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ORACLE Health

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U.S. House of Representatives
Committee on Veterans' Affairs

Hearing on:
"Beyond Go-Live: VA Electronic Health Record Modernization Status Update"

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Introduction

Chairman Bost, Ranking Member Takano and members of the Committee, I appreciate the opportunity to speak with you today about Oracle's work with the Department of Veterans Affairs' (VA) Electronic Health Record Modernization (EHRM) program.

When Oracle acquired Cerner in 2022, we inherited an EHRM program that had experienced significant challenges with system performance, implementation, and adoption. Oracle recognized those challenges and made substantial investments to improve the technology, strengthen system reliability, and work with VA to establish a standardized, repeatable deployment model.

Today, we are seeing the results of those efforts. In 2026 alone, VA and Oracle successfully deployed the new EHR at thirteen additional VA Medical Centers (VAMCs), more than tripling the number of live VAMCs from six to nineteen. More than 42,000 clinicians and front-line staff now use the system to support care for over 780,000 veterans across eight states.

These results represent a significant turning point. After years of setbacks, the VA EHRM program has moved from isolated problematic deployments to a model that can scale nationally, positioning VA to complete its modernization by 2031 and deliver a more connected, consistent, and modern healthcare experience for veterans across the country.

The vision of establishing a single medical record from enlistment at the Department of War (DoW) to lifelong care at VA and providing a consistent level of quality and service across VA, remains an essential program for our nation's veterans and will undoubtedly improve veterans' care. As the selected vendor for the EHRM program, Oracle delivers products and services at VA's direction. We have been and will continue to be responsive to the needs of our country's veterans as determined by VA and Congress.

Oracle shares the Committee's goal of ensuring that veterans receive the highest quality care and that the technology supporting their care is reliable, secure, and worthy of the substantial investment being made by taxpayers. Our commitment in this regard has been consistent since we took on this contract in 2022 and will always be uncompromising.

Today, I am pleased to be accompanied by the Honorable Seema Verma, Executive Vice President and General Manager of Oracle Health and Life Sciences. Engagement with Congress regarding this program remains an important priority for Oracle. Between the two of us, we have appeared before Congress ten times[i] and participated in three Member

roundtables[ii] in the four and a half years since Oracle acquired Cerner in June 2022. We are happy to be back today to answer your questions.

Additionally, on Oct. 21, 2026, Ms. Verma provided a briefing to Committee and Member staff regarding the EHRM program and contract extension (the "October briefing"). Exhibit A is a copy of slides presented at the October briefing. Over the course of the last several weeks, we also have sent four letters to the Committee in response to your questions and to provide information regarding the program and contract extension.

This testimony is intended to provide an update on the program as well as the program's cost, contract extension, and other items that we know are of interest to the Committee.

Key Successes of the 2026 Deployments

The thirteen successful EHR deployments in 2026 represent a turning point for VA's modernization program. Aside from the deployment in 2024 to the joint VA-DoW Lovell Federal Health Care Center, this year's deployments are the first done by Oracle since taking over the contract from Cerner.

A smooth deployment alone, however, does not define success. The ultimate measure is whether the new EHR improves the quality, safety, accessibility, and efficiency of care. We are seeing meaningful results in each of these areas.

Early results show improvements in timely access to care. At the Indianapolis VAMC, reported emergency department length of stay declined by more than an hour, a reduction of 66.5 minutes, even as patient volume increased. Arrival-to-triage time was approximately four minutes. By bringing patient histories, clinical orders, test results, and patient tracking into one workspace, the EHR helps care teams coordinate treatment. For veterans, these early results point to shorter waits and faster care when they need it most.

The new EHR is also making it easier for veterans to obtain medications. Prescriptions can be transmitted electronically to community pharmacies, eliminating the need for veterans to carry paper prescriptions between their providers and pharmacies. Between April and June 2026 alone, more than 10,000 electronic prescriptions were transmitted. This allows pharmacies to begin processing prescriptions before veterans arrive and supports better coordination between VA and community care.

Patient-safety safeguards are becoming part of routine care. Clinicians can review records across VA, DoW, and participating community providers, reconcile medications and allergies, and access prescription drug monitoring information within their workflow. Clinical decision support helps identify prescribing risks, including high-dose opioid use, while barcode scanning helps verify medications and patient identity before administration.

