance targets.

Based on new claims projections from June, we have asked Congress to increase the level of mandatory funding by nearly $3 billion, less than a week's worth of payments, to ensure we can pay nearly 7 million veterans and survivors on time on October 1st.

Despite performing and producing at such a high level, we are not slowing down. We are focused on delivering for veterans and survivors while navigating the complications that come with scaling up.

As with any organization, we are not immune to challenges and we recognize that accountability is critical to our success. We are a learning organization and that means we will make mistakes.

While a vast majority of our employees are dedicated and committed public servants, there have been instances where the performance of a limited number of employees, including certain leaders, has fallen short of what we expect and our veterans deserve.

When issues are identified we do not shy away from addressing them. Instead, we take action, inform this committee, refer matters to the office of Inspector General when appropriate, and notify our external partners and media. We also work to correct and learn from any shortcomings.

This commitment is essential to building and maintaining the trust of the veterans we serve. We recognize that along with our record-breaking success there is always potential for improvement.

Accountability at VBA starts with me. I own the challenges we face, and I stand proudly behind the incredible work we have done and will continue to do as we eliminate inefficiencies and build on our record-breaking achievements to deliver even higher quality benefits to those we are privileged to serve.

Thank you for your continued support of veterans, their families, caregivers, and survivors. I appreciate the opportunity to appear before you today, and I am ready to answer any questions you or other members of the committee may have.

[THE PREPARED STATEMENT OF JOSHUA JACOBS APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Jacobs.

Thank you all for your testimony. We are going to go to questions now, and I will yield myself 5 minutes, which may go over just a little bit, just so you know.

Mr. Jacobs, you told us, well, I am told us, VBA has $1.4 billion in extra resources to pay benefits, but if you are short by even one dollar at the end of the month every veteran's benefits will be delayed. How much more money do you exactly need and do you need to get through the end of the month?

Mr. JACOBS. Congressman, or Mr. Chairman, thank you for the question. What you are referring to is the money that as we track our actual spend on a month-by-month basis where we have identified that we do not believe the projections may require us to use all of the funding.

The way that the pay file is structured if we are even one dollar short we cannot pay any veteran because the pay file is constituted by 95 percent of the veterans and survivors that we serve.

We believe it is prudent to maintain our original request to ensure that there is no risk whatsoever in our ability to pay without delay the veterans and the survivors who rely on those earned benefits.

The CHAIRMAN. Okay. The other part of my question.

Mr. JACOBS. Yes.

The CHAIRMAN. How much money do you actually need?

Mr. JACOBS. Mr. Chairman, we have maintained that we still need the approximately $3 billion for the monthly benefits to be paid on time——

The CHAIRMAN. Okay.

Mr. JACOBS [continuing]. on October 1st.

The CHAIRMAN. All right. You also told us on September 20th that September 20th is the deadline to receive the $3 billion supplemental appropriation from Congress. What happens on the 20th if additional funding is not provided?

Do not confuse my question that we are not going to provide it. I just want to know from you.

Mr. JACOBS. No, I know.

The CHAIRMAN. Okay.

Mr. JACOBS. I understand and I appreciate your assistance, sir. Every month, on about 10 days before the end of the month, we transmit our pay files to the Department of the Treasury.

There are multiple steps that have to occur between us submitting the pay file, the Treasury Department processing it, and those payments being made either through direct deposit through Elec-

tronic Funds Transfers (EFT) to financial institutions or to the approximately 2 percent of veterans and survivors who receive paper checks, to print and send those checks.

Every day past the 20th increases the risk that we are not able to pay on time. We do have some room built in because occasionally there are challenges with those pay files that we have to fix and then correct before we transmit it. It is very hard to go back and recoup those moneys after we have submitted it.

Oh, I will also add we have the ability to accelerate the timeline for direct deposit. It does come with additional risk.

The real challenge and the real length and process is those veterans and survivors with checks because that process is time-consuming and particularly for veterans and survivors in rural areas there may be delay of up to 2 weeks.

The CHAIRMAN. Okay. Now, this is for both the undersecretaries and either, but this is vitally important. Why did you wait until after both appropriation committees had finished their bills to fund VA to tell Congress about the shortfall?

Mr. JACOBS. Congressman, I will start with VBA. As you know, and we have been communicating, we are delivering more benefits than at any other time in our history.

The CHAIRMAN. Right.

Mr. JACOBS. We have been closely monitoring the trends. What happened is during June during statutorily mandated mid-session review where we go over our financial trends and the actuals versus those projections, we updated our claims projections.

We added new assumptions to include updating the number of claims we anticipated being able to complete this year from 2.2 million to 2.5 million. It is at that point that we identified the risk that we may need additional mandatory funding. We then worked with the Office of Management and Budget to verify that our assessments were, in fact, reasonable. Once we did that, we immediately came to notify you of the potential need of those dollars.

We did it as quickly as we had faith in our updated projections.

The CHAIRMAN. Dr. Elnahal.

Dr. ELNAHAL. Thank you for the question, Mr. Chairman. In our experience, we started the Fiscal Year thinking that we could get through the Fiscal Year and meet all the veterans' care needs with essentially, you know, a level number of employees after such a historic hiring year in Fiscal Year 2023.

We made every attempt to do that by conducting the access sprints. That is the effort where we scheduled more patients into daily clinics, we offered night clinics, weekend clinics, more convenient options for veterans, and we actually succeeded at delivering many more appointments and reducing wait times.

However, we also were faced with decisions on whether we opened up the system even more to get more veterans into care and we decided, knowing that this could have been a potential budget risk, but we felt it was the right decision to do anyway, to accelerate eligibility for all of the cohorts that would otherwise have to wait every 2 years up to 2032 to get into VA healthcare.

We deployed post-911 vet, every veteran exposed to toxins. On March 5th we did that and then we started to see many veterans

take us up on it. Now, more than 40,000, well over 40,000, veterans from that move alone has enrolled into VA healthcare.

We are well up in both direct care and in community care. If you recall when the secretary testified before this committee and the other three committees overseeing the VA, he did say that we were operating under a tighter fiscal picture and if we felt that we needed more funds to sustain this momentum for veterans and maintain the outcomes we would come back.

As soon as we came to that determination we briefed your committee in July, and we hoped to be able to get this in the Continuing Resolution (CR) as an anomaly in the CR.

The CHAIRMAN. Okay. Staying with you, Doctor, you, because we have asked you and you have not answered the committee's questions about the healthcare shortfall. You even postponed the key briefing that we were supposed to have last Friday.

When I asked your CFO, Ms. Duke, about the shortfall in late July she said, " We are still diving into those costs to see what is driving them." Are you able to explain the reasons exactly for the shortfall?

I know you gave a little bit of it then, but the—and what the exact amount is that we need now?

Dr. ELNAHAL. Absolutely, Mr. Chairman. We need to be able to deliver even more care on both the direct care side and in the community care side.

We are up about 16.1 percent on the community care side just over last year and in multiple categories of care within direct care, 15 percent up on mental health appointments, 16 percent up on telehealth, up in essentially every category of care that we are offering in the ambulatory setting.

We came to the conclusion that in order to sustain that momentum and keep wait times level or down and, by the way, maintaining our historically high quality and veteran trust outcomes, that we ultimately needed this funding.

The other piece of our request is a really unanticipated medical inflation phenomenon in both prosthetics and in medication. The fact that out of the $12 billion about $3.8 billion of that is just due to the increased costs and volume of delivery of prescription drugs and prosthetics of all types.

That is essentially what goes into the $12 billion that we need.

The CHAIRMAN. All right. When we are talking about that $12 billion the concern that I have, do you believe you have accurately explained to this to us that the Toxic Exposure Fund, what all it should be paying for? We had a problem with what it was paying for and the secretary himself actually answered a question last year when we talked about a particular funding of a building.

When we asked why he was using that he says because we can. Do you know what it is and why it is that, you know, as you come forward with $12 billion, and I want to clarify this. I want it on the record. We are not saying we are not providing it, but our job is oversight.

We want you to implement the PACT Act, but I also have concern, well, I will let you answer that and then there is another question I have and then I will turn it over. Yes.

Dr. ELNAHAL. Yes, Mr. Chairman, I fully respect your constitutional responsibility for oversight, and we are always happy to work with you on how we are using the toxic exposure fund to ensure that it meets congressional intent and be as transparent as possible.

If we have not been I apologize for that. We will definitely keep that cadence with you.

We are very confident, Mr. Chairman, that we can use all of the $12 billion that we requested in the Toxic Exposure Fund for direct care to veterans exposed to toxic substances.

We have been screening now well over 5 and a half million veterans for those exposures and well over 40 percent of veterans tell us that they were exposed to a toxin.

We have a very specific methodology that ensures we map as accurately as possible to veterans getting care for toxic substances. It is a methodology that we have been transparent and worked with you on, but we know that since this money is going directly into care, including the cost of care for prosthetics and medications, that we will be able to use all of it for veterans exposed to toxic substances.

The CHAIRMAN. Just real quick because we need an answer to this question because of some comments that have been made.

First off, I do not think there is a Republican one on this dais that wants to privatize the VA. Let me say that again. There is not a Republican one that wants to privatize the VA. Okay?

We want to make sure that it is handled correctly and that we want to make sure that people understand that the VA was not created for the bureaucracy of the VA. The VA was created for our veterans to receive the care that they deserve.

If that bureaucracy climbs to a point it is our responsibility to make sure that the veterans are getting the care, regardless of where they get it.

Now, I do not believe we are turning down VA in any way, shape, or form, but we are making sure with the community care that they are getting the healthcare that they need when they need it, not to attack the VA in any way, shape, or form or change it, except for the fact for the betterment of the veterans.

With that, I will recognize Representative Ramirez for her 5 minutes plus.

Ms. RAMIREZ. Can I get 30 seconds more, too? I am kidding. I am kidding. Okay. Thank you, Chairman and certainly Ranking Member Takano for holding today's hearing.

I also want to thank the four of you witnesses for joining us today. It is certainly an important hearing.

As a member of this committee, I am clear that strengthening our democratic processes and working collaboratively with Federal agencies like the Department of Veterans Affairs is critical to ensuring our veterans get the care and the constituents we serve can trust our oversight of agencies and trust the services that we are providing them.

Now, there is a difference between oversight, which is the act of working with Federal agencies to address challenges and issues that they are facing and using oversight as a guise to push a partisan political agenda.

Today's hearing is another partisan attempt to erode trust in agencies and our power to conduct oversight as a committee. The spite of this, I am ready to address the real issues, and I am ready to work with the Department of Veterans Affairs to identify the root causes of the problems they are experiencing and to discuss solutions with you so we can move forward and work together for our veterans.

With that, I want to turn over to my questions. This year the VA reached a settlement with American Federation of Government Employees (AFGE) to provide relief to certain employees that were adversely affected by the VA's unlawful implementation of the discipline authority under the 2017 VA Accountability Act.

To date, the VA has paid out $106,800,774. Let me read that again and say $100 million to save some time. Over $100 million have been paid out because of violations of employees' rights to due process arising from the unconstitutionality of that Trump law.

Despite these massive payouts for Trump era policies, the Republicans choose to focus on the $11.6 million improperly paid to senior executives through the CSI bonuses, 92 percent of which has been recouped already.

Dr. Elnahal, does the VHA have the tools and authorities it needs to investigate and discipline employee misconduct?

Dr. ELNAHAL. We believe we do, Congresswoman and, you know, I think you are familiar with the history of the use of the 714 authority and how the courts have rendered it effectively not usable for the purpose that it was intended or at least no different from the Title 5 authority tools that we have right now.

In every situation, Congresswoman, where we have evidence of things like malfeasance, neglect, misconduct, and ultimately a need to remove leadership and employees, we do believe we have the authority to do it. Of course, employees have rights and we have to respect those rights throughout those processes.

We do, in fact, believe we have the tools that we need.

Ms. RAMIREZ. Good. Talk a little bit more about how you address instances of misconduct or mismanagement at the facilities under your leadership?

Dr. ELNAHAL. First thing I will say, Congresswoman, is that, you know, the vast majority of our employees and our leaders, who by the way, have led us to three-quarters of a million veterans enrolling under the PACT Act, historically high veteran trust, you know, the average outcomes in the typical experience of veterans is better because of our leaders and employees, rather than the opposite.

Of course, there are instances in which we must undertake an investigation on the quality of leadership. In those instances we often do temporary reassignments while offices like the Office of Accountability and Whistleblower Protection or our workforce management colleagues in the healthcare system itself can do a thorough investigation and ultimately determine a recommendation for administrative actions if necessary. All of that is, of course, consistent with the respect for employee rights under the law but also our obligation to hold leaders accountable when necessary.

Ms. RAMIREZ. Thank you. I certainly agree with Ranking Member Takano's remarks that the goal for community care and VA care should be symbiotic relationship, not parasitic.

Right now, though, community care is disproportionately draining resources from direct care. When we hold VA providers to high quality of care standards and we strive for low wait times, we should also be expecting the same from the VA community care providers.

When we demand the best technology and infrastructure in our VA facilities, I believe we should also be ensuring that VA patients get that also when they seek care in the community.

My last question for you is do you feel like you have the adequate authority and tools to perform oversight over community care providers?

Dr. ELNAHAL. Oversight of our community care has been a pretty longstanding challenge, Congresswoman. We are trying to use every tool that we can through our contractual authorities to hold our third-party administrators accountable to do so.

We are also trying to have more seamless exchange of health information between our private sector partners and the VA. Increasingly, we do depend on community care more and more for veterans in rural areas for certain categories of care like long-term care where we simply do not have enough institutional capacity.

This is not to disparage at all our community care providers. We do need them in many cases for veterans. What we are trying to do with an effort that we call the interoperability pledge is partner with our high volume and best partners in the private sector, 13 health systems, to seamlessly exchange information electronically to eventually include quality outcomes and essentially records of care for veterans that we have to treat in the private sector and come back into VA.

We are always trying to explore new ways to do that.

Ms. RAMIREZ. Thank you.

Mr. BERGMAN. [Presiding.] Thank you.

I recognize myself for 5 minutes. It is good to see your familiar faces there at the testimony table. I know you all go to work every day trying to do the right thing for the veterans.

I am going to, kind of, revert to an old hat I wore in the Department of Defense when I was in the Program Objective Memorandum (POM) process for budgeting within the Marine Corps and budgeting for the Department of Defense and the hat I currently wear as a member of the Budget Committee and task force chair of, you know, oversight of improper payments, if you will.

I look at things from a budgetary standpoint and we have all heard the old phrase, more money and more people will solve every problem until it does not. You know, it is just the way it is.

Was there any type of failure or not—I am going to say not mistake, but just something you did not see in the budget process at the VA that led to this issue not being discovered until just 2 months before disability benefits would start to be cut? Was it a aha moment? Kind of clue me in here.

Mr. JACOBS. Congressman, for the last 2 years we have been performing what I believe is the most aggressive forward-leaning outreach campaign in VA history. We had a 40 percent increase in the number of claims submitted in 2023 relative to the previous year. We are on the same pace to receive about that many.

Our workforce has grown and delivered more benefits than at any other time in our history. Right now we have already——

Mr. BERGMAN. Yes, I got that.

Mr. JACOBS. Yes.

Mr. BERGMAN. Hold on, hold on, because in your statement you made—what I heard you say was you grew the VA workforce by about 30 plus percent.

Mr. JACOBS. Correct.

Mr. BERGMAN. Did I get that right? Okay. Is that the metric or is the outcome the metric or can you show that growing the workforce by 30 plus percent was going to lead to the 80 percent level this uptick in benefits and services provided to the veterans? Is there some kind of a chart?

What I saw at the beginning with the sign behind over here, it was the classic. It was an appropriate primary color because it reminded me of a red herring.

This committee, as the chairman has said, we are charged with oversight. We want to be that partner that helps you deal with whatever, you know, the 80 percent norm and then the 20 percent unexpected.

Mr. JACOBS. Yes. We have a pretty robust model to project the production, both inventory and backlog, and it is comprised, as you would guess, people, process, and technology elements.

Within the people element——

Mr. BERGMAN. What changes the faster, people, process, or technology——

Mr. JACOBS. People——

Mr. BERGMAN [continuing]. at the higher rate, faster rate of change?

Mr. JACOBS. People. Right now it is people. It is about 80 percent to 85 percent of our production capacity, our existing employees, new employees, and a reliance for many years on mandatory——

Mr. BERGMAN. Is it retention?

Mr. JACOBS. We have high—we have higher retention. Ultimately, it is our employees delivering more benefits beyond what were already very aggressive projections.

It is a workforce that has continued to grow and to improve and to deliver rates higher than we actually thought possible.

Mr. BERGMAN. As we project forward here, knowing that time moves on regardless of the good or bad things that happen in life, it just continues to move on, can you all project where the next uptick will be positive or the potential where you see as vulnerabilities to what you are doing that could present a downward trend?

Mr. JACOBS. Right now we are, and that is subject to some variables that are outside of our control and some that are within our control.

Mr. BERGMAN. Okay.

Let me ask you a question because I have only got a minute left. Mr. Missal, any thoughts?

Mr. MISSAL. Yes. My thought is that we have already opened a project with respect to looking at VHA's projections, such as what were the circumstances upon which they now changed the projection that they have and we are planning on doing one with respect

to VBA to assist this committee in getting answers to some of the questions you have.

Mr. BERGMAN. Okay. Well, and I am going to yield back just a couple of seconds here. We always expect things happen we could not have planned for, budgeted for, but the same thing should not happen twice. That is what we look for here is how do we take the little things that happened and, you know, grow with them?

With that, I am going to yield back. You have got 7 seconds.

Mr. JACOBS. I am a temporary steward of this role. I know at some point I will be gone. I want this organization to learn the right lessons. I do not want them to learn from this, hey, we should manage to a budget. We should stop the outreach. We should stop processing claims.

I appreciate the oversight and will continue to work with you to get better.

Mr. BERGMAN. Thank you very much.

