VA FIRST, VETERAN SECOND: THE BIDEN-HARRIS LEGACY

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS

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C O N T E N T S

THURSDAY, FEBRUARY 6, 2025

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THURSDAY, FEBRUARY 6, 2025

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS' AFFAIRS,
U.S. HOUSE OF REPRESENTATIVES,
Washington, D.C.

The subcommittee met, pursuant to notice, at 2:03 p.m., in room 360, Cannon House Office Building, Hon. Jennifer A. Kiggans [chairwoman of the subcommittee] presiding.

Present: Representatives Kiggans, Ciscomani, Self, Ramirez, Kennedy, and Conaway.

OPENING STATEMENT OF JEN KIGGANS, CHAIRWOMAN

Ms. KIGGANS. Good afternoon, everyone. The subcommittee will come to order.

I would like to welcome everyone to the first hearing of the Subcommittee on Oversight and Investigations of the 119th Congress. While not new to the committee, all of our members other than myself are new to the subcommittee.

I am confident that we will continue to work in a bipartisan manner to hold the VA to its mission of providing world-class care for our veterans.

Additionally, I would like to congratulate Mr. Doug Collins on his confirmation to serve as the VA Secretary. I look forward to working with him this Congress.

Last Congress, we uncovered countless instances where the VA failed to hold bad employees accountable and ultimately let veterans down. Time after time, career government employees were protected at the expense of veterans. Protecting bad employees from the consequences of failing the veterans they serve is unacceptable, especially at the cost of the taxpayer dollar.

Veterans should always be at the forefront of VA's mind when they make decisions. Unfortunately, too many times bureaucracy is put first and veterans come in second. I do believe that 99 percent of VA employees are dedicated and hardworking public servants that in many cases want to serve their fellow veterans while still working in a productive, accountable workplace.

Over the past few years, whistleblowers continue to describe situations where VA leaders face little discipline despite investigations substantiating the allegations against them.

It takes an incredible amount of strength and fortitude to come forward to blow the whistle on wrongdoing in the VA. I want to take a moment to thank the whistleblowers who have courageously

come forward to the VA and to Congress to bring attention to these problems. Your bravery is one of the reasons we were able to do our oversight work in Congress.

In Buffalo, one veteran with cancer did not receive care for 10 weeks because the leadership at the facility failed to connect him with the care he needed. This committee sent multiple questions regarding ongoing investigations or disciplinary actions for this failure in care, and our questions went unanswered.

In my own district, the poor management at the Hampton VA Medical Center caused the facility to be left with one anesthesiologist to serve every patient. Despite VA taking action, I have heard continued allegations about the quality of care issues at Hampton. To date, I have still not received clear indication that the VA fully investigated the local leaders at this facility. As a former provider and nurse practitioner, these stories are heartbreaking. Our patients deserve better.

Unfortunately, this is not an isolated issue. Even more shocking, there have been instances where the VA promoted leaders even after they were found to have engaged in misconduct. This is why Chairman Bost, along with every Republican on this committee, reintroduced the Restore VA Accountability Act of 2025.

This legislation makes clear that bad VA employees need to be held accountable to ensure that the best Federal employees are serving veterans. Congress needs to solidify this good government measure.

This legislation will address many of the concerns and challenges that we will hear from our witnesses during today's hearing. As a provider myself, I know that leaders at local hospitals play a critical role in ensuring patient safety. They are responsible for creating a positive work environment that allows nurses and doctors to care for the patients they serve, and at the VA that is veterans. If the leaders are not holding themselves to a high standard, then they do not need to be in leadership. It is that simple.

As someone with experience working with the VA in veteran care, I know firsthand the bulk of VA employees do good work and provide safe patient care for our veterans. This work is valuable to our Nation, and these employees deserve safe and sanitary working conditions. The American people have given us a mandate to make sure their government works for them, not poor-performing career government employees, and the VA is no different.

It should go without saying that veterans have earned a system that serves them well. I am looking forward to working with the Trump administration to course-correct the mistakes from the previous 4 years. I look forward to hearing from our witnesses today about how the VA will hold its employees accountable to the mission. By restoring accountability at the VA, we will ensure that the VA puts veterans first.

I now recognize Ranking Member Ramirez for her opening comments.

OPENING STATEMENT OF DELIA RAMIREZ, RANKING MEMBER

Ms. RAMIREZ. Thank you, Chair Kiggans. I look forward to working with you on the Oversight and Investigations Subcommittee as its ranking member.

I believe we, as members of this committee, have an obligation and a shared responsibility to ensure that the VA is succeeding in its mission to provide veterans world-class healthcare and benefits that they have not just earned but that they deserve.

The title of this hearing and the Republican majority's approach to this topic makes it clear to me that not everyone in this room takes that responsibility seriously. It is clear the intent of the majority is to undermine the VA and its mission by vilifying and persecuting an important asset, the hundreds of thousands of public servants who show up to work every single day to serve our veterans.