Cleveland reported improving inpatient medication and patient-identification scanning rates and achieved complete discharge medication reconciliation on multiple reporting days. In Dayton, inpatient medication and patient-identification scanning rates remained above 98 percent across successive reporting days. These results demonstrate the use of safeguards that support safer medication management and continuity of care.

More integrated workflows are also reducing administrative work and freeing time for patient care. Pharmacy staff can check medication inventory within the prescription verification workflow, reducing a process that previously took more than two minutes to less than thirty seconds, a reduction of more than 75 percent. Social work teams estimate that more efficient group-therapy documentation saves up to 45 minutes per day. Shared care plans and less duplicate documentation are helping staff spend less time navigating systems and more time attending to the veterans they serve.

Facilities are returning to their usual patient volumes as staff become familiar with the new system. Michigan and Southern Ohio have restored outpatient appointment volumes to their previous levels, consistent with recovery periods typical of commercial EHR conversions. Across Indiana sites, outpatient appointment volume is now above 95 percent of baseline. Cleveland and Alaska are showing encouraging early results, reaching approximately two-thirds of their usual outpatient appointment volumes during the second week after go-live, while Cleveland's emergency department handled patient volumes above its previous average. Restoring these volumes is essential to maintaining veterans' access to timely care.

The new EHR is also helping VA strengthen billing and collect revenue that supports veteran care. Payments owed by insurers help VA hospitals fund services, supplies, and other patient-care needs. In FY2026, facilities using the new EHR reached 108 percent of VA's collections target. Early results show average monthly dollar amounts billed increased by 4 percent in Michigan, 9 percent in Southern Ohio, and 20 percent in Indiana compared with each market's 12-month average before go-live. Southern Ohio returned to its baseline for claims ready to submit without correction in fewer than 90 days. Across live sites, billing and follow-up

backlogs fell by 13 percent. These improvements help VA capture payments for care already delivered and preserve resources for the veterans it serves.

Lessons from earlier deployments are also helping reduce support requests as new facilities come online. Revenue-cycle support tickets fell by approximately 74 percent between the Michigan and Indiana deployments. Across all support areas, Indiana recorded approximately 25 percent fewer tickets per user than Michigan and 15 percent fewer than Southern Ohio during the first 12 days. Cleveland and Alaska's early ticket volumes per user were also below Michigan's and comparable to Southern Ohio's. These results provide further evidence that better preparation, standard workflows, and lessons carried forward are making deployments more predictable and reducing the support burden on VA staff.

These results matter beyond the individual facilities where they were achieved. The common deployment approach builds on improvements in system stability, clinical workflows, training, and coordinated go-live support. That repeatable approach provides a stronger foundation for bringing the new EHR to the rest of the VA system.

The Turning Point: Standardization

A standard national baseline and a repeatable deployment model are helping the program move forward. During the pause and reset, VA and Oracle had to resolve the enterprise decisions and standardize the configurations that were incomplete when deployments first began. The resulting "big rock" issues included national code set standardization, geriatrics and extended-care workflows, patient-record flags, workload credit, service-connected and special-authority requirements, prosthetics, and referral management. Completing this work was necessary to replace the early site-by-site model with a repeatable enterprise deployment model.

Additionally, VA initiated enterprise role standardization after determining that the existing model contained unused, redundant, and overlapping roles, which required users to switch roles to complete workflows. Oracle redesigned and consolidated those roles, remapped the associated access, privileges, and workflows, and assessed the effects on billing, scheduling, and interfaces. Oracle also provided the testing, training, communications, and live-site transition support the change required.

Under the standard deployment model, during each go-live, a coordinated command-center structure provides continuous monitoring, rapid escalation, and transparent reporting across adoption, help-desk, and patient-safety teams. Onsite adoption coaches and clinical experts

provide at-the-elbow support, while real-time data sharing helps identify and address emerging issues quickly.

Results from the Indiana market deployment demonstrated the value of this model: clinicians received real-time support during complex procedures, adoption increased across all care settings, and issues were quickly triaged and resolved through the enterprise operations center.

Prior Statements

As discussed in our letter dated Oct. 30, 2026, I testified before the Senate and House Veterans' Affairs Committees, respectively, in July 2022, approximately one month after Oracle acquired Cerner and assumed its responsibilities under the EHRM contract. In my testimony to this Committee on July 27, 2022, I stated:

> "First, as for Oracle Cerner's part, we intend to deliver the EHR system across the entire VA for the amounts contemplated in the current contract *under the current scope*. That includes our intention to move to our Oracle Cloud Infrastructure data center, and that includes fixes or upgrades for things like the unknown queue or referrals. *Of course, if there are big new pieces of functionality not included in the scope, that's a different discussion.* However, if there are significant cost overruns – as apparently the IDA believes there will be – we are prepared to bear those costs and remain within the existing budget envelope." [Emphasis added.]