Mr. Kennedy, you are recognized for 5 minutes.

Mr. KENNEDY. Thank you.

Inspector General, Under Secretary, Deputy Under Secretary, thank you for your testimony. Thank you for your service to this country and to our veterans.

I represent Buffalo, New York, Niagara Falls and the Buffalo Niagara region. We know that the Buffalo VA hospital has recently had a removal of their leadership. The head of the hospital and the chief of staff have been removed put in now interim leadership there because of really outrageous actions that are alleged and the lack of care for some veterans.

Dr. Elnahal, first of all, thank you for taking the time with me this past weekend to discuss what is happening over there and your commitment to rectifying the situation. I know right now there is a investigation that is ongoing.

Inspector General Missal, can you just give a timeline on when you expect that to be completed?

Mr. MISSAL. Our investigation has been completed. As is our practice, we provided VHA with a draft of the report, which includes the recommendations, and we are waiting to hear back from VHA on their responses to the recommendations.

Mr. KENNEDY. The completion of the investigation and the follow up will be—what do you expect on that?

Mr. MISSAL. As soon as we get it back from VHA, which should be relatively soon, then we will be able to turn it around and publish the report and provide briefings to you and your staff.

Mr. KENNEDY. Thank you.

Dr. Elnahal, just again, thanks for your leadership. You know, we toured the VA hospital with members of this committee, the staff members. You are committed to coming to Buffalo to visit the VA and see first-hand.

There is a real crisis of confidence in the hospital system right now based upon the removal of the leadership and the stories that we have heard, a lack of staffing appropriately, what has been deemed as a hiring freeze from what we have found out is it is a real hiring delay of 9 months, effectively a hiring freeze.

We discussed the finances that should be included in the CR in order to not only rectify Buffalo, because I think Buffalo is a real

demonstration of what is happening across the Nation. Can you talk about what that funding in the CR, what the level you would need to fund our VA hospital staffing levels appropriately, as well as other VAs across the Nation for our veterans to receive the care they deserve?

Dr. ELNAHAL. Thank you, Congressman. I am happy to do that and I just wanted to let you know that my personal attention is on making sure that things improve and improve fast at the Buffalo VA. It is what the veterans in your district and around the Buffalo area deserve.

I will first say that part of the supplemental will support our ability to increase our overall staffing level by about 5,000 employees over and above where we were in mid-June.

We have retreated a little bit since then so that number may change by the end of the fiscal year, but the point is we would be able to grow responsibly and within the budget to be able to meet growing veteran care needs.

That is exactly what we are seeing in Buffalo and in medical centers across the country. Inclusion as an anomaly in CR is an extremely important tool for us to be able to do that and maintain within the budget.

Mr. KENNEDY. The number that has been discussed is $12 billion. Is that accurate from your estimation?

Dr. ELNAHAL. Yes, Congressman, that is the request in the supplemental.

Mr. KENNEDY. Thank you. The fact that that is not included in this continuing resolution is a real problem, not just for Buffalo staffing but for staffing across the Nation but, you know, Buffalo being right in the heart of the district that I represent and having these issues, I think it is outrageous that it is not included.

Let us talk about moving forward in infrastructure. The hospital in Buffalo, I know it is not alone, but it was built in the 1940's. It had opened up in 1950. It is going on 75 years now.Heating, Ventilation and Air Conditioning (HVAC) system. You know, the building itself is falling apart in many ways while we are putting band aids on it. You know, thank God for the staff that is working there that is taking care of our veterans, but they need resources there.

We ultimately need a new hospital, a new VA hospital in Buffalo and we are not alone. We are talking about putting hundreds of millions of dollars into the current VA hospital. We need a new VA hospital that is technologically advanced, that gives our frontline heroes, the nurses, the healthcare practitioners the resources they need to take care of our veterans.

Can you comment on that, what it will take to get that done and do we have your commitment to making that happen?

Dr. ELNAHAL. Listen, I agree, Congressman. We have requested in multiple budgets substantially more major and minor construction funding. I look forward to visiting the Buffalo VA with you in the coming weeks to witness myself what the condition of the infrastructure is.

The fact that the average medical center's age of plant is over 60 years, I have not seen any other health system with infrastructure that old. We need to invest in it.

I have already contacted our construction and facilities management team and our team that works on infrastructure will work with you to get it on the priority list to make sure that we address it.

It is going to take some time but my commitment to you is that we will start that process.

Mr. KENNEDY. Thank you.

Mr. BERGMAN. The gentleman's time has expired.

Dr. Murphy, you are recognized.

Mr. MURPHY. Thank you, Mr. Chairman.

Dr. Elnahal, I just, kind of, want to ask you a few things going back to community care. Somehow it just is beyond me why this has become a partisan issue where some of our Democratic colleagues just start pejorative about community care. That is how I see patients from the VA where we are.

Can you give me an estimate of how much care for the country is delivered by community care?

Dr. ELNAHAL. For veterans?

Mr. MURPHY. For veterans.

Dr. ELNAHAL. About 40 percent of the total care that VA pays for is offered by the community.

Mr. MURPHY. Okay, so that is primarily for specialists, correct?

Dr. ELNAHAL. It is really everything, but a lot of specialty care, a lot of long-term care included as well.

Mr. MURPHY. People lament that community care cost so much. Well, specialty care costs more. Community or long-term care costs more and so, hence, that is the reason it costs more.

Here are some of the problems that I see with community care because we take it in my office but we do not get paid. You do not get paid. You know, guys, when you have a private office, which I do not have any more, it is kind of hard to keep the lights on.

Then I get told by veterans that their VA does not want to refer them to community care and it gets delayed. They wait on a referral. They wait on a referral. They wait on a referral. In the end it is 6 months until they get a follow up.

I had the same thing with the woman who her husband had a tibial fracture, months and months and months and months to get referred.

I do not know what culture is about referral to community care, but it should be absolutely seamless to get our veterans cared for number one.

Number two, you talked about access to records. You are still on Cerner, right?

Dr. ELNAHAL. Right now we have six medical centers on Cerner, Congressman. The rest is on our homegrown system.

Mr. MURPHY. Absolute disaster of a pick. Cerner should be abandoned today. Six out of 160 sites after 10 years, is that correct?

Dr. ELNAHAL. I believe so, Congressman.

Mr. MURPHY. Okay. I am not going to name the other system, which is much more predominant in the country, so when I log into said system I can see anybody's record from around the country. The VA is supposed to send records to me? Zero—zero in 25 years.

I have to tell the veteran to go back, physically get their records put on paper and brought to me. You guys need to stop Cerner tomorrow.

It is not a system that is meant for the VA medical system the size of this. This is a mistake that for 10 years money has been poured into, poured into, poured into, and you literally have less than 4 percent of the whole systems on Cerner now.

Its interoperability with other large systems is paltry. This is a huge problem and why will the VA not recognize they screwed up 10 years ago and fix it today? It will cost an outlay of money, but it will actually deliver care to veterans that need it.

What is the hold up with that? Why is the VA not willing to say we screwed up. We made a mistake. We picked the wrong system and we move on to a better system.

Dr. ELNAHAL. Well, first thing I will say is I respect your view on this as a physician, Congressman, and somebody who is dedicated to the veterans in your district and across the country.

We are dedicated to trying to get this right, and I will be the first to admit that it has not gone——

Mr. MURPHY. It has been six sites in 10 years.

Dr. ELNAHAL. The initiative has not gone as it should have been. I fully admit that. It has been an effort across now two administrations to try to get it right, but we are now poised to be able to start deployments again, hopefully within——

Mr. MURPHY. What, and add another five systems next year? There are 160 sites. This is wrong. You guys, you know, there is a time when you pull the string and say, yep, we made a wrong decision. We need to cut the cut the line and do something different because what are we saying, it is going to be another 10 years?

That is absolutely wrong and then every system will be out of date and it will cost hundreds of millions of dollars, if not billions of dollars, to update this. It is an antiquated system. It cannot fit the VA's needs and you guys need to change it, period.

I actually know what I am talking about on this. This is not political rhetoric. This is actual physician taking care of patients that the information is needed.

Dr. ELNAHAL. Well, we will definitely commit to being transparent with you, Congressman, on what we are doing to try to get this right. Again, I am not belying at all your experience as a physician and a provider, but my commitment to you is to keep you posted on making this better.

Mr. MURPHY. Guys, it is just that it demonstrates the inefficiency in the bureaucracy of the VA in not understanding that this is a wrong path and fixing it.

Thank you, Mr. Chairman. I will yield back.

Mr. ROSENDALE. Mr. Chairman, before we move on I would like to state a point of clarification. It is no longer the Cerner system. It is Cerner has been purchased by Oracle so Oracle is replicating and duplicating the exact same mistakes that Cerner did and are continuing to collect billions of dollars. Thank you. I yield back.

Mr. BERGMAN. Point taken.

Ms. Budzinski, you are recognized for 5 minutes.

Ms. BUDZINSKI. Thank you, Mr. Chairman and thank you Ranking Member and thank you to the panelists for being here today.

Dr. Elnahal, in rural America there are many areas where community care is the only care that is feasible for veterans and we value the ability of many non-VA providers to fill this critical gap in healthcare access, especially in rural areas like many that I represent.

When veteran patients have to rely on external providers we should be certain that they are getting the care they deserve and are able to access this care in a timely manner.

To me it seems that the VA has work to do both inside and outside of the VA to ensure that both VA and community care providers are working hand-in-hand ensuring a seamless experience and a warm handoff for our veterans.

My question for you, what are some of the steps the VA is taking to improve communication and information sharing with community care providers to ensure veterans are getting high quality care at community care facilities?

Dr. ELNAHAL. Well, the first then most important thing we have to do, Congresswoman, is to make sure that every veteran, when the veteran elects and ultimately we decide that the community care option is the next best step that they get that care as soon as possible.

We have been focusing now since the 2 years I have arrived on reducing the time to scheduling into the community with effective care coordination to have a seamless pass off between our clinical care teams and our community care offices and to reduce the barriers for veterans to be able to get that care.

That time to get scheduled is still too long. We have reduced it on average by many days and we are going to continue that effort. That is the first point.

The second point is to ensure that we get better at selecting the right providers who have a record of working well with us by sharing records back to veterans.

One of the most important frustrations I hear from veterans is that they get care in the community and they come back into the VA and they realize that the VA does not have a record of what happened. That just cannot happen and it is happening too much.

We are focusing on innovative ways to do that and that is part of what we are trying to achieve with the interoperability pledge, which is a way for us to electronically do so seamlessly without having to focus on, you know, fax machines, e-fax, the old way of doing business.

The third way we are doing this is through innovative pilots like external provider scheduling, so external provider scheduling is a tool that we are now using in many medical centers. We do plan to expand it.

As long as the community provider commits to connecting with us technologically, which sometimes takes significant effort and costs on their side, it reduces the amount of time it takes to get that appointment scheduled from days sometimes into minutes or hours.

What we want to do is perfect it. We want to make sure that we have a system that incentivizes community providers to participate, but that is one really promising effort that we are undertaking now.

Ms. BUDZINSKI. Great, thank you. Thank you for that. I have a follow-up question specifically too around women veterans who often have limited choices to gender-specific care depending on where they live. This is true where whether it is VA care or community care.

Could you speak to how the VA is going to ensure our women veterans are getting access to unique care, such as Military Sexual Trauma (MST) treatment or reproductive care and how Congress can be helpful in that effort?

Dr. ELNAHAL. Fastest growing demographic by far are women veterans. Many post-911 generation veterans are women who are enrolling and so it is our responsibility to make sure that we have the capacity and the respectful and effective care environments to be able to meet all of their needs. That includes gender-specific care.

We have two main ways we do this. We, of course, have specialists in women's health, so Gynecology (GYN) providers, folks who focus on things like urogynecology for veterans who are older, you know, postmenopausal therapy.

Also we have a training system for our primary care providers because we know that many conditions can present differently in women. Some of our providers have been in the VA for a long time and obviously the gender distribution has changed in favor of more women.

What we are trying to do through our Office of Women's Health is ensure consistent and effective training across as many of our primary care providers as possible.

Then, of course, we also put out a rule that allowed for more expansive reproductive health offerings, including abortion counseling and abortion services where the veteran's life or health is at risk. You know, a lot of things we have done in the last couple of years and we have more to do.

Ms. BUDZINSKI. That is great. Thanks. I am going to try to fit in one more question. On this committee we often urge VA to meet a standard that we know they are able to attain but are often not resourced adequately enough to do so.

We have heard from numerous offices within VA about their budget being cut in order to fund rising community care costs. Though these two avenues of care should not be in conflict, VA care seems to be at the expense of expanding community care access.

Can I ask Dr. Murphy (sic), I would like to get your thoughts on this? Do you believe it is possible for the VA to continue meeting high quality health standards and outcomes while sustaining rising community care costs?

Mr. MURRAY. Yes. I am actually not a physician. I am an accountant so we—I do work very closely with the administrations on their accounts, budget to plan. They had the ability, we call it transfer authority, to move money between accounts as one does. It is what secretary said, call it you have the money in the wrong pocket. Sometimes you need to move it around.

I do not see any conflicts between the programs. You know, I can pass it to a Dr. Elnahal, but I think that we can sufficiently fund the programs and that I think it is healthy when we transfer funds from one program to another where there are execution variables.

When one executes hotter than another we have the funds in one account and not another and we, kind of, level set to make sure we can optimize the care and benefits we provide veterans. No, I have not witnessed anything in that area. Thank you.

Ms. BUDZINSKI. I think we are out of time but thank you. Thank you very much.

Thank you, Mr. Chairman.

Mr. ROSENDALE. [Presiding.] Thank you. Thank you, Representative.

I will now recognize myself for 5 minutes of questioning. We have traded seats around here.

I want to thank Ranking Member Takano and Chairman Bost for holding this hearing, and I appreciate seeing you all here again and voluntarily coming in to answer these questions so we do not have to use our subpoena authority.

The program integrity tool is what I want to talk about because that is where we are having some problems with loss of revenue and loss of revenue is what we are going to be discussing, of course, again next week as well as we try to fulfill this supplemental that you need.

I am troubled by the fact that the program integrity tool has been offline since February 21st, 2023 due to data integrity and accuracy issues. I am going to start with Inspector General Missal.

Mr. Missal, you estimated that the VA did not collect $665 million in insurance payments and co-pays during the 12 months while program integrity tool was offline, but the program integrity tool has been offline for more than 18 months. Can you estimate the total value of those uncollected fees?

Mr. MISSAL. Yes, sir. We project it is about $55 million a month, so the 5 months that were after our work ended would total about $277.5 million and continuing.

Mr. ROSENDALE. Mr. Missal, that is just the missed medical collections. The program integrity tool is also supposed to prevent inaccurate, duplicate, and fraudulent community care claims from being paid in the first place.

Over $28 billion of claims were paid in the year that you examined. Can you estimate how much money was wrongly paid out while the PIT has been offline?

Mr. MISSAL. We do not have an estimate for that. I think VHA would be in a better position to have any estimate of claims that went into the PIT.

Mr. ROSENDALE. Okay.

Dr. Elnahal, good to see you again and I do appreciate all the work that you have done. I do have to commend you guys for actually when you identify these problems, as we have seen even at Fort Harrison in Montana, going in and taking action.

In one briefing the committee did receive on the VHA shortfall your CFO, Laura Duke, said that $700 million in medical collections were missed this year because of the Change Healthcare ransomware attack, but she never mentioned the program integrity tool problems.

What is the impact of the PIT problems on your budget?

Dr. ELNAHAL. Quite significant, Congressman. It is in the hundreds of millions. We will get to you and to this committee, sort of,

the exact contribution of our collection shortfall between the Change Healthcare issue and the program integrity.

The IG's report, Mr. Missal's team, was very helpful and informative on the program integrity tool. Cannot get that fully online soon enough. We have restarted the program integrity tool. We are at a clip that is faster and hope to get it fully online and then use for collection soon.

Then most importantly to get it also online for the fraud, waste, and abuse monitoring activities that it is critical for. The one silver lining is that when it comes to collections we do not actually have a time limit that is, you know, going to exceed when this care was provided, meaning we will fall within our authority to collect once everything comes back online. We are in the process of doing so right now.

Once we bring all those collections back in we will notify the committee and it is a huge priority for us to do so.

Mr. ROSENDALE. Very good. Dr. Elnahal, the explanation about the Change Healthcare ransomware attack does not make sense. If $700 million of medical collections should have been captured in the Fiscal Year 2024 and now will be collected in 2025, how does that contribute to a shortfall in 2025 when it was 2024 revenues or receipts?

Dr. ELNAHAL. Well, I would characterize this, Congressman, not as a budgetary issue but more of a cash-flow issue. Ultimately, the cash in the bank account is lower than we had hoped and expected because of the collection issues between the PIT and the Change Healthcare incident.

Now, we are fully back online when it comes to Change Healthcare, thankfully. That was this conduit that essentially, you know, a huge chunk of medical claims payments across the country was going through.

The PIT is coming back online for collections, but ultimately, it is essential for us to make sure it comes back online and we do not see a decrement again. It is a cash in the bank account issue that is contributing to our need, for example, to eat into the carryover into Fiscal Year 2025, this fiscal year.

Mr. ROSENDALE. Before I surrender my time up, I would like to thank—he is not here—but Dr. Murphy for bringing up once again the shortcomings of the EHR, the money that has been bleeding out from the VA into that system and the recognition by everyone sitting here that a change has to be made.

I do appreciate all the conversations that we have had with the VA about establishing some metrics that Oracle has to abide by in order to keep this moving forward, and I think that we all can agree that that is the best path. Meet the metrics, we have some standard set, and then you continue your compensation.

I will now yield back.

I think that Representative Landsman, we will recognize you for 5 minutes of questioning.

Mr. LANDSMAN. Thank you, Mr. Chair and the ranking member and all of you. I appreciate you for being here and all your work on behalf of veterans.