Let us keep in mind that a third of VA employees are veterans themselves. The end goal of their vilification is the privatization of the VA for the profit of Trump's billionaire bosses. I want to suggest a more appropriate title. Perhaps this should be more like Unaccountable Billionaires First, Veterans Last: The Musk-Trump agenda.

In the 18 days that Trump has been in office, he has gone on a chaotic rampage to make the Federal Government a hostile workplace for its employees, for its three million employees. Trump wants to either fill those positions with Make America Great Again (MAGA) operatives and loyalists or outsource contracts for his billionaire bosses who were lined up right in the front row at the inauguration.

Folks, that does not feel like it is about our veterans. It is not about accountability. It is about profit. Trump is not even hiding that. On January 31st, he sat in the Oval Office after sending Federal employees a buyout email identical to the unelected, unaccountable President Musk, who sent to his former Twitter employees and said, quote, "It is our dream to have everybody, almost, working in the private sector."

Trump and Musk are the definition of horrible bosses, and they are using the bad boss playbook to push public servants out of their jobs. For those VA employees listening, look, I want to say this to you: I know you have figured this out yourselves, but do not take deceptive offers. Stay in the fight with us. We need you. Our veterans need you.

What Musk and Trump are doing to the Federal workforce through various executive orders (EO), Office of Management and Budget (OMB) memoranda, and tweets is demeaning, it is shameful, and it is threatening. Their actions are going to have dangerous impacts for our veterans, because within hours of being back in the office Trump ordered an across-the-board hiring freeze at Federal agencies. After the outpour of confusion, of concern, and Trump-inflicted chaos VA employees experienced, Trump eventually gave in to the onslaught of pressure from Democrats and exempted some VA healthcare positions from the freeze.

Let me be clear. Despite our advocacy and pressure, there are still thousands of vacancies for jobs at the VA that will go unfilled. These jobs are mission-critical claims processors, disability examiners, maintenance workers, environmental management technicians, food service workers, just to name a few.

The VA cannot deliver the benefits our veterans have earned and deserve without these people. Patient safety cannot be com-

promised, because we know what is going to happen. Veterans are going to suffer. That is the whole point, right? That is exactly what Trump and Vance want. They want to cripple VA so they can sell it off piece by piece to the highest bidder.

The greedy billionaires sitting in awe in the front row at Trump's inauguration stand to turn their billions into trillions at the expense of Federal workforce, everyday working-class American taxpayers, and ultimately veterans.

I want to make myself very clear. I take our oversight responsibility very seriously, and in my role as the ranking member extremely seriously.

Since I joined this committee, there have been several investigations into employee wrongdoing that came to our attention, and they were alarming. We heard hearings last Congress that touched on issues at the VA Central Office, Hampton, Loma Linda, eastern Colorado, Buffalo and Mountain Home.

In each of those cases, the Inspector General (IG) and VA identified wrongdoing, rooted it out and disciplined the employees in accordance with the law.

It is a misrepresentation of the law to say that VA does not have adequate legal authority under Title V to hold employees accountable. VA disciplined employees under Title V every single day. I have no problem with holding employees accountable, and I implore the VA to do so to ensure veterans are receiving the best care and benefits they deserve.

What I am not going to be standing for is an excuse of my colleagues across the aisle as they complicitly work with the Trump administration to abuse their power, subversion of due process rights afforded to Federal employees and the deconstruction of the services and programs that provide veterans the benefits they have earned and they deserve.

Look, if you want to have real conversations about accountability at the VA, let us have it. I am at the table ready to talk, and I know that my colleagues are as well.

Let us talk about ensuring that veterans get the benefits they promise. Let us talk about improving training for HR and supervisors. Let us talk about breaking down reporting silos for employees to disclose misconduct when they actually see it. Let us talk about our expectations for leadership when issues arise at a facility. Let us talk about ensuring VA staff work in an environment that empowers them to put veteran safety first.

When we have a President who removes over a dozen Inspectors General charged with being independent arbiters of truth and transparency in government in the middle of the night, I find it hard to believe that this is the party that is truly interested in making the VA more accountable for veterans.

With that, I want to introduce our minority witness today, Mr. Donald Sherman, who is going to be joining us from Citizens for Responsibility and Ethics in Washington, or CREW. CREW's ethos is Americans deserve a democracy that is ethical, accountable, and open. I could not agree more. If there is an expert on government accountability out there, it is you, Mr. Sherman.

Thank you for being here. I look forward to your testimony.

With that, Chairman, I yield back.

Ms. KIGGANS. The chair now recognizes Ranking Member Takano for 5 minutes for any remarks.