In the four years since I delivered that testimony, much has changed with the EHR program, making it in many ways unrecognizable from the program that Oracle took over in 2022. VA's requirements, volumes, implementation needs, and program duration have substantially changed. The slides attached in Exhibit A show these changes in detail.

As I said in 2022, Oracle is and remains committed to absorb performance remediation and cost overruns necessary to deliver work contemplated in the scope of the original contract and which VA has ordered at firm-fixed price assumptions.

When Oracle acquired Cerner, our intention and hope was to deliver this contract on-time and on-budget. My testimony from 2022 reflected that intention. However, since then, VA's requirements, volumes, implementation needs, and program duration grew substantially. Furthermore, the program's rollout was paused by VA in 2023, a fact that obviously we did not know in 2022.

Oracle has not repriced the original baseline for core EHR licensing, software maintenance, hosting, or labor-rate escalations through the original contract year term. Additional costs reflect greater quantities, added products and services, and a longer program period. The EHRM contract is an Indefinite Delivery Indefinite Quantity contract, which means it has a ceiling on what may be spent, but no funds are spent unless a task order is issued for specific work. Each task order is negotiated separately and issued at a fixed price. If there are cost overruns and the final cost of fulfilling the task order is higher than the original cost, Oracle absorbs the cost of the overrun, just as I committed: "If there are significant cost overruns…we are prepared to bear those costs."

When I noted that "big new pieces of functionality not included in the scope, that's a different discussion," I was referring to requirements and capabilities that had not been defined, sized or priced in the original program assumptions. The additional ceiling capacity reflects the extended timeline, increased volumes, additional capabilities, more concurrent users, and third-party products and integrations.

For example, VA has increased the number of interfaces from the original contract from 57 to 164 (a 187% increase); expanded the system's capacity to manage longitudinal veteran health data from 8 million to 26.1 million records (a 226% increase); and the number of concurrent users from 85,000 to 195,000 (a 129% increase).

The 2018 contract also assumed that VA would take over several recurring functions at defined points. Sustainment training was to transition to VA after Year 3, help desk and on-site support after Year 6, and revenue-cycle transition services after Year 1. None of these transitions occurred, and Oracle continues to perform all three. These functions remain necessary to operate and support the EHR and carry costs whether performed by VA or Oracle. Their continued inclusion in Oracle's contract reflects responsibilities that remained with Oracle, rather than new requirements or costs that VA would otherwise avoid.

As a further example, VA initially chose to use a third-party dental solution contracted through Cerner and the Cerner patient portal, but later reversed that decision after the work had been substantially started. VA also revised initial workflow and configuration decisions to improve standardization and the user experience, requiring additional work to be performed.

Oracle has made additional investments at its own expense to advance the VA's EHR modernization. For example, Oracle is providing VA with: the new Pharmacy Reimagine

module that is anticipated to go live next year; our advanced interoperability Qualified Health Information Network (QHIN) so that veterans can have strong interoperability when receiving care in the community; and the migration of the EHR from the on-premises data center to Oracle Cloud Infrastructure and the associated cybersecurity protections and modern platform that Oracle Cloud provides – all at Oracle's cost. We have also made over 4,700 configuration changes at our expense.

Oracle has consistently acknowledged that early delays in the program were due in part to poor system stability under the original Cerner system. Shortly after the acquisition, Oracle invested in technology that improved Cerner's product resiliency and database stability and scalability to support the VA's workload at its own cost. Oracle also agreed to Service Level Agreements that provide financial credits to VA if the system does not meet agreed-upon performance standards. Additionally, as noted earlier, we are paying for the entire cost of moving the system to the cloud.

While COVID had already created delays and while the system had stabilized, a pause was announced in April 2023 that later turned into a two-year "reset" of the program. During that reset, the VA focused on improving its governance of the program, standardization, and creating a repeatable deployment model. That delay, and the re-work of the EHR's configuration and necessary customizations, drove significant costs outside the original scope of the program.