Dr. Elnahal, in the case of Hampton, part of the big issue, and this is across the healthcare sector in general, is insufficient staff-

ing and the role that it has played in exacerbating existing issues at VA facilities.

The facility in my district in Cincinnati has faced similar staffing challenges. I have heard directly from a whole host of folks, including the VA nurses, about how these shortages affect their ability to care for veterans.

How can the national contract regarding staffing support, sorry. How can the national contract regarding staffing support assist Hampton in cases like the anesthesiology department and the lab?

Dr. ELNAHAL. It can assist, Congressman and, in fact, the medical center and VISN 6 are engaging on the integrated clinical staffing program contract which we put in place very specifically for this reason. It is a fast vehicle to bring on temporary support while you are recruiting for folks.

In the anesthesiology department that is where we have the most significant need, and they are engaging with it right now.

Mr. LANDSMAN. How fast is fast? I mean, what is the timeframe and where do you find folks temporarily or for a temporary role?

Dr. ELNAHAL. You know, there is a good number of healthcare providers, Congressmen, that decide to spend at least a portion of their career going into temporary contracts. It is a higher compensation, you know, per day worked, per patient seen.

It is not necessarily a sustainable lifestyle for a lot of people, but there is a pool of clinicians that often able to be entering your organization on a temporary contract. That is what Hampton is using for anesthesiology right now.

Mr. LANDSMAN. Is that across departments or is this unique to anesthesiology, the temporary employee piece?

Dr. ELNAHAL. It is a very flexible tool that can bring in clinicians of many, many different types but also administrative and support staff as well.

Mr. LANDSMAN. How long on average does a temporary position—how long are they there?

Dr. ELNAHAL. When——

Mr. LANDSMAN. I know it depends on the hiring but, I mean, in general.

Dr. ELNAHAL. We really try to minimize the time that we need contracted staff. Per Full-time Equivalent (FTE) it is a higher cost as you might imagine for our healthcare system. The most important thing and the ultimate goal is to bring on permanent healthcare workers onto our team.

We can get data back to you and the committee on average how long these folks end up being in our medical centers. It is also a function of how long it takes to——

Mr. LANDSMAN. Yes.

Dr. ELNAHAL [continuing]. onboard our employees which, in my view, is still too long.

Mr. LANDSMAN. Yes.

I want to talk to the question to the Inspector General. One of the things that we have seen Hampton, Aurora, Loma Linda, others, is some leadership issues, culture challenges. Some of the senior leadership and staffing issues have been addressed and, you know, those leaders who are causing, you know, problematic cultures were removed. I think that is a good thing.

Dr. Elnahal placed interim leadership in those facilities that have taken steps toward addressing challenges like degraded culture, unclear, unenforced policies, staffing shortages, et cetera.

Can you speak to the role of the interim leadership at these facilities that face challenges such as Hampton and Aurora and what are the characteristics that you observe among leadership at these high performing VA facilities?

Mr. MISSAL. Having acting leaders can be a challenge. Many of them feel they are caretakers and they are not looking forward as they should be. What we have found with the good leaders is they are engaged in what they do.

They understand that they have to make clear roles and responsibilities. They ensure there is a focus on patient safety and they look at the back end. What kind of quality reviews, quality assurance are they doing? We have seen that at different facilities.

I would also like to say that with respect to some of the facilities that you mentioned, what we found was very passive VISN oversight.

The VISN is in place to ensure that the facilities under their responsibility are doing their job. At each of the ones you mentioned, the VISN was not there at the appropriate time to identify issues and make changes if necessary.

Mr. LANDSMAN. Thank you and I yield back.

Mr. ROSENDALE. Thank you, representative.

I now recognize Representative Luttrell for 5 minutes of questioning.

Mr. LUTTRELL. Thank you, Mr. Chairman.

Mr. Elnahal, Ms. Budzinski brought up a pretty valid point. I have a very rural district as well, so community care is very important to my veterans. I understand there needs to be a synergy there between the VA and between community care and the back and forth needs to be very fluid.

One issue that—I have had the opportunity to meet with some of the VA leadership of my district recently. It was a veteran town hall.

One of the biggest discrepancies, I guess, and maybe you can answer this question for me whether or not there needs to be legislation or something the VA can enact.

If a veteran is pushed out to community care for specific treatments, whatever that may be, say a surgery, a leg surgery, a knee surgery that the VA cannot handle, after the surgery the VA can handle the rehab. Okay.

What is lost in translation to the veteran is that, hey, we are going to send you to community care to a neurosurgeon but you are going to have to come back to the VA for rehab. Talking with the VA staff, like, that system, that particular portion, there is no communication.

How do we fix that? As oversight how would we fix the communication problem between the VA, community care, and the veterans so they do understand? Or is that specifically to that particular department?

Dr. ELNAHAL. Well, the most important thing we have to do, Congressman, is ensure that we are communicating as clearly and

effective as we can to the veteran, setting expectations to understand exactly what they should expect.

Mr. LUTTRELL. Should that come from the VA or the community care or both?

Dr. ELNAHAL. It should come from our referring providers into the community in the VA. We should be the ones holding the hand of the vet through each step of the process and——

Mr. LUTTRELL. Educating them saying, hey, look, you are going to have knee surgery here in the community but you are coming back to the VA——

Dr. ELNAHAL. That is right.

Mr. LUTTRELL [continuing]. for rehab. That needs to be that needs to be very clear and it is not currently.

Dr. ELNAHAL. Listen, I take that feedback and for any specific cases, obviously, we will dive on it, but that is good feedback for me to have. It is our responsibility to coordinate the care. It is not on the community care.

Mr. LUTTRELL. To piggyback on that particular issue, you know, and we talked about this earlier, the transference of the medical record is not coming back in time, if you will.

The way that I understand it is, and correct me if I am wrong, but the way I understand it community care has no window to push back the person's medical record back to the VA because I have veterans say, hey, look, I have been—I am back at the VA. They do not have my record. They do not have any idea I had the surgery.

When the VA reaches out to the community care provider, like, yes, we will get it to you but there is no legislative timeframe, like, 30 days. Are you familiar with that?

Dr. ELNAHAL. I am. I am, Congressman. It used to be a requirement for payment for community providers to get records back to the VA and a number of years ago that requirement was taken away so that we could essentially pay community care providers.

Mr. LUTTRELL. Okay. Is that something that this committee needs to reengage and re-legislate or is that something the VA can do?

Dr. ELNAHAL. I believe we have the latitude, Congressman, to set this either policy or regulation but I do not want to misspeak on that and we will get back to you. Obviously, if there were legislation on this we would respect it and implement it.

Mr. LUTTRELL. I would like to—let us sooner than later have those answers so we can move on it if it is necessary for us or if the VA can handle it. Mr. McDonough, I will speak to him directly and say, hey, I think this is a good—I will let you guys do it. Thank you.

Mr. Jacobs, with the ask for the supplemental, the $2.8 billion or the $2 billion, I think I heard you correctly. We had moved appropriations and then you had the annual VA meeting where the projection increased. Is that correct?

Mr. JACOBS. We updated our projection in about June and then we had to work to verify and validate that the assumptions going into that updated projection were valid.

Mr. LUTTRELL. Okay. As extremely challenging as this may be to follow where Congress is when we are doing our job——

Mr. JACOBS. Yes.

Mr. LUTTRELL [continuing]. or not, is there any way we could have those assumptions beforehand?

Mr. JACOBS. I share your frustration. If there was any way I would have shared those earlier. What I will commit to you, though, is we are working to figure out what changes we need to make on the front end.

I will say our original assumptions underestimated our workforce because they over delivered. They have been over delivering and we anticipate——

Mr. LUTTRELL. Which is great.

Mr. JACOBS. It is a great thing——

Mr. LUTTRELL. Good on that.

Mr. JACOBS [continuing]. for our veterans.

Mr. LUTTRELL. If we are looking at the books, which we have to do, if the assumptions in the workforce could work in parallel that makes it extremely easier for us to keep tabs with you and make sure that you have everything that you need.

Mr. JACOBS. Yes, sir.

Mr. LUTTRELL. With the IG investigation, I got to tell you it is— I am not going to say it is always inert. I do not have enough time for that question.

Mr. Chairman, I yield back and I apologize.

Mr. Missal, you are fortunate, sir. I was going to leverage your statements, but I would like to catch both the under secretaries after class for some talking points.

Mr. MISSAL. Will do.

Mr. LUTTRELL. Thank you.

Mr. ROSENDALE. Thank you very much, Representative.

I now recognize the ranking member, Representative Takano——

Mr. TAKANO. Well, thank you.

Mr. ROSENDALE [continuing]. for 5 minutes.

Mr. TAKANO. Thank you, Mr. Chairman. Well, I would like to say to the panel we all know that accountability should be looking at the root problems which, by the way, involves much more than just finding out who knew what when.

Accountability is also about taking responsibility for problems, identifying areas for improvement, and following through with solutions. They measure success based on how an individual or organization course corrects and safeguards against that problem recurring in the future.

This Congress, I have visited VA facilities across the country, including in eastern Colorado, Loma Linda, Hampton, and Buffalo. I did not visit Hampton and Buffalo but my staff did.

We have met with the leadership and staff to hear directly how these facilities are responding to the various challenges they face. It became clear during our visits that there are cultural changes happening at these facilities and their staff with dedicated individuals who truly live by the VA mission and deeply care for veterans.

Leaders are learning from their prior shortfalls and pivoting to ensure that they foster a positive environment to both give and receive care.

Dr. Elnahal, you are leader of the largest integrated health system in the country. You oversee operations of 172 hospitals and

about 1,100 patient outpatient clinics, and more than 371,000 employees who care for over 7 million veterans each year. How do you identify and approach the many challenges that VA faces?

Dr. ELNAHAL. One of the most important things we have to do, Mr. Ranking Member, is set clear expectations for all of our leaders on matters like oversight matters, like, who is responsible for what in the leadership team and the chain of command.

We released a policy in part in response to the many findings that Mr. Missal and his team in the OIG have found on lapses in oversight that have allowed problems to linger longer than one should expect or hope.

We released that policy in mid-August and we intend to enforce it. We are enforcing it to ensure that every leader understands their responsibilities.

I will say that the vast majority of our leaders are achieving historically high outcomes on veteran trust, quality, and access, at least compared year-over-year. Where we are seeing shortfalls on the list of the facilities you mentioned, a common theme is, you know, problems were lingering, medical centers did not necessarily raise those issues to VISNs, which means they do not get to our attention at headquarters.

That just cannot happen. We have to be internally transparent so that we can be externally transparent to veterans and this committee.

Mr. TAKANO. Well, thank you. I want to move on to another topic. We both have talked about the growth of community care or for-profit care. Not all the community care is for-profit but a big chunk of it is, the growth of that, of non-VA care, impacting VA's budget.

Can you talk about how it is, what the impact has been, the rate of growth? What strategies you are employing to staunch that growth and maybe even roll it back?

Dr. ELNAHAL. Community care growth, Congressman, has been very substantial over the last several years. So far this Fiscal Year we are at about 16 percent growth in referrals in the community compared to last year alone.

Last year and the year before it ranged between 16 and 18 percent. This is all year-over-year growth.

One of the things we have done is ensure our entire operation is empowering every single veteran who comes into care with all of their options, including if they qualify for community care, to say, yes, you qualify for community care.

Here are your set of options. You can also receive a telehealth appointment on this date, an in-person appointment on a different date. A clinical resource hub can help you, whatever it might be.

As a result, we started at the beginning of the Fiscal Year with about a 20 percent year-over-year growth in care in the community as of January and now we are at 16 percent, not because we are not offering community care options but side-by-side we are increasingly offering other VA options.

Just one metric that you might be interested in, our clinical resource hubs, which is the VISN-wide capacity source for many veterans across that region, we are up 30 percent year-over-year on those appointments.

We are also up significantly on interfacility consults over 16 percent, meaning a veteran normally gets care at one medical center we refer instead of the community to another VA medical center.

They take us up on it and they choose that option instead. We are not affecting the list of options. We are simply adding and ensuring that we are reliably offering VA options at every turn.

Mr. TAKANO. Well, I certainly appreciate that you initially started at 20 percent referrals and now are at 16 percent. That is still very high. Does VHA have any plans to update its cost projection models moving forward so it can better forecast its budgetary needs?

Dr. ELNAHAL. We are definitely looking into that, Mr. Ranking Member. We noticed since the MISSION Act was passed that the main way that we project our costs into the future, which is a tool called the enrollee healthcare projection model, there is beginning to be some deviation between what our actual costs end up being and what that model predicts

It all, kind of, seems to at this point map to exactly when the MISSION Act was passed which, as you know, vastly opened the doors of eligibility into community care.

We are doing a lot of work now on understanding how we can project more accurately, especially with the experience of this year. The other important policy, as you know, Congressman, is the PACT Act, which massively expanded the doors that veterans overall can enter into the system.

Those are big changes and we do have to alter our projections to map to those phenomena.

Mr. TAKANO. Well, thank you.

I yield back, Madam Chair.

Ms. KIGGANS. [Presiding.] The chair now recognizes Mr. Crane for 5 minutes.

Mr. CRANE. Thank you, Chairman.

Thank you, gentlemen, for showing up today. I am going to be honest. I love being lectured and gaslit by Democrat members on this panel that have never served this country, are not veterans, and have never received healthcare at the VA about how we are trying to privatize the VA.

I want to repeat what Chairman Bost says. That is absolutely not what we are trying to do. We are here to conduct oversight because this is not your money. It is not my money.

This is the taxpayers' money and they sent us here to try to be better stewards of it, something that we all know that we are not good at in this town.

I want to start with you, Dr. Elnahal, did I pronounce that correctly?

Dr. ELNAHAL. Perfectly.

Mr. CRANE. Great. You are seeking an additional $3 billion today after the VA budget was fully funded. Is that correct, sir?

Dr. ELNAHAL. VHA, the healthcare system, is requesting $12 billion in additional funds for the healthcare system. You may be referring to the VBA funding.

Mr. CRANE. Okay, thank you. $12 billion?

Dr. ELNAHAL. Yes for VHA.

Mr. CRANE. We do understand, sir, that the VA is a massive organization and has a very important mission and that projections are not always able to foresee and account for every unexpected thing that might come down the path with how big the mission is.

It does make it harder to swallow when we read reports from the IG about how millions of dollars that were supposed to be used for veterans go to bonuses for senior executives at the VA. You understand how that might create an optical issue?

Dr. ELNAHAL. Of course, Congressman.

Mr. CRANE. Mr. Missal, you are the Inspector General. Is that correct?

Mr. MISSAL. That is correct.

Mr. CRANE. How much money are we talking about here? How much money was supposed to go toward veterans that went toward bonuses for senior executives?

Mr. MISSAL. $10.8 million.

Mr. CRANE. $10.8 million?

Mr. MISSAL. Yes.

Mr. CRANE. It is not a small sum, is it, sir?

Mr. MISSAL. No, sir.

Mr. CRANE. Did you interview Dr. Elnahal on this matter, sir?

Mr. MISSAL. Yes we did.

Mr. CRANE. What did you find?

Mr. MISSAL. What we found is that Dr. Elnahal did not follow the process that was in—or VHA did not follow the process that was in place, which was really to not group employees very broadly.

What they did is they gave the incentive to all senior executives instead of looking at what their criteria was. Are these people that fall under different categories? Then the controls broke down that were in place where people should have raised questions but did not.

Mr. CRANE. Mr. Jacobs, did you sign off on that decision?

Mr. JACOBS. I did approve that decision, yes.

Mr. CRANE. Why is that?

Mr. JACOBS. Congressman, as we were working to implement the PACT Act one of the critical concerns we had was about, excuse me, recruiting and retaining the workforce and the leadership that we need to meet the growing demand of veterans as a result of the PACT Act.

I was concerned about our ability to retain the leadership that was critical to our ability to launch the PACT Act within months rather than years and to grow and implement the policies that were needed to do so.

Ultimately, what we realized is that we erred in the way that we implemented it. There were missed opportunities as an organization where voices raised concern or there were concerns raised that did not get to us expressing disagreement, and there were also personal shortcomings on——

Mr. CRANE. Real quick, Mr. Jacobs, what has been done to rectify this issue?

Mr. JACOBS. Congressman, we have recouped 93 percent of the senior executive CSI payments for central office leaders. We notified——

Mr. CRANE. Were you ordered to do that? Dr. Elnahal, was that your call to recoup that money or was it the secretary?

Dr. ELNAHAL. It was the secretary's call. He did work with Under Secretary Jacobs, Under Secretary Jacobs and myself and we, of course, agreed with that decision.

Mr. CRANE. When we see things like that happen because, Dr. Elnahal, I am sure this is not the last time that you will appear before this committee, is there anything else, any decisions that you have made along those same type of lines that the OIG or the, excuse me, the IG is going to be writing reports about in the future that you know of?

Dr. ELNAHAL. Not that I am aware of, Congressman. As my colleague Josh just said, I definitely made mistakes myself. There were mistakes made across the agency on this.

To the extent that any veteran heard about this and had their trust compromised in the VA, I apologize to them. My most important task now is to make sure that this never happens and we implement all of the recommendations that we concurred with in Mr. Missal's and the IG's report.

My commitment to you is to ensure that all of them are implemented.

Mr. CRANE. Thank you, Doctor, and I appreciate you taking accountability for that. It is not something that happens often up here in Washington. I yield back.

Ms. KIGGANS. The chair will now recognize myself for 5 minutes.

To Mr. Missal, the OIG has published several reports involving the Hampton VA Medical Center that substantiated many allegations related to clinical care. These reports highlight substantial failures to deliver adequate care, endangering veterans, and undermining the trust of the Hampton Roads community.

There was a 2022 report, " multiple failures in test results follow up for patient diagnosed with prostate cancer," a 2023 report, " delay in diagnosis and treatment for a patient with a new lung mass," a 2024 report, " mismanaged surgical privileging actions and deficient surgical service quality management processes."