OPENING STATEMENT OF MARK TAKANO, RANKING MEMBER, FULL COMMITTEE

Mr. TAKANO. Thank you, Chair Kiggans, for this courtesy.

Let us talk about accountability at the VA. If my majority colleagues want to use this committee's time to take a look back at the Biden-Harris administration, I offer to take us back a bit further. I appreciate the opportunity to do a history lesson for those who may be unfamiliar or who have forgotten how Trump and his lackeys sabotaged the VA from within during his first administration by sowing fear and hostility in its workforce. He is following that same playbook now that he has regained power, and it is clear that Trump is on a witch hunt against VA employees.

Just earlier this week, he sent Elon Musk's entourage to the VA Central Office to do who knows what. Trump has allowed Musk's team of teenage interns to access, collect, and poke around the private information of American citizens at Treasury, some of which includes veterans' data. I am deeply concerned that they are doing the same at VA.

Veterans are at very real risk, and we demand answers. Unelected bureaucrats and billionaires now have access to hordes of private data, but are not being held to any of the same privacy standards we ask of VA employees or partners. That does not sound very accountable to me, but perhaps this is all part of the Republicans' plan for VA.

As I have explained many times, a key step of the Republican VA death spiral is an erosion of veteran trust in the VA workforce. That is the purpose of this hearing today. My colleagues are painting a distorted picture of the past to make sure—to make their case as to why Congress needs to rush past—rush to pass their incredibly flawed and unconstitutional Restore VA Accountability Act of 2025.

Let me tell you why their case fails. This is their third bite at the apple, of the apple to attempt to make—and I say to attempt to make—it easier for VA to fire employees. I say "attempt" with emphasis, because when the Republicans tried this in 2014 and 2017, they failed egregiously, and veterans and taxpayers were left holding the bag.

The 2014 Veterans Access, Choice, and Accountability (CHOICE) Act included expedited authorities to remove VA senior leaders or demote them to a lower position. Employees who were removed or demoted using that authority challenged the law's constitutionality in court. The Department of Justice ultimately declined to defend the law from those challenges, and VA ceased using the law to discipline employees.

Now, I want to be clear that I did, in fact, vote in favor of CHOICE and the VA Accountability and Whistleblower Protection Act of 2017. We were still dealing with the fallout of the Phoenix wait time scandal, and at the time these bills seemed like they would help VA weather that crisis.

However, hindsight is 20/20 and I learned a valuable lesson, not to trust Trump with power. Instead of using the 2017 law to im-

prove VA, Trump and his corrupt allies weaponized the bill to intimidate employees who were perceived to be unloyal to Trump and to remove employees without due process.

During Trump's first go-round at VA, his team set up the Office of Accountability and Whistleblower Protection, otherwise known as OAWP, as required in the 2017 law. They then used that office to retaliate against the whistleblowers they were supposed to protect. I wish I was making this up, but it is well-documented truth.

The Inspector General and other watchdog organizations, like the Project on Government Oversight and Government Accountability Project, helped bring this malfeasance to light. Ultimately, however, during the Biden-Harris administration, OAWP was able to turn things around and become a respected organization we regularly relied on to investigate and recommend discipline for employee misconduct.

The death knell for the 2017 law came when the Court scrutinized its implementation and VA ultimately quit disciplining employees under its so-called Section 714 authorities to avoid further litigation.

As a reminder, this is exactly what happened with the 2014 law. Settlements from the use of the 2017 law resulted in 140 million taxpayer dollars being paid out to former employees. If that is not a failure for veterans, I do not know what is.

The Restore VA Accountability Act of 2025 is just more of the same. It is essentially a codification of Trump's various executive orders to give his political appointees sharpened tools to exact swift justice on VA employees for perceived disloyalty or insubordination. They want to make it as easy as possible to fire VA employees without cause. It is that simple.

Restore is opposed to—is opposed by nearly every major labor union. VA has testified time and time again that they do not need the authorities in Restore to hold employees accountable for misconduct, nor will Restore speed up the disciplinary process, contrary to what my colleagues believe.

Hampton, Loma Linda, eastern Colorado, Buffalo and now Ann Arbor all present issues that warrant our attention so that we can help VA improve patient safety and veteran dissatisfaction—veteran satisfaction at those facilities.

Let me be absolutely clear. The Restore VA Accountability Act will not fix those issues. The Restore Act is not going to hire more people to process referrals. It is not going to bring in more qualified executive leadership. It is not going to improve patient outcomes. What Restore will be is an empty promise to veterans and a tool used to harm the Federal employees that serve them.

I know that Ranking Member Ramirez and I are committed to work to ensure VA is an accountable organization that holds its employees to the highest standards for our veterans. Let us come back together and explore opportunities for bipartisanship.

I yield back.

Ms. KIGGANS. Thank you.