During the deployment pause, Oracle had to continue operating and supporting the production system at the five sites already deployed. This included maintaining the software and hosting environment, applying security patches, vulnerability remediation, software fixes, and upgrades that required testing. Recurring services included infrastructure and database administration, system monitoring, performance and capacity management, and maintenance of interfaces and integrations.

Oracle also continued help desk support, incident and problem management, user provisioning and access administration, configuration and workflow changes, and release management. Sustainment training, onboarding support, updated training materials, and release communications remained necessary as personnel, workflows, and software changed. Continuing these services throughout the extended pause resulted in additional costs beyond those contemplated when the original contract ceiling was established.

EHRM is a complicated and difficult technology modernization that has been beset with challenges and delays from its early days including, of course, the COVID pandemic. The challenges also included the opportunity for improved governance and standardization, and delays tied to the need for the VA to build national standards, make common workflow decisions, implement repeatable testing and training, and build a disciplined, repeatable model allowing for successful deployments.

In short, where Oracle has had responsibility for cost overruns, Oracle has taken on those costs and has also provided additional offerings at our own cost. However, deployment delays and growth of implementation requirements resulted in additional costs, which are the subject of the "different discussion" I referenced in my statement.

The EHRM Contract

The original EHRM contract signed in 2018 between VA and Cerner established a ten-year framework for deploying and supporting VA's new electronic health record, which was contemplated to be the Cerner Millennium commercial off-the-shelf product. The contract had a $10 billion ceiling on spending that, in plain terms, covered operating the system, providing the software, adapting and maintaining it, managing the program, and bringing sites onto the new EHR.

When Oracle acquired Cerner in June 2022, the program was four years into implementation and five VAMCs were live on the new EHR. A sixth joint VA–DoW deployment followed in March 2024. The early deployments demonstrated that the original approach did not provide a sufficiently standardized, repeatable model for nationwide delivery. During the Reset period, VA and Oracle worked to improve governance, standardize configurations, and establish a repeatable deployment model. The extended pause, related rework, and continued operation of live sites created material costs beyond the original pricing assumptions and delivery model.

Since the EHRM contract was originally entered in 2018, neither Cerner nor later Oracle after we assumed contractual responsibilities, have sought to increase the original pricing for the contract for core software licenses, software maintenance, and base hosting services. VA has not paid, and will not pay under the contract extension, a new or higher price for the original Millennium and core platform licensing or the original hosting baseline simply because the program was paused, reset, or extended. The additional costs associated with the increased ceiling value reflect added capacity, products, services, or time—not a repricing of the original baseline.

This is a critical point because during the Reset period in 2024 -- and in anticipation of VA exiting the Reset and resuming deployments in the near future -- VA asked Oracle to develop a standardized deployment-pricing approach rather than continue to rely on a custom estimate for each VA Medical Center. In response to VA's 2024 request, Oracle provided VA with the underlying assumptions, facility-sizing methodology, and initial dollar estimates for small, medium, and large facilities and their associated clinics.

VA reviewed and worked with Oracle on that approach throughout 2024, including the service lines, training, hardware, and other deployment assumptions necessary to support a repeatable deployment model. The July–August 2026 negotiation did not introduce a new deployment-pricing construct. It applied the framework developed during the 2024 Reset to the remaining program, the extended schedule, and the requirements identified before deployments resumed. This is an example of continuity in pricing from one Administration to the next.

In December 2024, VA announced plans to resume deployments in 2026, beginning with four Michigan facilities. And in March 2025, VA announced an accelerated schedule encompassing thirteen facilities in 2026 and targeting enterprise completion in 2031. The restarted program subsequently deployed thirteen facilities across Michigan, Ohio, Indiana, and Alaska in 2026. Under VA's current schedule, twenty-six additional VAMCs are planned for deployment in 2027. The restarted deployments provided a clearer basis for estimating the remaining work and confirmed that the program would extend beyond the original 2028 completion assumption.

As of September 2026, VA had obligated approximately $9.2 billion under the original IDIQ contract. Those obligations support the enterprise EHR foundation and associated infrastructure, as well as deployments at approximately fifty VAMCs and more than 300 associated clinics—including the nineteen live sites, the 2027 deployment schedule, and planned 2028 deployments.