What has the OIG identified as being the root cause of these substantiated allegations and to what extent were Hampton VA's leadership responsible for the facility's many failures?

Mr. MISSAL. I think the bottom line is the leadership is responsible for the failures that occurred. There was a theme in all three of these reports that some basic fundamental processes were just not followed.

Some of them were just not even—the leadership was not even aware of it. Again, going back to what I was saying about VISN oversight, the VISN was not involved in the facility at all, never recognized that there were issues with leadership at the facility.

Ms. KIGGANS. Why was the VISN not involved with leadership there?

Mr. MISSAL. They took a very passive approach and they said they were not aware of it. Nobody told them what the issues were. We have seen in report after report when there is passive VISN oversight they are not able to identify problems as early as they should and to deal with them when they should.

Ms. KIGGANS. Has that changed with some of the leadership changes that have happened recently?

Mr. MISSAL. We are still looking at that. We have open recommendations, certainly on the most recent report about Hampton, so we are going to follow up on that.

Ms. KIGGANS. Please keep a close eye as the person who represents many of the veterans that use that facility.

A follow-up question for Mr. Missal. In each of these reports the OIG mentions a series of recommendations that the Hampton VA Medical Center must implement.

Which of these outstanding recommendations have not yet been implemented and have you received feedback from Hampton VA Medical Center explaining why hospital leadership has not been able to implement your OIG's recommendations?

Mr. MISSAL. We check with the facility on a quarterly basis to see the progress that they are making. The two earlier reports, I believe there is still one outstanding recommendation, but we understand the facility is working on it.

Then the most recent report it is too early at this point to have them closed out, but again, we are available to speak with the facility about any issues they may have and we help them close them out and ensure that the recommendations address the issues and that the issues will be improved going forward.

Ms. KIGGANS. Will you continue to follow up and make sure each of the recommendations have been followed?

Mr. MISSAL. Absolutely.

Ms. KIGGANS. Thank you.

To Dr. Elnahal, in your testimony you state how the VISN's chief medical officer has been addressing issues in the Hampton since August 2023. Over a year later there are still clearly issues present.

Why did it take so long for the medical center director to be removed pending an investigation, and why is it taking so long to address these concerns?

Dr. ELNAHAL. I think those are very fair questions, Congresswoman, and I have been working with you and your staff for some time on all of these problems. It is never an easy decision to detail out a leader.

Ultimately, our network director made that decision based on many of the findings that have accumulated over time with investigations from the Office of the Inspector General and the Office of Accountability and Whistleblower Protection.

When he recommended that decision to me I immediately accepted it, and we made those moves for temporary reassignments and brought in a very experienced and effective leader, Walt Dannenberg, who is normally the director at Long Beach, California.

I have already had contact with him about the improvements he is trying to make and he is dead focused on making sure that things improve there for veterans at Hampton.

Ms. KIGGANS. We have met with him as well recently and are very encouraged by that leadership change. I have only been in this position for almost 2 years now in my first term, but this has been the biggest issue that we have heard complaints about.

We get complaints about a lot of things. You would be surprised. The VA healthcare issue for myself representing one of the largest veteran populations in the country it was unconscionable, just the number of not just patients but the whistleblowers.

I think we interviewed 25 whistleblowers from janitors to surgeons. Thank you very much for working with my office to rectify those issues and to provide new leadership. We are looking forward to also continuing to follow with them to make sure that we are seeing improved patient and clinical outcomes.

Then just to follow up, Mr. Elnahal, Hampton currently has a dangerous shortage of providers as well. That was one of their issues.

For example, employees have expressed concerns to my office about a dangerous and persistent shortages of personnel at the clinical laboratory and the hospital currently only has one anesthesiologist on staff. What are you doing to ensure the staffing issue specifically about anesthesiologists is resolved?

Dr. ELNAHAL. Yes. One of the immediate things is making use of a nationwide staffing contract vehicle that we now have called the integrated clinical staffing program. It turns out that we have a number of certified registered nurse anesthetists, but we need ultimate supervision from physician anesthesiologists and so we are primarily trying to recruit through that vehicle.

The most important thing to do is to get permanent anesthesiologists on and we maintain our efforts to try to get those folks on permanently.

I will again say that the $12 billion anomaly in the CR, which would go directly into VA healthcare, would allow us to grow our workforce instead of having to attrit our workforce to maintain within the budget.

That will be a very helpful tool to liberate every medical center that needs to bring in more clinicians, activate new services, and better serve the veterans in their regions. We hope that Congress considers that.

Ms. KIGGANS. I ask that you allow nurse anesthetists to be able to practice to the full scope that they are allowed to practice. I think they are a great way to supplement that anesthesiology shortage, and I know that we have heard even in this committee setting just about the length of time that it takes to hire and bring on new providers.

Just making sure that we are expeditiously doing the entire process in clearance and whatnot but hiring them because I think we lose some good providers along the way.

Last question for me, Dr. Elnahal, some of the OIG reports at Hampton mentioned outdated software and the EHR concerns is contributing to patient safety problems. Can you speak to what the VA is doing to modernize the VA's IT system to ensure veterans are receiving 21st century standard of care?

Specifically, I would like to know what is being done to assist community care providers outside primary care providers, the ability to have access to health information and patient safety flags?

I know as a nurse practitioner practicing in a primary care setting it was very frustrating. I could get charts and information and notes from all kinds of specialty clinics.

When it came to my veterans I would look right at them and say you have got to go there yourself. You got to get it printed out. You got to hand carry it from the VA to our office because I will not be able to get it. All of my wonderful office staff will not be able to get it via fax or any other way.

That was a problem and it created a lot of continuity of care problems. What are you doing specifically to address that technology needed in the 21st century?

Dr. ELNAHAL. There was definitely a contribution when it came to our technological tools on, you know, it was really difficult to read some of these reports, but the really tragic case of a veteran with lung cancer who had serial delays at every step before they started treatment for ultimately what became a malignancy that spread to other organs.

Part of that was the tools needed for referral into the next step and making sure folks were in scheduling queues when they needed to be. I think the bigger contributor, though, was reliable follow-through on our processes and holding all staff accountable for following through on every veteran, but in particular veterans with serious diagnoses like cancer.

Of course, we are trying to improve our systems around scheduling so we have a lot of work going in collaboration with Office of Information Technology (OIT) to make it easier to schedule veterans into every subsequent step in their care.

One specific move we are making is to do what is called provider-based scheduling which allows you to see all the options for any physician or clinician available in any number of their clinics that they work in across the VA.

That is we hope to go live with that soon and that will significantly reduce the task flow burden for every single person trying to coordinate that veteran's care. That is just one of many examples of some of the tech tools that will help us.

We are still primarily accountable, though, for follow-through for every veteran with the tools that we have.

Ms. KIGGANS. Thank you and I look forward to continuing to work on the EHR integration throughout the VA as well.

Then just one final question, just because this has been a topic that has come up multiple times including in the media in my district, but that is with community care specifically for chiropractic care and what we have advocated on different levels, including meeting with the new executive director about that approval process.

For some reason, chiropractic care is always the one that is highlighted, but I believe, as a nurse practitioner again, that we should be able to treat the veteran with the pain modality that they respond to the best.

If it is chiropractic care, great. If it is physical therapy, if it is medicinal, whatever. Whatever that pain modality is.

Why cannot we get that approval process done so that our veterans who respond best to chiropractic care can continue to get that chiropractic care? I do not want them to resort to other types of—either we see overdose issues. We struggle with mental health issues.

Let us get our veterans the proper treatment with the pain modality they respond to, and if it is chiropractic care it should be that. What is the VA doing to address that issue?

Dr. ELNAHAL. Congresswoman, I would say that this occurs most of the time when it comes to our employees trying to assist every veteran with the next best step in their care. We have to though make sure it happens every single time where we engage the veteran in care decisions.

If he veteran tells us that chiropractic care is assisting with their pain and their function we should do everything we can to honor that.

Now, there may be, sort of, many dimensions of your question around how requests for service are approved to continue a community care episode, making that initial decision to refer a veteran to the community if we do not have chiropractic care.

There is a lot of ways to tackle that, but we need to just be extremely veteran-centered on how we improve these processes. That is my commitment to you.

Ms. KIGGANS. Thank you very much and I agree.

All right. The chair now yields.

I will yield to Mr. Obernolte for 5 minutes.

Mr. OBERNOLTE. Well, thank you very much, Madam Chair. I would like to thank Chairman Bost, Ranking Member Takano, and the other members of the Veterans Affairs Committee for allowing me to waive onto this hearing.

It is very important to me because it highlights an issue that is critically important to my district. I represent a district with five military bases, over 40,000 veterans, and I also represent Loma Linda and the Veterans Affairs facility there.

What goes on at Loma Linda has a direct impact on all of the veterans that I represent and the quality of care that they receive.

As you all are aware, we have had some pretty troubling developments at VA Loma Linda, and I know everyone here on the panel is as committed as I am to trying to get to the bottom of those problems and fix them.

What has become abundantly clear after this investigation, which I led with Chairman Bost and we conducted dozens of interviews with whistleblowers, we had a bunch of letters, a couple of site visits, and we continue to review thousands of pages of documents.

It seems very clear that a hostile work environment exists there and thank goodness for the whistleblowers because without them we would not have visibility into the situation there.

When you have a hostile work environment the concern is that people do not want to work there, and if people do not want to work there you are not going to attract the best quality people.

If you cannot attract the best quality people then our veterans are not going to be receiving the quality of care that they should receive. I know that we are all committed to fixing that problem.

Dr. Elnahal, I would like to start with you. Recently, the Office of Accountability and Whistleblower Protection conducted a climate review of VA Loma Linda. I think it is fair to say the results were pretty damning.

It is crystal clear that the employees there have a severe lack of trust in the leadership of Loma Linda. Do you believe that this is an indication of poor leadership or is it something else there at the facility? What needs to be done to fix that?

Dr. ELNAHAL. I read that climate review cover to cover, Congressman, definitely some very concerning findings. What I think we need to do there is open every single avenue we can to have frontline voices heard when they consider a vulnerability or they report a vulnerability in the quality of care.

We need to make sure employees are treated right by every supervisor. There is a very notable case of a supervisor who had a very toxic environment, ultimately went through the disciplinary chain and counseled that supervisor to improve.

It takes a time, Congressman, to change culture but we are putting every single effort that we can into that medical center to hear the voices of our staff to ensure that veterans do better.

The one piece of good news that tells me that they are on a better trajectory is that they were formally on what we call the highest tier of need, tier 1 on quality and patient safety. They have since graduated because they are starting to improve their quality metrics.

There is still a lot of work to do as highlighted by that climate report but we are dead focused on it.

Mr. OBERNOLTE. I am glad to hear that. One of the most troubling aspects of that report to me was the fact that it highlighted that employees are still afraid to disclose wrongdoing because they fear retaliation. With some of the allegations that were made, you know, their fears are justifiable.

What are you doing to reassure employees that they can come forward and report wrongdoing without being retaliated against?

Dr. ELNAHAL. The most important thing as a leader you can do to earn trust is to show up and to listen and to not be only interacting with employees when you have bad news or you want them to do something.

When I was a Chief Executive Officer (CEO) of a single hospital before this in Newark, I would spend most of my days, at least a portion of it, doing what is called rounding, showing up to the units both clinical and non-clinical.

I know the director there is doing that himself. He is asking all of the executive leadership team members to do that. When you show up and you are supportive, that is when trust is built.

It takes much more time to build trust than it takes to lose trust. I know that things are in a better direction there but there is still much more work to do.

Mr. OBERNOLTE. Well, let me ask you about another aspect that I have heard about from whistleblowers, and this is the frustration that nothing that they say ends up mattering. The supervisorial employee that you highlighted earlier when we were discussing the situation is a good example.

There was someone that was promoted despite these allegations and then most recently the director of the Loma Linda medical center just received the highest possible performance rating.

This is a big frustration to the whistleblowers that I have spoken with because they feel like they bring these issues up, nothing is

done, and the people that they are talking about end up getting promoted instead of disciplined.

What can you tell those whistleblowers that might restore some of that trust?

Dr. ELNAHAL. Well, the most important thing that they should know is that we have to not only show up but to follow through on what they are saying. You know, I know what it is like as a physician to raise concerns to leadership about vulnerabilities in care only to not see anything happen after that.

Every single patient safety report that is flagged is a serious concern, needs follow through. When you hold forums you have to follow through on what you are hearing. That is part of accountability and leadership.

I will definitely be reinforcing that with the VISN and medical center leadership.

Mr. OBERNOLTE. Well, thank you very much. I see my time has expired, but I want to thank everyone for their testimony today and let us all work together to try and get this situation resolved.

The most troubling aspect of that climate review was the revelation that this problem is an ongoing problem. It is not one that has been solved yet and so we really need to take action and restore trust there to make sure our veterans are receiving the kind of care that we all want them to receive.

Thank you very much, Madam Chair. I yield back.

Ms. KIGGANS. Ranking Member Takano, do you have any closing remarks?

Mr. TAKANO. I do not, Madam Chair.

Ms. KIGGANS. Okay. Thank you, Ranking Member.

Thank you all for being here today. It is clear the VA has an accountability problem that we are working to fix. It is unacceptable that time and time again VA employees who have engaged in misconduct are just moved throughout the organization.

Such moves allow these employees to infect other VA offices with their bad behavior or even put veterans at risk for adverse health consequences.

I just want to say a personal thank you for taking action at the Hampton VA to replace the top three leadership there, the executive director, the chief of staff, the chief of surgery. I think these were changes that were certainly needed, and I really look forward to a change to the positive direction with the Hampton VA.

For all these reasons that we talked about today is why Congress needs to pass the Restore Accountability Act of 2023. This bill would speed up the disciplinary process. A more efficient process would not only make sure employees found of wrongdoing were appropriately disciplined in a timely manner, but also allow VA employees accused of wrongdoing but never found responsible to have their name cleared.

Accountability does not just mean appropriately dealing with misconduct. It also means showing good judgment and being transparent.

This is why it is unacceptable the VA has failed to provide additional briefings on its budget shortfall since first notifying this committee of the budget issue nearly 2 months ago. Full transparency is needed here so such a situation never happens again.

With that, I ask unanimous consent all members shall have 5 legislative days to revise and extend their remarks and include any extraneous material. Hearing no objections, so ordered.

The hearing is now adjourned.

[Whereupon, at 1:20 p.m., the committee was adjourned.]

APPENDIX

PREPARED STATEMENT OF WITNESSES

Prepared Statement of Michael Missal

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

STATEMENT OF MICHAEL J. MISSAL
INSPECTOR GENERAL FOR THE
US DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
US HOUSE OF REPRESENTATIVES
HEARING ON
"ACCOUNTABLE OR ABSENT?: EXAMINING VA LEADERSHIP
UNDER THE BIDEN–HARRIS ADMINISTRATION"
SEPTEMBER 10, 2024

Chairman Bost, Ranking Member Takano, and committee members, thank you for the opportunity to discuss the efforts of the Office of Inspector General (OIG) to address leadership and governance issues within VA as well as our findings and recommendations to increase accountability at every level. This statement discusses the foundational elements of accountability that I shared with this committee in a prior testimony, drawn from the recurring themes that OIG oversight personnel often see when identifying failings in VA. It also highlights reports we recently issued on the Hampton VA Medical Center in Virginia and the VA Eastern Colorado Health Care System in Aurora, Colorado, as two case studies on how veterans' care is affected when there is ineffective leadership and management officials are not held accountable for providing personnel with a safe and supportive culture. Several examples are also provided in which accountability breakdowns resulted in missteps that had significant financial consequences (the critical skills incentives for VA Central Office senior leaders and the pause of the Payment Integrity Tool).

I want to acknowledge from the start that the vast number of VA personnel and leaders OIG staff encounter in VA medical facilities work extremely hard to care for veterans, often in the face of significant challenges. I also recognize that VA senior leaders seek to have a culture of accountability where staff feel comfortable reporting problems without fear of retaliation or retribution. However, more work needs to be done to achieve this objective.

In a system as large as the Veterans Healthcare Administration (VHA), there will be occasions when processes break down, clinicians do not meet standards of care, and offices or services within a facility are mismanaged. Mistakes happen. The real test for VA is how leadership—at the facility, regional, and central office levels—works to promptly identify these deficiencies and hold themselves and their staff accountable for correcting them before they lead to poor or even tragic outcomes for veterans. The OIG has also recently testified and published repeatedly on quality assurance weaknesses within the Veterans

Benefits Administration (VBA) that affect both beneficiaries and VA's stewardship of taxpayer dollars, as well as the failings by multiple leaders and senior personnel across VA in awarding critical skills incentives to nearly every VHA and VBA senior executive working in VA's central office.[1]

When I testified before this committee last year on how enhancing accountability at VA is an OIG priority, I discussed the OIG's goal to provide the department with the information and recommendations to not only improve its services, programs, and operations, but also to increase accountability.[2] This is no small task. It requires sustained efforts by OIG auditors, healthcare inspectors, and investigators to conduct the most impactful oversight work possible. It also necessitates that VA leaders be engaged and responsive to our findings and recommendations. In interactions with VA personnel and leaders, this is routinely true. Secretary McDonough, other department and administration leaders, and the vast majority of VA personnel with whom OIG staff engage are dedicated to serving veterans and receptive to independent oversight to improve their efforts. The OIG recognizes that changing the culture of any organization takes time and sustained effort. Given the importance of VA's mission, every individual at VA should feel a responsibility to identify risks, report those risks and any resulting problems, and then take action to address the underlying causes and mitigate the chances for future occurrences. That is a culture that has not yet consistently taken hold across VA.

FOUNDATIONS OF ACCOUNTABILITY

The OIG's work often focuses on identifying gaps in the five components of accountability described below.

Strong governance and clarity of roles and responsibilities

Misconduct, failures to take appropriate action, and persistent problems are often the result of VA personnel or contractors not understanding their roles and responsibilities. In other cases, they understand their duties, but simply do not or cannot fulfill them. This may be due in part to outdated policies and procedures, conflicting guidance, or a lack of clear decision-making—often with those best positioned to act lacking the authority to do so.