Before the chair introduces the witness from our first panel, I just think there is a time and place for partisan politics, and I really wish it was not in this committee. I think it is really important for us to continue to focus on the issues at hand, rooting out mis-

conduct and ensuring the VA effectively holds those accountable who allow it. That should not be partisan. I have said it before and I will say it again. Partisan games have no place when veterans' care is on the line.

With that, I would like to recognize the witnesses on our first panel. Testifying before us today, we have Mr. Ted Radway, the Acting Assistant Secretary of the Office of Accountability and Whistleblower Protection.

We have Ms. Tracey Therit, the Chief Human Capital Officer, Office of Human Resources and Administration, Security, and Preparedness.

We have Dr. Mark Upton, Deputy to the Deputy Under Secretary for Veterans Health Administration (VHA).

Then we have Mr. David Case, the Acting Inspector General of the Inspector General.

We also have with us Mr. Donald Sherman, executive director and chief counsel of Citizens for Responsibility and Ethics in Washington.

If the witnesses could please stand and raise their hand, and we will swear you in.

[Witnesses sworn.]

Ms. KIGGANS. You may be seated.

Let the record reflect that the witnesses answered in the affirmative.

Mr. Radway, you are now recognized for 5 minutes to provide VA's testimony.

STATEMENT OF TED RADWAY

Mr. RADWAY. Good afternoon, Chairwoman Kiggans, Ranking Member Ramirez, Ranking Member Takano, distinguished members of the subcommittee. Thank you for inviting us today to discuss the VA's efforts to improve accountability within the Department.

Joining me is Ms. Tracey Therit, Chief Human Capital Officer in VA's Office of Human Resources and Administration/Operations, Security, and Preparedness; and Dr. Mark Upton, Deputy to the Deputy Under Secretary for Health.

VA is committed to providing veterans with the care and benefits they have earned through service to our country. Our veterans and their families, caregivers, and survivors deserve nothing less. We and the more than 450,000 VA employees are devoted to the sacred duty and work diligently daily to fulfill this mission.

Sometimes, even with the best intentions, VA recognizes that the performance and action of some employees and leaders fall short of expectations and what our veterans deserve. When that happens, holding employees accountable is integral to effective management and we take that responsibility seriously. In today's hearing, we welcome the opportunity to discuss our improvements to strengthen our accountability.

The Office of Accountability and Whistleblower Protection promotes and improves individual and organizational accountability across VA in numerous ways.

First, we investigate allegations against senior leaders involving misconduct and poor performance and allegations against all super-

visors involving retaliation against whistleblowers. Our highly skilled professional investigators and analysts work hand in hand with our attorneys, who ensure that investigations are properly scoped, within our jurisdiction, all relevant issues and potential misconduct are identified and the conclusions and recommendations are legally supportable and appropriate.

We issue reports with recommendations for disciplinary actions, but we do not carry out those actions. Instead, our report is issued to the appropriate management official with authority to propose and/or carry out those actions. If our recommendations are not taken, we report that, along with the deciding official's reasoning, to Congress.

OAWP employees have led a remarkable turnaround in productivity, success, and impact on individual accountability. From Fiscal Year '21 to '24, the number of incoming complaints increased by over 60 percent to 3,305 complaints. This shows VA employees' trust in OAWP's ability to resolve complaints fairly and efficiently.

Despite the rapid increase in case volume, OAWP's efforts have dramatically reduced the time it takes to close a case. From Fiscal Year '21 to '24, we reduced the time it takes to close a complex case by over 75 percent.

In addition, we have seen a jump in acceptance by management of our recommendations. In Fiscal Year '21, management took some action or the employee retired or resigned in only 64 percent of our disciplinary recommendations. In Fiscal Year '23, that number jumped to 100 percent; and in Fiscal Year '24, we doubled the number of recommendations we issued and management took some action or the employee retired or resigned in all but three cases, or 92 percent.

We also issue nondisciplinary recommendations for relief for the whistleblower, training, or policy modifications. Management regularly takes these recommendations between 96 and 100 percent of the time.

OAWP also drives organizational accountability. By statute, we provide advice, reports, and recommendations to the Secretary on all matters relating to accountability. In the past two years, this included providing the Secretary with eight reports on the VA's efforts to support veterans with military sexual trauma (MST). Half of the 32 recommendations have been implemented to date, driving greater organizational accountability and a better experience for our veterans with MST.

OAWP also launches climate reviews that give leadership insight into the whistleblower reporting environment and make recommendations to improve the reporting culture to drive greater accountability and whistleblower protection.

In 2019, VHA began a transformational modernization. The transformation into a high-reliability organization, or HRO, was central to this effort. An HRO is an organization that experiences fewer than anticipated accidents or events of harm despite operating in highly complex, high-risk environments where even small errors can lead to tragic results.