For the 2026 contract negotiations, VA issued a draft solicitation on July 16, and Oracle submitted an initial proposal on July 28. The Oracle proposal carried forward the standardized pricing developed during the 2024 negotiations and also reflected the updated schedule and the expanded requirements identified through the Reset and resumed deployments. That proposal supported an approximately $18.5 billion increase to the original ceiling (provided to the Committee in our letter dated Oct. 30, 2026). VA issued its final solicitation on August 12.

Following negotiations, Oracle submitted a final proposal on August 14 reflecting a $16.9 billion ceiling increase, moving down from our initial estimate of $18.5 billion. VA awarded the modification on August 18, establishing a total IDIQ ceiling of approximately $26.94 billion, and publicly announced the award on August 19.

The resulting ceiling is intended to support completion of the deployment program and continued operation of the EHR through 2031. It does not contemplate sustainment costs after 2031, when EHR deployment is expected to be complete. The ceiling reflects standardized deployment pricing, VA's expanded requirements, and the recurring cost of hosting, software, program management, training, support, and sustainment during the extended program period. VA controlled the public announcement and Congressional notification of the award under the contract.

As Oracle previously communicated to the Committee in our recent letters, the 2026 contract extension for the EHRM program was negotiated exclusively between Oracle personnel responsible for operating the EHRM program and VA procurement officials, through VA's established procurement procedures and channels.

Neither Oracle's founder, Larry Ellison, nor I participated in or sought to influence the negotiations related to the EHRM contract extension. The entirety of this contract renewal and renegotiation occurred *entirely* within contract and procurement channels at VA and Oracle.

The Path Forward

For the EHRM program to be completed by 2031 for the dollar amounts now contemplated, it is critical that there be no further delays and no further material changes in requirements, deployment assumptions, site readiness, or schedule that would add time or cost to the program. VA continuing to increase its strong governance and decision-making processes for the program to maintain the enterprise-level deployment model is also key.

The work undertaken over the past several years has fundamentally changed our ability to predict and manage the cost of future deployments. We now have a standardized, repeatable deployment model, facility-based pricing, and actual experience from thirteen successful deployments in 2026 to inform our estimates for the remaining facilities. These improvements provide greater visibility into deployment requirements, resource needs, timelines, and costs than existed during the program's earlier phases.

Working with VA, we are committed to maintaining disciplined management of the program, identifying risks early, and providing transparency into the cost and schedule implications of any proposed changes in scope. Based on the current scope and deployment schedule and assuming no changes, we believe the revised contract ceiling is sufficient to complete the nationwide rollout by 2031. Our responsibility is not simply to complete the deployments, but to deliver the program with the financial discipline, predictability, and accountability that veterans and taxpayers deserve.

Closing:

Chairman Bost, Ranking Member Takano, and members of the Committee, veterans and the clinicians who serve them deserve an electronic health record that supports safe, timely care. Congress and taxpayers deserve a clear accounting of the investment required to deliver it. The thirteen deployments completed this year represent meaningful progress. Thank you for the opportunity to appear today. I look forward to your questions.

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Exhibit A

Oct. 21, 2026 briefing slides

[i] Senate Committee on Veterans' Affairs hearing held on July 20, 2022; House Committee on Veterans' Affairs Subcommittee on Technology Modernization hearing held on July 27, 2022; Senate Committee on Appropriations Subcommittee on Military Construction and Veterans Affairs hearing held on Sept. 21, 2022; Senate Committee on Veterans' Affairs hearing held on March 15, 2023; House Committee on Veterans' Affairs Subcommittee on Technology Modernization hearing held on May 9, 2023; House Committee on Appropriations Subcommittee on Military Construction and Veterans Affairs hearing held on Sept. 13, 2023; House Committee on Veterans' Affairs Subcommittee on Technology Modernization hearing held on Feb. 15, 2024; House Committee on Veterans' Affairs Subcommittee on Technology Modernization hearing held on July 22, 2024; House Committee on Veterans' Affairs Subcommittee on Technology Modernization hearing held on Feb. 24, 2025; House Committee on Veterans' Affairs Subcommittee on Technology Modernization hearing held on Dec. 15, 2025

[ii] House Committee on Veterans' Affairs Subcommittee on Technology Modernization and Subcommittee on Oversight and Investigations hearing held on Dec. 14, 2022 (hearing was converted to a roundtable shortly before it was set to begin); House Committee on Veterans' Affairs Subcommittee on Technology Modernization roundtable held on Feb. 10, 2025; House Committee on Veterans' Affairs Subcommittee on Technology Modernization roundtable held on March 16, 2026