[1] Recent OIG testimony to Congress related to VBA issues can be accessed here. Recent reports regarding the National Cemetery Administration are also available on the OIG reports page. Given the focus of this hearing, however, this statement addresses recent OIG oversight of VHA. As mentioned later in this statement, Inspector General Missal's written testimony to this committee on VA's critical skill incentives to headquarters' senior leaders outlines a litany of missteps and failures in accountability.

[2] VA OIG, Statement of Inspector General Michael J. Missal before the House Committee on Veterans' Affairs, February 28, 2023.

Adequate and qualified staffing to carry out those duties

Historically, VA has faced high vacancy rates across its programs and operations, especially within VHA. Shortages of qualified personnel in key positions have made it difficult for VA to carry out its goals and functions. Having the right people in the right positions committed to doing the right thing is essential to building a culture of accountability, as is instilling that culture in new hires.

Updated information technology (IT) systems and effective business processes to support quality healthcare, accurate and timely benefits, and efficient operations

VA is in the process of modernizing a number of significant systems that are critical to its operations. The OIG has been proactively overseeing VA's implementation of these crucial systems. However, as detailed in multiple reports, VA has had significant troubles with upgrading or replacing key systems that support patient care, supply management, benefits to veterans and their families, and the stewardship of taxpayer dollars. VA's process for replacing crucial IT systems faces significant ongoing challenges. Major plans to modernize electronic health records, supply chain management, claims processing, and financial management systems have been marked by critical missteps. These have typically included weaknesses in planning, insufficient stakeholder engagement, failures to promptly fix known issues, and program management or coordination deficiencies. These issues must be resolved for VA to remain accountable for the care, services, and benefits it provides. The OIG understands the tremendous complexity and cost of these efforts and continues to provide recommendations that are as practical and actionable as possible to support VA personnel working to ensure patient safety and to deliver benefits and services to eligible veterans.

Effective quality assurance and monitoring to detect and resolve issues

VA often lacks controls that adequately and consistently ensure quality standards are met. Breakdowns in routine monitoring and the continual use of work-arounds undermine efforts to provide timely quality services and benefits to eligible veterans and their families. Failures in quality assurance and monitoring relate not just to systems and processes, but to personnel as well—particularly in areas such as personnel suitability programs, credentialing, privileging, and monitoring of healthcare professionals entrusted with veterans' care.

Stable leadership that fosters responsibility for actions and continuous improvement

VA leaders at every level often do not get the information they need to make effective decisions; some fail to take necessary and prompt action, while others struggle to create a culture in which every employee feels empowered to report problems. The frequent turnover in key positions or the long-term use of acting positions exacerbates these challenges.

Many of these foundational elements for accountability were lacking in the OIG's recent reporting on the Hampton and Aurora medical facilities (detailed in the sections that follow). It is important to stress that OIG recommendations that focus on just a single medical facility or benefits process are often a road map for other facilities and offices across VA to help prevent or correct similar problems that have

gone undetected or unaddressed. It is vital that OIG findings are routinely shared with VA leaders across the enterprise to promote positive change within their respective programs and operations.

THREE OIG REPORTS ON THE HAMPTON MEDICAL CENTER FOUND LEADERS FAILED TO APPROPRIATELY ADDRESS CLINICAL CARE CONCERNS

For each of the last three years (2022–2024), the OIG has published healthcare inspection reports of the Hampton facility that substantiated a range of concerning allegations related to clinical care. These reports collectively uncovered failures in care coordination, communication, quality of care, administrative and clinical oversight, quality assurance, and overall employee engagement. These failings contributed to increased risks to patient safety and adverse outcomes.

Unfortunately, within VHA and the private sector, substandard care and delays in diagnoses and treatment are not as rare as they should be. There are instances in which delays and deficiencies are reported to OIG staff but VHA leaders are already in the process of taking appropriate action to correct the issues. In those instances, the OIG may allow VHA to attempt corrective action before determining whether additional review is warranted. What OIG healthcare inspectors find most troubling is when facility managers and leaders are either unaware of personnel and patient concerns or do not ensure the required quality management processes are carried out that would detect and correct them. High reliability organization principles foster a culture of "collective mindfulness," in which all staff look for and report small problems or unsafe conditions before they pose a substantial risk. If leaders are not aware of concerning singular events or more systemic challenges, they cannot ensure the appropriate steps are taken to safeguard patients. Implementing quality improvements to address specific patient safety issues requires open and honest communication from, and among, staff at every level of a facility.

Staff Responsible for Quality Assurance Failed to Take Appropriate Actions

First, in the 2022 Hampton facility report, the complaint made to the OIG focused on the delay in a single patient's diagnosis of prostate cancer.[3] However, the OIG team's review identified multiple healthcare providers who did not appropriately manage abnormal test results for this patient. As to this complaint, the mismanagement included the patient's surgeon, primary care provider, and nurse practitioner failing to take action (when required) or missing opportunities to do so (when they could have).

This inspection revealed that those tasked with the responsibility to ensure quality care did not take appropriate measures. According to VHA, a facility's patient safety program aims to prevent harm to patients by reporting and reviewing adverse events, identifying underlying causes, and implementing changes to reduce the likelihood of recurrence.[4] Facility policy requires that all staff complete patient

[3] VA OIG, *Multiple Failures in Test Results Follow-up for a Patient Diagnosed with Prostate Cancer at the Hampton VA Medical Center in Virginia*, June 28, 2022.

[4] Facility Policy 590-11-28, Patient Safety Improvement Program, April 30, 2020.

safety reports as soon as adverse events are discovered. The OIG determined that facility staff and leaders were aware of deficiencies in the patient's care that was the focus of the initial complaint; however, they did not initiate or submit patient safety reports. Further, quality management staff did not screen for and initiate peer reviews in a timely manner consistent with VHA policy, delaying facility leaders' ability to (a) identify staff who may need additional training, (b) improve quality of care, and (c) ensure patient safety. The chief of Quality, Safety and Value reported becoming distracted by other work and forgetting to inform the risk manager of the need for peer reviews.

The OIG made seven recommendations for the facility to make the needed improvements in its patient safety program. All recommendations have been closed as implemented after the OIG determined that the facility had shown sustained compliance with their action plans.

Oncology Leaders Failed to Implement Critical Functions Needed to Deliver the Highest-Quality Care

Second, in 2023, the OIG substantiated that a patient at the Hampton facility experienced a delay in diagnosis and treatment for a new lung mass that was highly suspicious for cancer.[5] The assigned team found facility leaders were unaware of the patient's case until the notification of the OIG inspection. The team identified deficiencies in primary and specialty care services' prompt scheduling and access to care that might have resulted in an earlier diagnosis and treatment of the patient's lung cancer.

In addition to the concerns with the delays in patient care, the OIG found a troubling absence of many practices critical to ensuring high-quality oncology care. VHA's Oncology Program policy "seeks to ensure that the delivery of VA cancer care is provided following a national standard of practice," which includes the requirement that each facility have a facility-level cancer committee, tumor board, and cancer registry.[6] VHA policy requires the use of the VA Cancer Registry System to monitor all cancers diagnosed or treated in VHA.[7] As such, each VA medical facility must identify and report data on patients with a cancer diagnosis.[8] The OIG found that, at the time of the inspection, the facility did not have an operational cancer committee, tumor board, or a cancer registry as required.[9]

The facility's chief of staff told the OIG team that the lack of a cancer committee was due to an "oversight." However, the facility director stated that a cancer committee had not been chartered earlier

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[5] VA OIG, *Delay in Diagnosis and Treatment for a Patient with a New Lung Mass at the Hampton VA Medical Center in Virginia*, September 29, 2023

[6] VHA Directive 1415, VHA Oncology Program, April 9, 2020.

[7] VHA Directive 1412(1), Department of Veterans Affairs Cancer Registry System, May 29, 2019, amended April 7, 2020; VHA Directive 1415.

[8] Each facility director is responsible for appointing a facility cancer registrar responsible for ensuring the provision of complete, timely, and accurate data of at least 90 percent of cases within six months of first contact with the facility.

[9] Since the inspection, the facility has taken steps to establish the cancer committee and tumor board, as well as to fill the facility cancer registrar position.

due to a lack of continuity in relevant staff. The OIG concluded that without an active facility cancer committee and tumor board, the facility was unable to conduct the additional review that assists with identifying and assessing cancer patients' needs. As a result, facility staff may have missed opportunities to ensure patients received the highest quality of oncological care available.

The components of accountability were clearly lacking in the Hampton facility. Leaders did not create an environment that fostered individual responsibility and continuous improvement. Staffing concerns and unclear roles and responsibilities meant the facility lacked functions critical to a high-performing oncology program. Two of the seven recommendations remain open (not yet fully implemented), and the OIG continues to follow VHA's progress in satisfying the recommendations.[10]

Facility Leaders Did Not Understand or Properly Employ the Basic Processes That Support Delivery of Safe Health Care

The third report, released in July, demonstrates that Hampton facility leaders did not properly address clinical care concerns and subsequent privileging actions involving the assistant chief of surgery.[11] In the course of this inspection, the OIG determined the facility mishandled the processes for professional practice evaluations of surgeons, the surgical service's quality management, and institutional disclosures to patients or their representatives of an adverse event that resulted in harm.

Facility leaders made numerous process errors when determining whether changes were needed to the assistant chief of surgery's clinical privileges.[12] For example, facility leaders failed to document any of the three focused clinical care review (FCCR) results in the appropriate system, did not provide the results of two of the reviews to the Medical Executive Committee (MEC), and delayed reporting the results of the third. These errors limited the MEC's knowledge of all reviews, which could have more fully informed members' decisions and recommendations about whether to reduce or revoke any of the assistant chief of surgery's privileges. The three FCCRs also were not completed by multiple reviewers to ensure interrater reliability and an objective evaluation of the assistant chief of surgery's clinical care.[13]

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[10] At quarterly intervals commencing 90 calendar days from the date of the report's issuance, the OIG sends a follow-up status request to the VA office overseeing corrective action asking for an implementation status report. The OIG follow-up staff provides VA with 30 calendar days to respond. Nothing precludes VA from providing interim progress reports. The next OIG request for an update on this report will be on or about September 29, 2024.

[11] VA OIG, *Mismanaged Surgical Privileging Actions and Deficient Surgical Service Quality Management Processes at the Hampton VA Medical Center in Virginia*, July 23, 2024.

[12] Clinical privileging is defined as the process by which a VA facility authorizes a physician to independently (i.e., without supervision or restriction) provide healthcare services on a facility-specific basis. Clinical privileges are based on the individual's clinical competence as determined by peer references, professional experience, health status, education, training, and licensure.

[13] Interrater reliability is the extent to which two or more independent raters or observers consistently obtain the same result when using the same assessment tool.

A summary suspension of privileges was issued to the assistant chief of surgery, but the OIG identified several inconsistencies between the MEC meeting minutes and suspension letters, as well as improper procedural actions taken by the facility director.[14] These inconsistencies had the potential to impact patient care because the assistant chief of surgery was unaware of which privileges were suspended, affecting the level of services available for patients.

While attempting to reduce the assistant chief of surgery's privileges, facility leaders did not send letters to the assistant chief in the correct order and did not include all required elements in the proposal letter to provide the necessary due process. As a result of these errors, facility leaders rescinded the proposed actions and restored the associate chief of surgery's clinical privileges. When the assistant chief of surgery transferred to another VA facility, their privileges at Hampton ended and facility leaders could not take additional privileging actions.

Hampton facility leaders failed to report the assistant chief of surgery to the state licensing board as well. Failing to report physicians with identified incidents of substandard care to the state licensing board may result in medical facilities, within and outside of VHA, hiring providers who do not meet generally accepted standards of clinical practice, increasing risks to patients.

An institutional disclosure enables facility leaders to inform a patient or their personal representative that an adverse event has occurred. This refers to an event that "resulted in, or is reasonably expected to result in, death or serious injury" and the disclosures are meant "to maintain trust between patients and VA healthcare professionals."[15] The OIG team found that facility leaders generally did not communicate and document required elements of an institutional disclosure, such as advising the patient or family about potential compensation or the option to obtain outside medical or legal advice. In fact, of the 10 institutional disclosures completed at the facility from July 1, 2022, through May 31, 2023, the OIG found that nine did not include "advisement about potential compensation." Such mistakes could result in patients or their personal representatives being unaware of their rights and options for recourse. Simply put, these types of lapses undermine VA's commitment to build and restore patients' trust.

The findings identified through this inspection highlight failures of facility leaders to make certain that required responsibilities were appropriately implemented. They also revealed leaders' lack of a basic understanding of the quality assurance processes that support the delivery of safe health care. This inspection underscores that negative outcomes can occur when such fundamental accountability elements are not present—including strong governance and an understanding of roles and

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[14] A summary suspension is a "summary action" taken by the VA medical facility director to suspend clinical privileges when the failure to take such action may result in an imminent danger to the health and safety of any individual. A summary suspension may be applied to one or more selected privileges or all privileges depending on the circumstances and clinical concern.

[15] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients,* October 31, 2018.

responsibilities, effective quality assurance and monitoring, and leadership that constantly fosters continuous improvement.

The OIG made 12 recommendations, including 11 to the facility director on issues related to FCCRs, summary suspensions, proposed reduction or revocation of privileges, state licensing board reporting, patient safety reporting, and institutional disclosures. VA concurred with the OIG's findings and all recommendations and has provided acceptable action plans and completion timelines. VA's progress in implementing these recommendations will be monitored until sufficient evidence is provided to warrant closure.[16]

THE AURORA FACILITY'S SENIOR LEADERS CREATED A CULTURE OF FEAR AMONG PERSONNEL, LEADING TO POOR COMMUNICATION AND STAFF DEPARTURES

Last month, the OIG released two reports on the VA medical facility in Aurora that tell a similarly disturbing story of accountability failures. The OIG found in its first report that key senior leaders created an environment in which a significant number of clinical and administrative service and section leaders and frontline staff felt psychologically unsafe, deeply disrespected, and dismissed. They feared that speaking up or offering a difference of opinion would result in reprisal. In a second report, an OIG team substantiated that leaders' actions to change the facility's intensive care unit from an open to a closed model (affecting which providers had patient care responsibility) were made without adequate planning and input from relevant leaders and staff. These problems were allowed to persist because Veterans Integrated Service Network (VISN) leaders did not fulfill their own required oversight of the medical center.[17]

Aurora Facility Senior Leaders Created an Environment That Undermined the Culture of Safety for Staff

The OIG substantiated that key senior leaders (including the facility director, chief of staff, deputy chief of staff for inpatient operations, and the associate chief of staff for education) failed to use high reliability organization principles, undermined the stability and psychological safety of service leaders and staff, and created a culture of fear.[18] Accountability is dependent on leaders maintaining a culture in which every employee feels empowered to report problems. Having failed to do so, the climate that key senior leaders created led to frequent turnover in core positions, which only exacerbated the facility's challenges.

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[16] The OIG will make the first request for an update on this report on or about October 22, 2024.

[17] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks that oversee the medical facilities in their designated area.

[18] VA OIG, *Leaders at the VA Eastern Colorado Health Care System in Aurora Created an Environment That Undermined the Culture of Safety*, June 24, 2024

In a "just culture," personnel feel safe reporting concerns and trust that actions are going to be "judged fairly."[19] Instead, personnel interviewed by OIG staff shared concerns and cited examples of key senior leaders not valuing their opinions and expertise, making decisions "in haste," and dismissing concerns. Facility staff shared their fear of retaliation from these key senior leaders. A staff member noted there were repercussions for sharing a different opinion, including being "berated in a meeting" or "pushed out" of their positions by being falsely accused of misconduct and enduring an investigation into the claims. Another clinical leader also described the weaponization of administrative investigations, with the intent of targeting individuals rather than finding the truth and making improvements. A clinical leader described more subtle forms of retaliation as well, such as having staffing resources removed from the department.

The OIG also substantiated there was a negative change in culture associated with the Peer Review Committee (PRC), which is responsible for clinical oversight. A majority of clinical PRC members, and some non-PRC clinical leaders and staff, perceived the committee to be psychologically unsafe and punitive. After the key senior leaders began attending and acting as voting committee members, clinical PRC members reported that these leaders took over or "dominated" committee discussions. In addition, PRC meetings and processes became focused on finding fault and assigning blame as opposed to identifying improvements to patient care, practices, and processes. It should be noted, there are other forums and mechanisms for doing so, such as the FCCR process discussed in the recent Hampton report, meant to complement efforts by the PRC and others to identify and redress problems before they escalate to adverse events or incidents that warrant investigation. The OIG team found that key senior leaders missed opportunities to understand and address PRC members' concerns. When leaders fail to foster a psychologically safe environment, staff avoid speaking up and sharing ideas for improvement.

The OIG substantiated that mid-level leaders' authority had been eroded and there was a lack of continuity of leadership at the service level due to many clinical service and section-level resignations and extended vacancies. These extended vacancies consolidated control among key senior leaders, leaving facility service and section chiefs with limited avenues for communication and with no one to advocate on behalf of their services. Twenty former leaders who had worked in the Aurora facility shared with the OIG the factors that contributed to their decisions to leave. They all reported that a work-related factor contributed to their decision, with the majority reporting poor or psychologically unsafe working conditions and all reporting a lack of trust and confidence in senior leaders. The majority also reported that unethical treatment of staff was important in their decision to leave.[20] An OIG analysis of the responses found common themes in their responses, such as fear of retaliation,

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[19] VHA, "Why is Just Culture important to a High Reliability Organization (HRO)?" VHA Journey to High Reliability, https://dvagov.sharepoint.com/sites/vhahrojourney/. (This website is not publicly accessible.)