The Department empowers all staff to lead continuous process improvements, and we strive to create an environment where employees feel safe to report harm or near misses. We are committed

to continuing to build on the great strides we have made in improving safety and quality of care.

As VHA advances toward HRO maturity, leaders are applying an organization-wide commitment to zero harm by developing an even stronger safety culture, featuring empowered frontline teams supported by engaged leadership within a climate of trust and continuous improvement.

The Office of Medical Inspector (OMI) is responsible for assessing the quality of VA healthcare through investigations of VA facilities. OMI issues comprehensive reports of its healthcare investigations, including recommendations for corrective action and/or improvements to the quality of veterans' healthcare. While it does make referrals to OAWP, OMI generally does not make specific recommendations related to discipline. Instead, it focuses on oversight and improvement in veterans' healthcare.

VA is proud of its large dedicated workforce who work hard to carry out VA's great mission every day. The Department is committed to and engages in continuous improvement of accountability to assess how to help identify and effect cultural improvements within the VA, hold employees accountable, and continue to work to protect whistleblowers.

Thank you, and we look forward to responding to any questions you may have.

[THE PREPARED STATEMENT OF TED RADWAY APPEARS IN THE APPENDIX]

Ms. KIGGANS. Thank you, Mr. Radway.

Mr. Case, you are now recognized for 5 minutes to provide your testimony.

STATEMENT OF DAVID CASE

Mr. CASE. Thank you, Chairwoman Kiggans, Ranking Member Ramirez, and members of the subcommittee. I appreciate this opportunity to discuss how the Office of Inspector General's (OIG) work enhances VA's accountability.

The OIG shares your goal of putting veterans first, and we do that by conducting effective independent oversight of VA so it can better serve veterans, their families, survivors and caregivers.

In fiscal 2024, our office released more than 300 oversight publications with over 1,100 recommendations to VA. We made nearly 250 arrests and secured 179 convictions. We had a monetary impact of more than $6.5 billion in addition to the invaluable work of our healthcare inspectors, who enhance patient care and safety.

These efforts to improve benefits and services for veterans and their families would not be possible without the funding and support we receive from Congress. The engagement of Veterans Service Organizations (VSO)s and other stakeholders has also been crucial to our success. In addition, we have a strong collaborative relationship with Government Accountability Office (GAO). We coordinate our efforts with them to promote more consequential oversight.

In my written testimony, I lay out the five principles that the OIG has determined are foundational to accountability and provide examples of each.

First, there must be strong governance and clarity of roles and responsibilities. We have found tension between the VA office with its policy and oversight functions and the leaders in the field who are not accountable to those offices. In other cases, staff do not fully understand their roles and responsibilities due, in part, to outdated or conflicting guidance. Several of our healthcare inspections identified facilities where leaders did not act on known issues, resulting in greater risk to patients or delays in veterans receiving care.

Second, there must be adequate and qualified staff to carry out clear duties. VA faces staff vacancies in key occupations, especially within VHA. These longstanding shortages make it challenging for VA to carry out some programs and functions. When implementing new programs, staff often must navigate rapidly changing guidance for processing VA benefits. The resulting confusion can affect the amount of money and services veterans receive.

Third, VA needs updated IT system and effective business processes. VA is modernizing significant systems critical to its operations. We have been proactively overseeing VA's implementation of these systems, including publishing 22 reports on the transformation of VA's electronic health record (EHR) system alone. Our work has identified poor planning, billions of dollars in unanticipated cost, patient safety issues, low user acceptance and gaps in functionalities, making it difficult for personnel to efficiently do their jobs.

Fourth, effective quality assurance and monitoring is essential. VA often lacks controls to consistently ensure quality standards are met. Breakdowns in routine monitoring and workarounds undermine efforts to identify and fix problems as well as make certain the eligible veterans and their families receive timely services and benefits.

Last, consistent and effective leadership is critical. Engaged and dedicated leadership fosters open communication, efficiency, and accountability among all staff.

These five themes are routinely highlighted in OIG reports. Although report findings and recommendations are often directed to a single facility, system, or program, they serve as a roadmap to help prevent or correct similar problems in other facilities or offices.

We recognize that VA is working to build a stronger sense of accountability. We routinely observe personnel committed to providing the highest quality care, benefits, and services to veterans and their families despite obstacles.

The OIG will continue to provide practical and meaningful recommendations to help VA remove these obstacles to serve veterans first, address fraud and other crimes, as well as waste and improve efficiency.

Finally, I want to thank Congress for passing the Elizabeth Dole Act, which includes a requirement that all new VA employees receive training on how to report and cooperate with the OIG.

Chairwoman Kiggans and members of the subcommittee, this concludes my statement. I look forward to answering any questions you may have.

[THE PREPARED STATEMENT OF DAVID CASE APPEARS IN THE APPENDIX]

Ms. KIGGANS. Thank you, Mr. Case.

Mr. Sherman, you are now recognized for 5 minutes to provide your testimony.

STATEMENT OF DONALD SHERMAN

Mr. SHERMAN. Chairwoman Kiggans, Ranking Member Ramirez, and members of the committee, thank you for the opportunity to testify before you today.

The Department of Veterans Affairs' mission to provide for the care, benefits, and support of veterans is the fulfillment of a promise that our Nation made and must continue to honor to those who have protected our Nation in the Armed Services.

My own family includes veterans who served in combat, and my grandfather proudly worked at the VA in his hometown of Tuskegee, Alabama. I thank our Nation's veterans and military families for their service and sacrifice for our country.

In order to meet its critical mandate, the VA plays many roles, including administering pensions, insurance and home loans for veterans, providing survivor support for veterans' families, and running the Veterans Health Administration, the largest integrated healthcare network in the United States.

The VA cannot falter in this mission. Yet, managing such complex systems is a daunting task. The VA has experienced challenges across both Democratic and Republican administrations that demand robust, independent oversight.

It is certainly reasonable to look backward at the Biden administration's stewardship of the VA and acknowledge areas of success and challenge. That is why it would have been useful to have former VA IG Michael Missal in attendance here today.

During his tenure, Mr. Missal's leadership of OIG garnered bipartisan praise, and he released numerous reports critical of VA officials during both President Trump's and President Biden's terms in office.

In 2024 alone, IG Missal's team published more than 300 reports with over 1,100 recommendations to help the VA improve the lives of veterans, with a monetary impact on at least $6 billion in taxpayer funds.

Under Mr. Missal's leadership, VA OIG pushed the agency to address deficiencies in its assessment of suicide risk, healthcare failures at facilities like the Hampton VA Medical Center, as well as longstanding management challenges.

Despite that staggering impact, President Trump fired Mr. Missal last month, along with more than a dozen other Inspectors General. That is not normal. In fact, these firings were illegal. Provisions of the bipartisan Securing Inspector General Independence Act require the President to provide Congress with 30 days' notice and an explanation before firing an IG. President Trump did neither.

Although it is beyond my expertise to opine on VA's mission-specific operations, independent oversight is essential for the agency to better support our Nation's veterans.

President Trump's firing of IGs, including Mr. Missal, was unethical, and our veterans will be among the many communities harmed as a result of these and other authoritarian actions.

These attacks include President Trump's gutting of the nonpartisan Civil Service. Veterans make up roughly 6 percent of the American working-age population, but nearly a third of the Federal workforce. Efforts to fire, suspend, and demote civil servants across agencies disproportionately impacts veterans. President Trump's hiring freeze on many components of the VA likewise undermines the agency's work to meet the needs of veterans and military families.

In January, my organization filed a lawsuit to force President Trump's billionaire-led Department of Government Efficiency (DOGE) to stop operating in the shadows and to the exclusion of veterans and other stakeholders.

The administration has also terminated programs aimed at meeting the unique experiences of diverse veterans. Having an independent permanent IG here today would be valuable to assess the impact of these policies and opine on reforms that this committee is interested in pursuing. That is why CREW has pressed for IG vacancies to be filled and for independent oversight under both Presidents Trump and Biden.

The VA OIG vacancy is especially concerning, given the corruption scandals at VA during the first Trump administration, including President Trump allowing cronies to help run the agency from Mar-a-Lago. OIG's investigation of Secretary Shulkin's lavish taxpayer-funded travel helped to lead to his removal in 2018.

In closing, President Trump's ouster of Mr. Missal suggests that even his successor could be fired on a political whim. That fact does nothing to help the VA better serve veterans and military families, address the longstanding challenges the VA has faced across administrations or prevent the corruption that plagued the VA during the first Trump term.

If this committee is serious about oversight of the VA, then I would expect Members of both parties to vocally oppose President Trump's illegal attack on IGs and the Civil Service.

Thank you. I welcome your questions.

[THE PREPARED STATEMENT OF DONALD SHERMAN APPEARS IN THE APPENDIX]

Ms. KIGGANS. Thank you, Mr. Sherman.

We will now move to questions, and I yield myself 5 minutes. Just before that, in accordance with committee rule 5(e), I ask unanimous consent that Representative Moylan from Guam be permitted to participate in today's subcommittee hearing.

Without objection, so ordered.

Mr. Case, the VA Inspector General has published three different reports about concerns with the clinical care veterans receive at the Hampton VA in my district. Each report highlights the importance of having quality assurance processes in place. If these are not in place, patients bear the consequences.

Can you tell me your opinion about why it is important for leaders to have quality measures in place for patient care, and can you also give us some examples of these quality measures?

Mr. CASE. Chairwoman Kiggans, we have published those reports, and the whole goal is to put the veteran first there. Quality assurance and important quality measures have to be in place. Ad-

herence to defined processes and objective assessments of basic patient safety activities is critical.