[20] For the purposes of the OIG report, unethical treatment factors included harassment or retaliation for voicing concerns, harassment, or retaliation for participating in a complaint process, and unethical behavior on the part of leadership or the organization.

feeling bullied, or a "toxic culture." Nearly half of these former leaders reported feeling undervalued or disrespected by senior leaders, and some reported experiencing medical conditions related to their facility employment.

Despite these losses, key senior leaders did not seek or use employee exit survey data to identify and address employee retention challenges. Turnover in VISN leadership positions and ineffective communication contributed to the then VISN director's lack of awareness regarding the extent of the staffing and culture challenges at the facility. The leadership failures found in this report reflect deficiencies in each of the foundational elements of accountability set out earlier in this statement.

The OIG made a total of seven recommendations for corrective actions that included conducting and utilizing a review of the VISN's awareness and oversight of the Aurora facility to help standardize roles and responsibilities across the system, with the goal of ensuring structured and robust oversight activities in support of high-quality healthcare delivery. All recommendations are currently open and subject to the OIG's routine monitoring and follow-up.

Inadequate Planning and Lack of Staff Input Led to a Troublesome Transition in the Operation of the Intensive Care Unit

In a second concurrent review at the Aurora facility, accountability issues were created by the lack of qualified staff to provide adequate coverage of the surgical Intensive Care Unit (ICU) and leaders' failure to involve key staff in the decision-making process to make changes.[21] Leaders also did not adequately communicate the operational changes up and down the chain of command.

The OIG found that facility leaders implemented surgical ICU changes that led to inadequate provider coverage for surgical patients, and adversely affected the provision of cardiothoracic surgical services. These surgeries were paused from September 2022 through August 2023 and the newly appointed chief of staff failed to notify the VISN of the pause so that VHA leaders would be informed.

The facility leaders and the acting chief of surgery proceeded with plans to resume cardiothoracic surgeries following an 11-month pause and the loss of all facility cardiothoracic surgical staff, without notifying or seeking required approval from VISN and VHA central office leaders. The OIG found the resumption of these surgeries met the VHA policy criteria for a "major augmentation of clinical services" that requires the approval of the under secretary for health or his designee.[22] The OIG escalated concerns about the facility's lack of readiness to safely conduct cardiothoracic surgical procedures to the VISN director in August 2023, after determining there was no detailed,

[21] VA OIG, *Extended Pause in Cardiac Surgeries and Leaders' Inadequate Planning of Intensive Care Unit Change and Negative Impact on Resident Education at the VA Eastern Colorado Health Care System in Aurora*, June 24, 2024.

[22] VHA Directive 1043, Restructuring of VHA Clinical Programs, November 2, 2016.

interdisciplinary evaluation and plan. Following additional internal reviews, cardiothoracic surgical procedures were restarted in late October 2023.

The OIG substantiated that facility leaders' changes to the medical ICU from an open to a closed model were made without adequate planning and input from service and section leaders and staff.[23] The sudden implementation of a closed ICU model resulted in a lack of ICU resident supervision and an ineffective teaching environment for residents. The chief of staff notified service leaders that due to a privileging concern there was a need to change medical ICU physician coverage, but the notification occurred only hours before implementing the change. In accordance with high reliability organization principles, the OIG would have expected facility leaders to plan and involve service and section leaders, and staff before implementing the change to a closed ICU model. The OIG substantiated that the sudden implementation of a closed ICU model resulted in a lack of ICU resident supervision and residents' reliance on on-call attending physicians or fellows. This created an ineffective work environment that did not meet the educational needs of ICU residents. After the change, ICU residents reported concerns to service leaders and cited in program evaluations the lack of on-site supervision, increased patient safety risks, diminished resident education quality, and decreased overall satisfaction.

The OIG recommended the under secretary for health to evaluate the VISN leaders' lack of awareness of the surgical pause and that the VISN director address issues related to cardiothoracic surgeries, facility high reliability organization principles implementation, and residents' education needs. Two recommendations to the facility director were related to on-call escalation and root cause analysis training. All of the recommendations are open, and the OIG will review VA's progress on implementing them during the routine follow-up process beginning September 24, 2024.

OTHER RECENT OIG OVERSIGHT THAT HIGHLIGHTS ACCOUNTABILITY CONCERNS

While this statement has focused on leadership failures within VHA, a number of recent OIG reports have found deficiencies within VBA programs and operations that can be traced back to the same accountability themes.[24] Every service within VA is susceptible to falling short of their mission if they do not fully embrace and constantly reinforce these foundations of accountability. The OIG's recent reporting on senior executives in VA's central office being improperly awarded critical skills incentives crossed two administrations and uncovered weaknesses in governance, leadership, and accountability,

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[23] ICUs may be structured as open or closed models. An open model indicates that multiple physicians or teams, whether assigned to the ICU or not, are permitted to provide care to a patient in the physical space of the ICU. A closed model indicates that only the ICU team specifically assigned to the ICU manages the patient's care for all patients admitted to the ICU.

[24] VA OIG, *VBA Needs to Improve the Accuracy of Decisions for Total Disability Based on Individual Unemployability*, July 17, 2024; VA OIG, *VBA Did Not Identify All Vietnam Veterans Who Could Qualify for Retroactive Benefits*, June 27, 2024; VA OIG, *Better Oversight Needed of Accessibility, Safety, and Cleanliness at Contract Facilities Offering VA Disability Exams*, May 8, 2024; VA OIG, *Without Effective Controls, Public Disability Benefits Questionnaires Continue to Pose a Significant Risk of Fraud to VA*, January 4, 2024.

with excessive deference to VHA and VBA leaders by individuals responsible for providing necessary checks and balances.[25] As detailed in OIG testimony before this committee in June, officials at multiple levels across VA did not ensure their actions met the appropriate requirements and intent of the law and did not successfully escalate concerns to the Secretary. VA concurred with both OIG findings and all recommendations and has provided acceptable action plans and completion timelines. The OIG will monitor VA's progress in implementing these recommendations until sufficient evidence is provided to enable closure.

Finally, VA's ability to accurately forecast budget needs for its administrations and staff offices, and then properly execute appropriated funds, is dependent on adherence to these same foundational elements of accountability. The OIG is currently engaged in examining the conditions and contributing factors to the projected $12 billion shortfall for fiscal year 2025.[26] Staff have also continued to document how the absence of well-functioning IT and internal quality monitoring systems can exacerbate financial management problems. A recent example affecting revenues is the OIG's July 2024 management advisory memorandum to VHA regarding the pause in using its Payment Integrity Tool (PIT).[27] VHA uses PIT data to determine if healthcare claims should be billed to veterans or private insurance companies for the treatment of nonservice-connected care. VHA paused using the PIT in February 2023 after becoming aware of numerous issues, including inaccurate or duplicate claims and defective code. The pause had two major impacts: First, VHA could not bill veterans or private insurance companies for community care copayments or coinsurance because VHA relies on PIT data to do so. Second, the pause impeded internal oversight efforts that utilize the PIT to prevent, detect, and mitigate fraud, waste, and abuse related to community care claims. While VHA has reported that use of the PIT partially resumed in recent weeks, they must now review the backlog of claims to determine which are eligible to be billed to veterans or private insurers. The OIG estimated that VHA will be delayed in billing an estimated 2.8 million community care claims totaling about $2 billion that were paid between February 1, 2023, and February 1, 2024. According to VHA, the pause resulted in veteran copayment billings that were approximately $23 million lower for the first two quarters of fiscal year 2024 than the same period in 2023. The pause could also negatively affect veterans because VHA may send them copayment bills for

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[25] VA OIG, *VA Improperly Awarded $10.8 Million in Incentives to Central Office Senior Executives*, May 9, 2024.

[26] According to the budget submission dated March 2024, VHA initially estimated needing about $149.5 billion to care for patients in fiscal year (FY) 2025.[1] However, by July 2024, VHA estimated that it would need an additional $12 billion in FY 2025 for medical care. The OIG recently initiated a review to determine what factors and conditions resulted in VHA's request for nearly $12 billion in supplemental funding.

[27] VA OIG, *The Pause of the Program Integrity Tool Is Impeding Community Care*, July 16, 2024. While the OIG made no recommendations in this memorandum, the OIG remains concerned about whether VHA's Revenue Operations will have sufficient resources to timely bill the backlog of community care claims, and how the pause will affect fraud, waste, and abuse activities for community care claims. In addition, the OIG currently has three open recommendations from the 2022 report related to Revenue Operations' private health insurance billing for community care. VA OIG, *VHA Continues to Face Challenges with Billing Private Insurers for Community Care*, May 24, 2022.

care that are over a year old. To ensure the PIT fully recovers from these issues and will be reliable moving forward, VHA must fully embrace the accountability pillars of strong governance, updated IT systems, and effective quality assurance and monitoring.

CONCLUSION

The OIG has repeatedly found that an overwhelming number of VA leaders and personnel are committed to serving veterans, and that VA's skilled and dedicated frontline employees work to provide high-quality and timely care and benefits. However, OIG staff routinely find breakdowns in processes, infrastructure, governance, leadership, and other failings that erode the foundational elements of accountability. These breakdowns impede VA's efforts to make certain that patients receive timely, high-quality healthcare and that veterans and other eligible beneficiaries are afforded the compensation and services they are owed. Just as important as having accountability for those engaging in wrongdoing is creating a culture that addresses the conditions that allow mistakes or misconduct to fester and grow, a culture in which every employee feels a responsibility to identify and report risks and concerns. In turn, leaders must take prompt, effective actions based on the input of stakeholders and available data to address the underlying problems. The OIG strongly encourages VA personnel at every level to lead by example and escalate matters that put veterans' health and welfare at risk, undermine VA's services and operations, or waste taxpayer dollars. Significantly, those in positions of authority should ask themselves what they are doing to reinforce the pillars of accountability, including executing efficient governance and clarifying all roles and responsibilities; maintaining adequate numbers of qualified staff; updating IT systems and improving business processes; conducting effective quality assurance processes and vigilant monitoring; and promoting stable and strong leadership that fosters responsibility for actions and continuous improvement.

Finally, I want to thank those individuals who have come forward to report wrongdoing and exemplify the tenets of accountability and encourage others to do the same. Chairman Bost, Ranking Member Takano, and members of the Committee, this concludes my statement. I would be happy to answer any questions you may have.

Prepared Statement of Joshua Jacobs

Good morning, Chairman Bost, Ranking Member Takano, and Members of the Committee. Thank you for inviting us here today to discuss VA's efforts to address accountability within the Department. Joining us today is Mr. Edward Murray, Acting Assistant Secretary and Chief Financial Officer for the Office of Management.

We at VA are committed to providing Veterans with the care and benefits they have earned through their service to our country. Our Veterans and their families, caregivers, and survivors deserve nothing less. We and the more than 400,000 employees at VA are devoted to this sacred duty and work diligently every day to fulfill this mission. Sometimes, though, even with the best intentions, we fall short in the delivery of this care and benefits. When we fall short, we—as a high reliability organization—are transparent about our errors, correct our mistakes, and learn from them. As part of that process, we hold ourselves accountable. In today's hearing, we welcome the opportunity to talk to you about the process that we follow to ensure that any errors are transparently investigated, corrected, and learned from, including by holding individuals accountable, and to discuss the status of the instances identified in your hearing invitation.

VA's High Performance

We would be remiss if we did not first underscore that these problem cases are exceptions. In fact, VA and its hardworking employees have been performing at an extraordinarily high level, especially over the past year. The numbers tell the story:

- Veterans trust VA at record rates, with 91.8 percent of VA's Veteran patients reporting that they trust VA health care, an all-time high level unmatched in the private sector and an increase of 6 percent over 2018 (when the survey began). Additionally, overall Veteran trust in VA has reached an all-time high of 80.4 percent—up 25 percent since 2016 according to the Veteran Trust in VA Survey.
- In 2023, VA delivered more disability compensation benefits to more Veterans than ever before. VA delivered $163 billion in earned benefits, including $150 billion in compensation and pension benefits to over 6 million Veterans and survivors. VA also processed almost 2 million Veteran and survivor claims, surpassing the previous all-time record set in 2022 by 15.9 percent. This fiscal year, we are outpacing last year's record-breaking rate by nearly 30 percent and are currently projected to complete 2.5 million compensation and pension rating claims in Fiscal Year (FY) 2024.
- For new patients, in Fiscal Year 2024 Quarter 3, there was a 9 percent decrease in average wait times for VA primary care and an 8 percent decrease in average mental health wait times when compared to the same period last year. These improved wait times come at a time when VA is delivering more care to more Veterans than ever before. Compared to the same time period last year (which was a record-breaking year for appointments), VA completed 7 percent more new patient appointments – including nearly 19 percent more new patient primary care appointments and 15 percent more new patient mental health appointments this year in Quarter 3. These outcomes represent sustained results from VA's Access Sprints—a concerted effort in the winter and early spring of 2024 to offer more appointments to Veterans across the system, including night and weekend clinics, telehealth, and more.
- More Veterans are choosing VA health care than ever before. As of July 14, 2024, VA has enrolled more than 412,000 new patient Veterans in VA health care over the past year—27 percent more than we enrolled the previous year. Since the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022 was passed, more than 710,000 Veterans have enrolled in VA health care, a more than 34 percent increase in Veterans enrolling compared to an equivalent period before the legislation was signed. And more than 843,000 additional Veterans already enrolled in VA health care experienced a health care priority group increase since the PACT Act was signed.
- Nearly 70 percent of VA hospitals received 4 or 5 stars in the Centers for Medicare and Medicaid Services (CMS) annual Overall Hospital Quality Star Ratings, compared to only 41 percent of non-VA hospitals.
- VA provided an all-time record $1.5 trillion in life insurance coverage to 5.6 million Veterans, Service members, and their family members in 2023. This includes new coverage awarded through VALife, a program that extended life insurance access to millions of service-connected Veterans. The VALife pro-

gram now provides more than $1.23 billion in coverage to more than 41,000 eligible Veterans.

- VA is supporting more Veterans in crisis. Upon the 2 year anniversary of 988, VCL has noted a 22.7 percent increase in calls/day, 76.7 percent increase in texts/day, and 27.5 percent increase in chats/day since the launch of 988. This means that more Veterans than ever are getting the support they need from caring, qualified responders during times of crisis. VA has also provided no-cost, emergency health care to 67,975 Veterans in acute suicidal crises through a new program launched in January 2024.
- VA has screened 5.6 million Veterans for toxic exposures, a critical step to document Veteran exposure concerns, provide education, and connect Veterans to available medical care, registry, benefits, and other services, as indicated.
- VA is providing more resting places to the Nation's heroes, with a record 5.4 million people—including 4.1 million Veterans—now buried in VA national cemeteries.

These accomplishments are the result of a highly motivated and talented workforce. The positive working environment and strong morale of the employees at VA are exemplified by our success in hiring new personnel during Fiscal Year 2023, with a record number of external VHA hires (nearly 62,000 new employees) and net growth of full-time equivalents (FTE) by 7.4 percent. To keep up with the record number of claims received since the PACT Act, VBA also significantly increased its workforce, which has seen a nearly 33 percent increase since October 1, 2022.

Additionally, as perhaps the best indication of the increased satisfaction among our employees, retention rates have improved significantly. Attrition has decreased from an 11 percent total loss rate in Fiscal Year 2022 to 8.4 percent in Fiscal Year 2023, the lowest rate in more than 10 years. VBA has similarly seen historically low attrition rates, reporting an Fiscal Year 2024 loss rate of 6.02 percent through the end of June 2024, compared to the 6-year average of 7.39 percent. Not surprisingly, in a recent All Employee Survey (AES) administered to VA employees, more than 88 percent reported that they feel a strong sense of pride and meaning in their work at VA. And trust among VA employees is at its highest level on record, and the score has steadily increased in recent years.

We are proud of these results and of our talented team at the VA, and we will not stop working to continue to provide quality care and benefits to our Nation's Veterans and survivors.

Accountability Process

While our employees are dedicated and committed to public service and have a proven record of providing quality care and benefits to Veterans, VA also recognizes that the performance of a limited number of VA employees, including certain leaders, has at times fallen short of what we expect and what our Veterans deserve. When that happens, holding individuals accountable is an important part of effective management, and we take that responsibility seriously.

VA has various, complementary, means of holding its leaders and employees accountable:

Office of Accountability and Whistleblower Protection (OAWP)

Established by the VA Accountability and Whistleblower Protection Act (the Accountability Act) of 2017, OAWP actively promotes and improves accountability at VA. OAWP is responsible for receiving and investigating allegations that senior leaders engaged in misconduct and poor performance and allegations that any VA supervisor engaged in whistleblower retaliation. OAWP also receives whistleblower disclosures and refers them to the appropriate VA organization for investigation and resolution of potential problems and concerns, and then OAWP maintains oversight of those referrals. OAWP further tracks certain recommendations made to VA by other oversight entities such as the VA Office of Inspector General (OIG), VA Office of the Medical Inspector (OMI), and Office of Special Counsel (OSC), and the Government Accountability Office. In addition, OAWP also educates VA employees and VA leadership on whistleblower rights and protections and provides advice and support to the Secretary on accountability matters.

After conducting investigations into allegations of senior leader misconduct and/or poor performance or whistleblower retaliation by a supervisor, OAWP issues a report that includes the allegations, background information, factual findings, conclusions, and recommendations for disciplinary and non-disciplinary actions where appropriate. In Fiscal Year 2023, OAWP made 72 recommendations including 20 disciplinary recommendations; *all* the disciplinary recommendations were either

fully or partially implemented, or the employee retired or resigned before discipline could be implemented. For Fiscal Year 2024, through July 17th, OAWP has made 103 recommendations, including 29 disciplinary recommendations. All but one of the disciplinary recommendations were fully or partially implemented, or the employee resigned or retired before discipline could be implemented. Seven recommendations remain open pending a disciplinary decision.