Leaders must be proactive in monitoring compliance and tracking and trending compliance. They then have to intervene, modify, or enhance resources in real time to keep patients safe. If they see problems, then there is constant monitoring.

An example from Hampton, is there were ineffective monitoring of the processes to address substandard care by a surgeon. By doing that, you allow a surgeon to stay in place who is believed to be not operating at the highest level or even at an acceptable level. By monitoring those processes, paying attention, demanding accountability, you ensure safety and patient safety.

Ms. KIGGANS. The IG also published a report that showed severe mismanagement in veterans' oncology care, resulting in serious delays, which is unacceptable.

How can leaders be proactive in their oversight and involvement in patient care? You talked about hands-on and just managing that care, but can you give me specific examples? Is this reviewing charts? Is this periodic reviews with small groups? Just a little more specific.

Mr. CASE. Yes. As a general matter, trust is critical between leaders and staff, but verification of performance and adherence to policy and standards is absolutely necessary. The stakes are too high, and the data is too readily available to assume patients are getting the care they need, especially those at high risk.

The best example that comes to mind is in Buffalo, where there was—the chief of oncology, the staff oncologist were demanding that a patient get an appointment scheduled in the community. The response from others was: we are taking care of it. We will get it done. It was not getting done.

That is an instance where you can trust, but you have to verify. You have to intervene and make sure that that patient is getting the care he needs, especially incumbent upon facility management, the staff oncologist and the oncologist.

Ms. KIGGANS. Which takes manpower and then also people who are very thorough and attention to detail in doing this. A follow up for their jobs, which I can appreciate. Thank you, Mr. Case.

Mr. Radway, from your experience in the last 4 years, what has OAWP identified as repeat areas of concern across the VA in patient care?

Mr. RADWAY. We have not, Congresswoman, really focused on patient care issues per se. We have really looked more at misconduct.

We have seen several cases where there was a failure to oversee providers who were alleged to have committed misconduct in terms of patient care and improperly treated patients. Then we will look at the activities of those senior leaders who failed to oversee their providers, their chiefs of surgery, things like that.

Ms. KIGGANS. The office—and Mr. Radway again—the Office of Medical Inspector is responsible for assessing VA's quality of care. How do the recommendations made in the OMI reports work to mitigate repeated errors in the care provided in the VA?

Mr. RADWAY. Dr. Upton, do you want to——

Dr. UPTON. I would be happy to take that, Madam Chairwoman.

The OMI recommendations come to both the leaders of the facilities as well as to our senior leaders in VHA. They, as was mentioned earlier, look at important quality and safety issues within our system, often charged by the Under Secretary for Health or others.

We—the OMI specifically makes sure that those recommendations are followed through, and we take them very seriously as part of our commitment to quality.

Ms. KIGGANS. You follow up at each facility individually?

Dr. UPTON. We review them as leaders, as the senior leadership team. They also work with each facility, because many of these are very facility-specific. We certainly try to take lessons learned across the system as well.

Ms. KIGGANS. Very good. Thank you.

Let us see. Then we will now—I want to—we will now move to questions from the ranking member.

Ranking Member Ramirez, you are recognized for 5 minutes.

Ms. RAMIREZ. Thank you, Chairwoman.

I want to just thank all of you for being here again. I really appreciate your testimonies and having an opportunity to read through them.

I want to do a little quick level-setting exercise with some of the witnesses here today, because we are I know a little bit in a time crunch. I want to go down the row with three of you and ask you each to answer a question.

Ms. Therit, in your work, do you put veterans or VA first?

Ms. THERIT. Congresswoman Ramirez, yes.

Ms. RAMIREZ. Veterans?

Ms. THERIT. Veterans first.

Ms. RAMIREZ. Mr. Radway, in your work, do you put veterans or VA first?

Mr. RADWAY. Veterans.

Ms. RAMIREZ. Dr. Upton, you are a provider who cares for veterans. Do you put veterans first or VA?

Dr. UPTON. Veterans first every time.

Ms. RAMIREZ. Thank you. I want to make sure that the record shows that it is crystal clear that these public servants before us put veterans first. I believe them.

We relied on each of you during the last 4 years to ensure the VA continued its journey to becoming an accountable institution that prioritizes patient safety, and I just want to thank you for your service.

Now, Ms. Therit, I appreciated VA's testimony that you provided regarding actions taken to hold employees accountable for misconduct. I want to ask you a couple follow-up questions.

How frequently does the VA use its authority under Title V to remove employees?

Ms. THERIT. Congresswoman Ramirez, last Fiscal Year we used our authority under Title V and the Accountability Act, because we use both of the authorities. We use 713 in the Accountability Act for our senior leaders and the Chapter 43 and Chapter 75 authorities in Title V.