Office of the Medical Inspector (OMI)

OMI is responsible for assessing the quality of VA health care through investigations of VA facilities nationwide. OMI investigations are initiated after receiving allegations and/or disclosures, including those referred by VA employees and leadership, OAWP, OIG, OSC, and Congress. OMI issues comprehensive reports of the health care investigations that generally include the allegations investigated, necessary background information, factual findings, conclusions, and actionable recommendations for corrective action and/or improvements to the quality of Veterans' health care. When OMI uncovers evidence of potential senior leader misconduct or poor performance during one of its investigations, it refers the allegations and/or evidence to OAWP for investigation of the alleged misconduct and/or poor performance. OMI focuses on issues related to oversight and improvement of Veterans' health care. For all OMI recommendations, an action plan to implement the recommendation is requested from the applicable medical center, Veterans Integrated Service Network (VISN), or program office. The action plan is approved by OMI leadership and then followed with quarterly updates until completion. OMI leadership approves closure of the action plan when appropriate evidence is submitted to prove mitigation of the original findings and satisfy the intent of the recommendation.

Authorities

The Accountability Act, specifically section 201, provides VA with the authority to take disciplinary and adverse action against senior executives and other covered employees based on poor performance and misconduct. The Accountability Act created a new section 713 that sets forth a streamlined procedure for taking accountability actions against senior executives for misconduct and poor performance and the process by which senior executives can challenge such actions. The Accountability Act also provides the authority for VA to recoup relocation expenses, bonuses, and awards under certain circumstances. Personnel actions taken against senior executives demonstrate that section 713 is being utilized to hold senior executives accountable. Since 2020, there have been more than 40 actions taken under section 713 against Senior Executive Service members and title 38 equivalent employees. For other VA employees, VA takes accountability actions using the same Title 5 accountability authorities generally used by other Executive agencies. Title 5 provides all of the authority that VA needs to hold employees accountable for poor performance and misconduct, including removals. Each year, VA uses these authorities to take disciplinary action against thousands of employees, including taking more than 4,000 adverse actions in each of the last 2 years (i.e., FYs 2022 and 2023).

Challenges at VA Medical Centers

VA runs the Nation's largest integrated health care system serving over 9 million Veterans at more than 1,100 health care facilities. When there are problems identified at a medical facility, we, with the assistance of OAWP and OMI, act to investigate, remedy the problem, and ensure individuals are held accountable, if appropriate. This includes senior leaders. For example, in Detroit, as a result of multiple site review findings and OMI/OAWP investigations, three executive leadership team members were detailed out of their positions. Two were proposed to be removed resulting in one retirement and one termination. The third individual was permanently reassigned out of the facility and retired shortly thereafter. The facility subsequently has experienced better performance, including improved 2024 Joint Commission findings from the last triennial review.

Similarly, in Montana, the VISN 19 Network Director detailed the Montana VA Healthcare System Director out of the position in July 2023 who subsequently retired in December 2023, immediately upon identifying operational oversight concerns, including systems and process issues, and subsequently appointed an Acting Director. The Network Director took additional steps, to include: (1) appointing a Special Advisor on Montana Oversight and (2) chartering a system-wide review to identify any additional issues and ensure implementation of comprehensive corrective measures throughout the System. Montana VA Healthcare System's trust scores from Veterans have increased to 89.6 percent, enrollment increased last year

by more than 2,000 Veterans, and the Montana VA Healthcare System received a 5-star Patient Rating from CMS and a 4-star rating in Quality.

In your hearing invitation, the Committee noted several medical centers where there have been allegations of misconduct and other problems. We appreciate the oversight of the committee and address our efforts at those facilities specifically:

1. **VA Eastern Colorado Health Care System**. When concerns were raised about facility leadership and organizational culture at this facility in October 2023, VISN leadership moved with haste to remove the Director and Chief of Staff out of the facility. Two other facility leaders resigned in the wake of the internal investigation. The VISN 19 Network Director appointed a senior executive to serve as Acting Medical Center Director to promote continuity of operations, psychological safety, and to ensure high quality health care for Veterans. On March 4, 2024, Dr. Elnahal visited and hosted a townhall for VA Eastern Colorado health care staff to discuss issues there. The new leadership at VA Eastern Colorado also has held multiple listening sessions and conducted a series of trainings and stand-downs. VHA leadership intends to remain actively engaged to ensure that the culture and management in VA Eastern Colorado continues to reflect the values of a high-reliability organization for employees and the Veterans we serve. We have concurred in all of the OIG's recommendations relating to VA Eastern Colorado, and we are committed to promptly reviewing and taking appropriate action based on OAWP's recommendations when finalized. It should be noted that VA Eastern Colorado has a 90.5 trust scores from Veteran patients and Rocky Mountain Regional VA Medical Center is the only hospital in the Denver metro area with 5-star ratings from CMS for both patient experience and overall quality.
2. **Hampton VA Medical Center (VAMC)**. The VISN's Chief Medical Officer has been actively addressing issues at the Hampton VAMC Surgical Service department since August 2023, conducting multiple trips and evaluations at the facility. As a result of the facility and VISN leadership's actions, the head of surgery has stepped down. The facility's Medical Center Director has been removed pending an ongoing internal investigation, and the Chief of Staff has resigned. VISN 6 officials have engaged in regular meetings with the Hampton VAMC medical and surgery leadership to establish an action plan focused on all aspects of performance and process to improve health care delivery for Veterans seeking surgical care. VHA also has concurred on all 12 of the recommendations in the OIG's recent report. Prior to the release of the OIG's report, Dr. Elnahal visited the Hampton VAMC on May 20, 2024, where the recommendations with mitigation strategies were presented, and VHA expects that all recommendations will be implemented by the end of 2024.
3. **VA Loma Linda Healthcare System**. Similarly, VA is committed to the continued improvement of the organizational culture at VA Loma Linda to ensure the well-being of all employees. Facility and VISN leaders have embarked on a plan of action based on insight from the VA all employee survey and feedback from organizational reviews, including a climate study conducted by OAWP. Toward that end, VA Loma Linda is now leading the VISN in the number of staff who have completed Clinical Teams Training, which is a program that provides clinical and administrative staff tools to improve patient safety and overall job satisfaction. The Medical Center Director has increased his office hours to meet directly with staff and address concerns, and all of VA Loma Linda leadership conducts monthly safety forums and bi-weekly meetings that are focused on strengthening organizational excellence by gathering staff to celebrate successes and share best practices. OAWP conducted 11 other investigations into allegations of whistleblower retaliation, and none of the allegations were substantiated. One OAWP investigation is still ongoing. Additionally, Dr. Elnahal visited the site with Ranking Member Mark Takano on August 7–8, 2023, where they met with leaders, staff, and union officials to hear concerns and the progress made in improving the culture and climate of the organization.

Critical Skill Incentives

The new critical skills incentive (CSI) authority established under the PACT Act is an important tool that helps VA close mission-critical skills gaps that are in short supply or high demand and directly relate to the duties and responsibilities of an employee's position. As we voluntarily informed the Committee last fall, VA erred in the way this CSI authority for career senior executives working at VA Central Office (VACO) was implemented and executed. Upon identifying the problem, VA immediately canceled and began recoupment for all CSI payments made to VACO

career senior executives. VA also referred the matter to the OIG and notified this Committee, VSOs, and the media of the issue. In May, the OIG issued a lengthy report that detailed the failures in the approval of these CSI payments to VACO senior executives. VA has concurred with the OIG's findings and its eight recommendations and is in the process of implementing these recommendations, which include reviewing all CSIs awarded to date and strengthening the policies and governing practices associated with CSIs. To date, VA has collected through the recoupment process more than 92 percent of the CSI debts from career senior executives at VACO. Several other executives are on restructured bi-weekly repayment plans. While several executives have requested hearings or waivers, all hearings to date have confirmed that the debt and amount are valid. In addition, consistent with the OIG's recommendation, OAWP is conducting a review to determine whether disciplinary action against any VA official(s) is warranted.

Conclusion

VA takes seriously all allegations of misconduct and poor performance to ensure it is providing the highest quality health care and benefits to Veterans, their families, caregivers, and survivors. VA is committed to holding leaders accountable for misconduct and poor performance, including taking disciplinary actions when appropriate. VA's record-high trust scores with Veterans, the high morale among VA employees, and the Department's recent accomplishments in providing more care and more benefits to more Veterans than ever before, all are, in part, a product of our effectiveness in holding ourselves accountable. Nevertheless, there is always ample opportunity for improvement in our execution of our sacred mission, and we appreciate the Committee's oversight in helping make us better.

Thank you, and we look forward to your questions.

STATEMENTS FOR THE RECORD

Prepared Statement of The Veterans of Foreign Wars of the U.S.

Chairman Bost, Ranking Member Takano, and members of the committee, on behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, thank you for the opportunity to provide a statement for the record regarding VA leadership accountability – specifically, the recent funding lapse VA reported to Congress this summer.

In mid-July, VA reported to Congress and the veteran service organization community that it expected to be nearly $3 billion short in appropriations to close out Fiscal Year 2024. As presented by VA, this meant that if Congress did not convene and approve emergency appropriations by September 20, 2024, then every single payment for VA compensation, pension, and education beneficiary due October 1 would be delayed.

First, this lapse would be unacceptable, and the VFW urges Congress to pass this emergency appropriation in time to deliver earned benefit payments. Veterans should not have to pay the price for actuarial miscalculations. Veterans who are on a fixed income rely on these timely payments to ensure that they can keep a roof over their heads and food on the table. Moreover, our government made a promise to these veterans, which is why these accounts are on the mandatory side of the ledger.

That said, the VFW has concerns over how this situation played out within VA leadership and we thank the committee for taking this issue seriously to ensure it never happens again.

Since news of the funding shortfall became public, the communications on the matter from VA has been inappropriately positive about VA "delivering more benefits than ever before," as if VA's miscalculation that now threatens the delivery of all compensation, pension, and education benefits is somehow a positive thing.

Since VA first briefed VSOs on the problem, we have had concerns about what was really driving the shortfall and questions on when VA first knew about it. In the beginning, VA blamed part of the education funding shortfall on the recent Supreme Court decision in *Rudisill v. McDonough*. However, VA has not updated its policies yet to reflect the *Rudisill* decision – meaning no veteran is in receipt of benefits because of the court. This looks like an effort to misdirect from the actual root of the problem.

We certainly appreciate the efforts that VA has made to deliver more benefits, and we want VA to keep up this momentum. However, we cannot ignore the larger context of the notification of budget shortfalls to the veterans' community and what this means for projections moving forward.

When VA briefed its projected shortfall of mandatory appropriations, it was presented alongside a projected substantial health care funding shortfall for Fiscal Year 2025 that was foreseeable, considering the influx of veterans into the system.

We have been very careful to not raise alarms with the veterans' community about the October 1 issue, but the presentation of these issues unfortunately speaks to potential budgetary disagreements between VA and OMB that must be resolved. We thank VA for bringing this issue forward, but this kind of openness invites both dialog and scrutiny to craft a responsible way forward.

Since VA notified the community this summer, we have consistently heard from appropriators that they have found ways to deliver VA the resources it asks for. If VA is not asking for the right resources, we must ask why.

Absent this actuarial miscalculation, the VFW must convey that under current leadership within Veteran Benefits Administration, there has been a noticeable culture change that focuses more on veteran outcomes. This is what veterans have wanted to see for quite some time. We hope this continues. However, it is clear to the VFW that the benefit-delivery actuaries did not keep pace with this customer-centric focus.

Regardless, as advocates for veterans and the VA benefits that they have earned, we must ask the larger question of how VA arrives at budget projections that are

presented to Congress to ensure that veterans have timely access to benefits and care. We look forward to working with this committee to make sure this never happens again.

Prepared Statement of Concerned Veterans For America

Statement of John Byrnes

Strategic Director, Concerned Veterans for America

For

"Accountable or Absent?: Examining VA Leadership Under the Biden-Harris Administration"

House Veterans Affairs Committee

September 10, 2024

Thank you, Chairman Bost, Ranking Member Takano, and Members of the Committee for the opportunity to submit this statement on behalf of Concerned Veterans for America (CVA). CVA is a grassroots network of thousands of veterans, family members, and patriotic citizens across the country which advocates and defends policies to preserve freedom and prosperity for all Americans. Our organization is driven to organize and amplify the American veteran's unique perspective to both the American people and our leaders in Washington.

CVA's History in Veterans' Health Care Reform

Concerned Veterans for America has been a leading advocate for reform and accountability at the Department of Veterans Affairs and for increased health care choices for veterans since 2012. CVA's history positions our organization well to discuss the importance of robust congressional oversight of the VA and the policies that so many of our nation's bravest rely on. As systemic failures came to light in 2014 after the Phoenix VA wait time scandal, CVA activists were on the front lines from the beginning demanding change and contributing to the passage of three major pieces of veterans' health care legislation.

In the immediate aftermath of the Phoenix VA wait time scandal, CVA fought for the Veterans Access, Choice, and Accountability Act of 2014, which established the first iteration of a choice program for veterans to seek care outside the VA. CVA also backed the VA Accountability and Whistleblower Protection Act of 2017, which gave the VA the freedom to fire poorly performing employees while shielding whistleblowers from retaliation. While these efforts laid an early foundation to change incentives at the VA and improve outcomes for veterans, more work was needed to improve veterans' care experiences.

CVA was a key supporter of the passage of the VA MISSION Act in 2018, which passed with overwhelming bipartisan support. This legislation incorporated many of the recommendations of the 2015 Fixing Veterans' Health Care Task Force convened by CVA, and the 2016 Commission on Care, of which our senior advisor Darin Selnick was a

member—namely by creating the Veterans Community Care Program (VCCP). By consolidating existing choice programs into an easier-to-use VCCP and simplifying access standards, the MISSION Act has been a game-changer for millions of veterans' access to timely and quality care.

CVA's VA Accountability Priorities

1) Ensuring the full implementation of the VA MISSION Act and holding the VA accountable for failures to do so have been consistent priorities of CVA's since the legislation passed. Since the MISSION Act's passage, the VA's reluctance to honor its regulatory and statutory obligations, including through rampant wait time manipulation, has limited millions of veterans' health care choices, too often resulting in delayed and denied care.

2) Congress should work to improve VA personnel incentives by passing H.R. 4278, the Restore VA Accountability Act. This legislation would reinstate standards passed in the wake of the Phoenix scandal that the agency stopped enforcing last March, with adjustments to ensure their durability in court.

3) Congress must leverage its power of the purse in future appropriations to ensure that VA remains committed to its core mission of veterans care, is adequately transparent with the American people, and carries out the will of Congress.

Each of these priorities is discussed in further detail below:

I: VA MISSION Act Implementation Failures: Community Care at Risk

Since the VA MISSION Act's passage, the VA has chosen to effectively pick and choose what regulations and sections of the law to follow.

Instead of supporting the success of the VCCP as a treatment option that will enable veterans to get care faster and improve the VA's capacity to provide care at its own facilities, the agency has taken several actions to minimize the VCCP's use among veterans. Reports have emerged of VA administrative staff overruling doctors' assessments of patients' best medical interests and overruling community care referrals, even though these clinical referrals are listed as a source of community care eligibility in the VA MISSION Act text.[1]

The VA engages in little-to-no outreach to veterans about the access standards for community care eligibility, and VA internal guidance discourages employees from offering to review veterans' eligibility for community care during appointment requests.[2] CVA's

[1] Jill Castellano, "The Mission Act is supposed to help US veterans get health care outside the VA. For some, it's not working." USA Today, November 1, 2021. https://www.usatoday.com/in-depth/news/investigations/2021/11/01/mission-act-aid-veterans-healthcare-va-isnt-letting-it/8561618002/

[2] "Standard Mission Act Guidance: Patient Eligibility and Scheduling Sheet." Department of Veterans Affairs, October 28, 2020. https://americansforprosperity.org/wp-content/uploads/2021/09/03-Mission-Act-Guidance-Oct.-2020.pdf

experiences with thousands of veterans across the country corroborates this guidance and reports from Congressional offices that constituents are simply not being told by the VA that community care is an option available to them.[3] In 2021, the VA announced plans to shut down the Office of Community Care itself and the VA MISSION Act website.[4]

If this weren't evidence enough of the agency's hostility to community care, documents obtained through an ongoing Freedom of Information Act lawsuit filed by Americans for Prosperity Foundation (AFPF) reveal that VA internal phone scripts actually direct schedulers to attempt to dissuade veterans who ask for community care from using it.[5]

This pattern of unelected bureaucrats subverting the stated will of Congress in the VA MISSION Act demands robust oversight and accountability from lawmakers.

VA Leadership Drives a Culture of MISSION Act Non-Compliance
The VA's culture of non-compliance with and active subversion of the MISSION Act comes from the top.

In June 2022, Secretary McDonough suggested before the Senate Veterans Affairs Committee that the increasing popularity of community care among the share of VHA services was grounds for tightening access standards, due to cost concerns. This proposal was only put on hold due to vociferous opposition from lawmakers and veteran activists, but it remains a long-term threat. Secretary McDonough's decision to seek a 34% reduction in community care funding in FY 2025 from the previous year despite increased utilization betrays an ongoing opposition to the promise of the MISSION Act.[6]

This pattern extends to VHA leadership as well. In August 2023, embattled VA Secretary Shareef Elnahal—currently under scrutiny for improperly awarding $11 million in bonuses to Senior Executives from funds meant to support PACT Act implementation—told VA staff in an employee town hall to "press the easy button less with community care."[7] Elnahal's comments frame community care providers are adversaries for VA staff rather than partners in delivering quality and timely veterans' health care through multiple pathways.

Finally, an internal VA "Red Team" report made public in April underscored that

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[3] Letter to Secretary Denis McDonough. Office of Senator Steve Daines. July 14, 2022. https://www.daines.senate.gov/wp-content/uploads/imo/media/doc/VA-%20Community%20Care-%20FINAL%207.14.2022.pdf
[4] Leo Shane III, "Changes to VA's community care program raise concerns about vets' health care access." Military Times, October 13, 2021. https://www.militarytimes.com/veterans/2021/10/13/changes-to-vas-community-care-program-raise-concerns-about-vets-health-care-access/
[5] Referral Coordination Guidebook. Veterans Health Administration, March 10, 2021. Pg. 62. https://americansforprosperity.org/wp-content/uploads/2021/09/Referral-Coordination-Initiative-Guidebook.pdf#page=62
[6] "FY 2025 Budget Submission: Budget in Brief," U.S. Department of Veterans Affairs, March 2024. https://department.va.gov/wp-content/uploads/2024/03/fy-2025-va-budget-in-brief.pdf, pg 5.
[7] "Letter to Secretary Denis R. McDonough re: Application of VA MISSION Act of 2018," Empower Oversight, January 18, 2024. https://empowr.us/wp-content/uploads/2024/01/2024-01-18-TL-to-VA-community-care_Redacted.pdf

McDonough and Elnahal's comments reflect the agency's strategic planning.[8] The Red Team report revealed the VA's explicit desire to reduce community care usage by tightening community access standards and using telehealth appointments to claim overall reductions in wait times for VA facilities. Alarmingly, the report recommends cutting back veterans' use of community care for services such as emergency treatment, mental health, and oncology, where access to a timely appointment is vital.[9] The report further recommends disrupting veterans' continuity of care by driving "repatriation" back into VHA facilities, regardless of veteran preferences.[10]

In light of these public statements and internal documents, VA measures to undermine community care discussed below should come as no surprise.

Case Studies: Wait Time Calculations

The VA has systematically ignored the very MISSION Act implementing regulations that it developed itself in 2019. Instead, the agency adopts legally incorrect, misleading, and often obsolete measurements that artificially make veterans' wait times appear shorter than they truly are.11 For years, the VA's failures to follow the standards of the VA MISSION Act in wait time calculations have come under criticism from the Government Accountability Office, the VA Inspector General, and veterans' organizations such as CVA.[12]

In May 2021, the Government Accountability Office wrote Secretary McDonough, outlining why the VA's current scheduling practices leave wait time calculations, central to determining community care eligibility, "subject to interpretation and prone to scheduler error."[13]

Documents obtained through the Americans for Prosperity Foundation's ongoing FOIA lawsuit with the VA corroborate the GAO's concerns.[14] These records reveal that the VA is refusing to refer eligible veterans for community care, manipulating wait time data by continuing to use outdated scheduling guidance to calculate wait times based on the "patient-indicated date" (PID) metric rather than a veteran's actual date of request for an

[8] "Empower Oversight Obtains VA Red Team Report on Community Care," Empower Oversight, April 30, 2024. https://empowr.us/empower-oversight-obtains-va-red-team-report-on-community-care/

[9] Kenneth W. Kizer, et. al., "The Urgent Need to Address VHA Community Care Spending and Access Strategies: 'Red Team' Executive Roundtable Report," Department of Veterans Affairs, April 30, 2024. https://empowr.us/wp-content/uploads/2024/04/VA-Red-Team-Executive-Community-Care-Roundtable-Report-post.pdf, pg. 10-11.

[10] Ibid, pg. 13.

[11] For a detailed explanation of the VA's wait-time calculation errors, see: "Delayed and Denied Care: Transparency and Oversight Needed for VA Wait Times." Concerned Veterans for America. February 22, 2022. https://cv4a.org/wp-content/uploads/2022/02/22_298900_VAPolicyBriefingHandout.pdf

[12] "Veterans Health Administration: Concerns with Consistency and Transparency in the Calculation and Disclosure of Patient Wait Time Data," Department of Veterans Affairs Office of Inspector General, April 7, 2022. https://www.va.gov/oig/pubs/VAOIG-21-02761-125.pdf

[13] "Priority Open Recommendations: Department of Veterans Affairs." Government Accountability Office to Secretary Denis McDonough. May 10, 2021. https://www.gao.gov/assets/720/714332.pdf

[14] Records confirm VA's use of inaccurate wait time numbers." Americans for Prosperity Foundation, October 1, 2021. https://americansforprosperity.org/records-confirm-va-inaccurate-wait-time-numbers/

appointment as directed in the VA's own guidance for the VCCP issued after the MISSION Act.[15] Through a variety of means, such as beginning wait time clocks after VA schedulers input requests into their scheduling system or restarting wait time measurements after existing appointments are canceled or rescheduled, faulty VA measurements make wait times appear artificially shorter than they truly are.

Wait time manipulation has concrete effects on how many veterans can access community care. For example, AFPF's FOIA revealed that the Southern Arizona VA's outdated PID wait time calculations left only 4.2 percent of veterans' primary care appointments eligible for community care providers, compared to the over 21 percent that would qualify if they used the veterans' "date of request" as the MISSION Act requires.[16] It's a similar story for specialty care, where the Southern Arizona VA's PID wait time calculations left only 9.3 percent of veterans' appointments eligible for community care, compared to the 26.7 percent that should qualify.[17]

II: Empowering VA Leaders to Restore Personnel Accountability

In the face of widespread VA personnel and policy failures, Congress needs to change incentives inside the VA. H.R. 4278, the Restore Department of Veterans Affairs Accountability Act, brought by Chairman Bost, would carry out the will of Congress as expressed in the overwhelmingly supported VA Accountability and Whistleblower Protection Act of 2017. CVA supported this 2017 legislation, along with a majority of legacy Veteran Service Organizations.

When fully in place, this law gave the VA Secretary the authority to discipline, suspend, demote, or remove employees that were poorly performing or had committed misconduct, expediting procedures to do so and requiring a greater burden of proof for these decisions to be overturned. Unfortunately, as discussed, litigation and administrative rulings rendered the 2017 accountability hollow.

In any organization, personnel incentives can make or break a culture. Protecting those who do not take their responsibility to our nation's veterans seriously demoralizes quality VA employees who want to help those who have served to the best of their abilities. On its staff, CVA has multiple former VA employees who were passionate about caring for veterans at the VA. They became disillusioned with an organizational culture that tolerated failure and too often did not reward or even discouraged employees from going above and beyond to provide quality care.[18]

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[15] "Veterans Community Care Program" Department of Veterans Affairs, Code of Federal Regulations, title 38 (2019): 26278. https://www.federalregister.gov/documents/2019/06/05/2019-11575/veterans-community-care-program
[16] "Records confirm VA's use of inaccurate wait time numbers." AFPF.
[17] Ibid.
[18] "My VA Story: Former VA Employee Sheds Light On A Dream Job Turned Into A Nightmare," *Concerned Veterans for America*, April 10, 2023. https://cv4a.org/the-overwatch/my-va-story-former-va-employee-sheds-light-on-a-dream-job-turned-nightmare/

The consequences of the status quo were clear in recent years at the Loma Linda VA Medical Center (VAMC) in California. At this facility, a supervisor accused of creating a toxic working environment remains employed despite three internal investigations in as many years, 36 witnesses, and 4,000 pages of evidence.[19] Two of the three investigations have recommended this individual's removal, yet inexplicably, this person remains entrusted to supervise those caring for our nation's veterans. The Loma Linda VAMC leadership has been unable to terminate this supervisor due to existing legal constraints, leaving employees with the choice to either tolerate a toxic environment or leave.

The Restore VA Accountability Act would revive the Congressional intent that actions taken against the 2017 VA Accountability law denuded. H.R. 4278 would provide a comprehensive follow-on. The bill would empower the VA Secretary with the disciplinary tools necessary to have on hand to maintain a constructive, motivating employee culture. The legislation would combat frivolous appeals that would delay an otherwise warranted personnel decision by ensuring that those supported by substantial evidence are upheld. It would also streamline the disciplinary process by eliminating the requirement for a personnel improvement plan (PIP) prior to disciplinary action being taken. At their worst, PIPs can allow employees, like the Loma Linda supervisor discussed above, to linger when it is clear to supervisors that they are holding back their team's operations.

Most importantly, the Restore VA Accountability Act would more widely apply accountability across the VA workforce. It would allow for expedited disciplinary processes to be employed not just on Senior Executives, but on supervisors and employees as well. The bill would also require supervisors and Senior Executives to appeal decisions directly to the VA Secretary rather than through the Merit Systems Protection Board. This step would give the Secretary greater control over the leadership standards he or she seeks to ensure are modeled for the rest of the Department.

III: Employing Congress' Power of the Purse

In December 2023, national media reported that the VA had a long-standing service-level agreement in place with U.S. Immigration and Customs Enforcement (ICE) and Customs and Border Protection (CBP) to process medical claims for unauthorized migrants in federal custody that required specialized care.[20] This practice is an egregious misuse of VA administrative resources. The VA's mission is to serve veterans, not to do paperwork for ICE and CBP. Lawmakers were right to point out the absurdity of an agency so resistant to facilitate community care access to veterans helping provide similar services for an unrelated agency. Fortunately, Appropriators showed how leveraging Congress' power of the purse can force agency change.

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[19] "Rep. Olbernolte, Chairman Bost demand answers from VA on Loma Linda employee misconduct case," *Office of Rep. Jay Obernolte*, April 13, 2023. https://obernolte.house.gov/media/press-releases/rep-obernolte-chairman-bost-demand-answers-va-loma-linda-employee-misconduct

[20] VA's role in migrant medical care draws scrutiny from advocates as border crisis intensifies," Fox News, December 1, 2023. https://www.foxnews.com/politics/vas-role-migrant-medical-care-draws-scrutiny-advocates-border-crisis-intensifies

The House's FY 2025 Military Construction, Veterans Affairs, and Related Agencies Appropriations (MilCon-VA) bill barred the VA from using any funds or staff time to process medical claims for unauthorized migrants.[21] This approach should be a model for combatting the other abuses described above.

Empowering VA leadership to hold poorly performing staff accountable is important, but leveraging the power of the purse is the only way Congress can drive a more fundamental VA commitment to carrying out its will over the long-term. Veterans' legislation and future MilCon-VA Appropriations should require the VA to take measures like publishing accurate wait times and consistently informing veterans of their community care eligibility.

To enforce such requirements, Congress should impose automatic funding penalties on the office of the VA Secretary, including freezing performance bonuses for senior VA leaders should the agency fail to comply. When in doubt, exercising the power of the purse is the best way to align the VA's incentives with veterans.

Conclusion
The VA's failures to carry out the VA MISSION Act place access to care for millions of veterans in danger and underscore Congress' role in holding the VA more accountable. Congress should continue to demand reporting from the VA on local, regional, and national average wait times, community care outreach efforts, and tie future funding to compliance. Putting veterans at the center of their health care by maximizing the choices they have available best keeps our promise to those who have borne the battle.

Sincerely,

John Byrnes
Strategic Director
Concerned Veterans for America

[21] "House Passes First FY25 Bill, Fully Funding VA Health Care and Bolstering National Security," House Appropriations Community, June 5, 2024. https://appropriations.house.gov/news/press-releases/house-passes-first-fy25-bill-fully-funding-va-health-care-and-bolstering

Questions for the Record Submitted by Morgan McGarvey and Jason Crow

House Committee on Veterans' Affairs
"Accountable or Absent?: Examining VA Leadership Under the Biden-Harris Administration"
Tuesday, September 10, 2024
360 Cannon House Office Building

Questions for the Record

Rep. McGarvey

I'm concerned that this year the VHA Office of Finance prevented the VHA Innovation Ecosystem from funding its innovation commitments to the field. I understand that these field-based projects have been funded each year since the program's inception and the dollar amount is nominal. This fiscal year, the VHA Office of Finance withheld the entire amount that had been committed to field innovators to develop their solutions. The total amount that had been committed was less than $2M and would have supported this program at more than 40 medical centers.

The VHA Innovation Ecosystem delivers significant impact year after year in empowering VHA providers, improving employee engagement, recruitment, retention, and reducing burnout. Additionally, each year many of these innovative solutions result in major cost savings for VA and improved clinical outcomes for veterans. Frontline providers are the backbone of the organization and those who are seeking this kind of small-scale seed funding to develop and test innovative solutions are the cream of the crop.

1. How is the decision to withhold this small investment in VHA's field-based innovation capability justified by VHA leadership?

2. What is VA's plan to ensure proper funding to the VHA Innovation Ecosystem and its field projects in the years to come?

Rep. Crow

1. Colorado is home to several military installations and therefore home to thousands of veterans, many of whom receive healthcare and treatment at Rocky Mountain Regional VA Medical Center, which is located in my district. Our nation's veterans deserve nothing but the best from our VA system, which is why I have provided oversight of the VA Eastern Colorado Health Care System (ECHCS) and the Rocky Mountain Regional VA Medical Center since entering office.

   Throughout this year and last, Dr. Elnahal, we have discussed several concerns raised by staff and the community, including concerns over leadership and culture. Dr. Elnahal, how does the Veterans Health Administration approach and instill cultural change at facilities? What role does steady facility executive leadership play in cultural change?

2. Dr. Elnahal, in your experience, how long does it take for a facility like Aurora to achieve the cultural change it needs?

3. Dr. Elnahal, do you believe Eastern Colorado is on the right path – is that culture change happening?

4. Dr. Elnahal, can you provide a timeline for when you'll be appointing permanent leadership at the Rocky Mountain Regional VA?

U.S. Department of Veterans Affairs Response to Questions for the Record

DEPARTMENT OF VETERANS AFFAIRS (VA)
QUESTIONS FOR THE RECORD SUBMITTED TO
SHEREEF ELNAHAL, MD, MBA, UNDER SECRETARY FOR HEALTH
"EXAMINING VA LEADERSHIP UNDER THE BIDEN-HARRIS ADMINISTRATION"
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

SEPTEMBER 10, 2024

Questions for the Record from Representative Morgan McGarvey

I'm concerned that this year the VHA Office of Finance prevented the VHA Innovation Ecosystem from funding its innovation commitments to the field. I understand that these field-based projects have been funded each year since the program's inception and the dollar amount is nominal. This fiscal year, the VHA Office of Finance withheld the entire amount that had been committed to field innovators to develop their solutions. The total amount that had been committed was less than $2M and would have supported this program at more than 40 medical centers.

The VHA Innovation Ecosystem delivers significant impact year after year in empowering VHA providers, improving employee engagement, recruitment, retention, and reducing burnout. Additionally, each year many of these innovative solutions result in major cost savings for VA and improved clinical outcomes for veterans. Frontline providers are the backbone of the organization and those who are seeking this kind of small-scale seed funding to develop and test innovative solutions are the cream of the crop.

Question 1: How is the decision to withhold this small investment in VHA's field-based innovation capability justified by VHA leadership?

VA Response: The Veterans Health Administration (VHA) appreciates the attention being given to this small, but important, program. VHA executed strategic hiring in order to meet the fiscal year (FY) 2025 budget without sacrificing the world-class care that we provide to Veterans. This requires strategic Veteran-centric decisions about which positions we should be hiring, filling, or managing through attrition. This also involves the return of unexecuted funds from all program offices, including the VHA Innovation Ecosystem Program Office, to the VHA Office of Finance to distribute to the field to address the care delivery needs.

Question 2: What is VA's plan to ensure proper funding to the VHA Innovation Ecosystem and its field projects in the years to come?

VA Response: VA appreciates Congress' interest in the VHA Innovation Ecosystem. VA will continue to assess the funding required to implement programs in the VA health care system within each year's available budgets.

Questions for the Record from Representative Jason Crow

Question 1: Colorado is home to several military installations and therefore home to thousands of veterans, many of whom receive healthcare and treatment at Rocky Mountain Regional VA Medical Center, which is located in my district. Our nation's veterans deserve nothing but the best from our VA system, which is why I have provided oversight of the VA Eastern Colorado Health Care System (ECHCS) and the Rocky Mountain Regional VA Medical Center since entering office.

Throughout this year and last, Dr. Elnahal, we have discussed several concerns raised by staff and the community, including concerns over leadership and culture. Dr. Elnahal, how does the Veterans Health Administration approach and instill cultural change at facilities? What role does steady facility executive leadership play in cultural change?

VA Response: VHA promotes high reliability organizations (HRO). HRO principles are crucial in instilling and inspiring cultural shifts within organizations in need. Consistent leadership plays a significant role in enacting any organizational change. VHA's focus has been to reinvigorate the HRO principles of the VA Eastern Colorado Health Care System (Eastern Colorado) and ensure that we have structural and operational oversight practices and processes for partnership with our staff, which will promote cultural change within the facility. The site is making measurable change, but more needs to be done, including the recruitment of permanent leadership. We are working as fast as possible to begin this search after investigations conclude.

Question 2: Dr. Elnahal, in your experience, how long does it take for a facility like Aurora to achieve the cultural change it needs?

VA Response: Lasting culture change can take years, but the Eastern Colorado facility is already seeing meaningful changes in safety culture. The Eastern Colorado facility and team are adhering to the HRO principles as they navigate this critical cultural shift. Even under interim leadership, they are achieving the HRO pillars of leadership commitment and continuous process improvement, which are essential tenets that will lead to positive cultural change within this organization. VHA recently issued policy, VHA Directive 1217, to clarify VISN leaders' roles and responsibilities with respect to oversight. The policy also clarifies structured practices and robust oversight activities across to support necessary change whether across the healthcare system or the enterprise.

Question 3: Dr. Elnahal, do you believe Eastern Colorado is on the right path – is that culture change happening?

VA Response: VHA Central Office has been working closely with the Veteran Integrated Service Network director and facility leadership to monitor and ensure they are on the right path. We are all committed to producing viable culture change at the

facility. To support this, the initial team that visited and assisted in identifying leadership concerns just completed a follow-up visit in October 2024 to assess the situation and ensure the right environment is in place.

Question 4: Dr. Elnahal, can you provide a timeline for when you'll be appointing permanent leadership at the Rocky Mountain Regional VA?

VA Response: As of October 1, 2024, the Medical Center Director position is not vacant at the Rocky Mountain Regional VA. Once the position becomes vacant, then the standard is that recruitment efforts aim to hire a permanent Director within 150 days. The Deputy Medical Center Director became vacant on July 27, 2024. VA announced the position in October 2024 with a goal to fill the position within 150 days.

Department of Veterans Affairs
December 2024