There were over 5,000 actions that we took to remove, to suspend, or to demote employees who engaged in poor performance or

misconduct. That number mirrors about the same number that were taken the first year after the Accountability Act was passed.

Ms. RAMIREZ. Pretty frequently.

How recently have you used Title V authority? When was the last time?

Ms. THERIT. We use the authorities that we have on a daily basis.

Ms. RAMIREZ. Got it. I am looking at a chart right now that compares year over year the total number of adverse actions taken by the VA. It says that for year 2024, there were 5,875 adverse actions. You just mentioned that. In year 2024, the VA would have been using Title V authorities for adverse actions, as you mentioned, correct?

Just to follow up, the chart says that in 2018, '19, '20, '21 and '22, the VA had 5,952, 5,653, 5,694, 4,673 and 4,068 adverse actions, respectively.

During that period, which authority or authorities for adverse actions would the VA have been using?

Ms. THERIT. Prior to Fiscal Year 2023, we were using a combination of Accountability Act, Chapters 713 and 714 authorities in addition to our Title V authorities.

I would say that we are always using all of our authorities, whether under Title 38 or Title V, to ensure our Title 38 and our Title V workforce are being held accountable.

Ms. RAMIREZ. Got it. VA uses Title V at the same or higher rates for adverse actions than they did with the authorities in the 2017 Accountability law, correct?

Ms. THERIT. Correct. We have a track record of legally defensible actions under Title V, because they have been before the Merit Systems Protection Board, they have been before third parties. Any time we take an action, we want to make sure that that employee does not come back if we remove them, if they are suspended that suspension is upheld.

We try and look at the case law to make sure that the actions that we are taking are legally defensible and that we will not have to reinstate bad actors who should not be at the VA serving veterans.

Ms. RAMIREZ. That sounds efficient.

Ms. Therit, my understanding is that you sit on Council with other agency chief human capital officers. Is that correct? Yes?

Ms. THERIT. Yes, ma'am.

Ms. RAMIREZ. I have another follow up. Are there other Federal agencies that also employee physicians, nurses, and housekeepers, like the VA?

Ms. THERIT. There are. The Department of Health and Human Services. The Department of——

Ms. RAMIREZ. Let me ask you, though. I have a couple seconds left here.

Do those agencies also use Title V to discipline employees?

Ms. THERIT. They do.

Ms. RAMIREZ. Ms. Therit, can you describe an instance when you could not remove an employee under Title V?

Ms. THERIT. If there are instances when an employee cannot be removed under Title V or Title 38, it is typically, as Mr. Radway

had alluded to, because of a lack of evidence, you know, an inability to support the level of discipline that is being proposed.

Rarely is it the authority that is limiting it as opposed to the substance of the investigation or the prior conduct or performance of that individual.

Ms. RAMIREZ. Thank you, Ms. Therit.

Just a quick question to Mr. Sherman. Thank you for being here again. How would you describe the first 20 days of the Trump's second administration in the last 10 seconds? Hard, I know.

Mr. SHERMAN. Lawless, evasive, chaotic. You know, I think if the President was serious about oversight of the VA in particular, he would not have fired the IG and he would not have sent minions from DOGE to root around there.

Ms. RAMIREZ. Thank you, Mr. Sherman.

I yield back.

Mr. SELF. [Presiding.] Thank you. I recognize myself for 5 minutes.

First of all, I want to thank you for being here. I want to assure you that you are not stage props. The hysteria and the hyperbole that you have heard today will not stop this committee from conducting reasonable oversight, which is our duty.

Mr. Case, your testimony, particularly your written testimony, is pretty damning. I will just quote a few sentences from it. "Accountability, components of accountability identified by the OIG are often lacking within VA programs and operations." You listed the five, gave a very detailed.

"The OIG regularly identifies instances of misconduct, broken systems, confusing and conflicting governing policies or guidance, and inefficiencies or missteps in implementing programs." Further, you say, "Misconduct, failures to take appropriate action, and persistent problems are often the result of VA personnel or contractors not understanding their roles or responsibilities. In other cases, they understand their duties, simply do not or cannot fulfill them. This may be due in part to outdated policies and procedures, conflicting guidance, lack of clear decision-making—often by those best positioned to act lacking the authority to do so," and you go on.

Everything that I just read is a leadership issue. I will tell you that during my first term in Congress on this committee, we spent an inordinate amount of time on countless scandals throughout the VA, normally at the leadership level.

In the past 2 years under the Biden administration, we have been made aware of many cases, not executing their jobs, employees not executing their jobs. This subcommittee sent over 80 letters—80 letters—to try to uncover why that is. I can only compare it to a dumpster fire in a windstorm. If you think it cannot get any worse, it blows up again.

Mr. Case, I want to go to you first. Have you found Veterans Integrated Service Network (VISN) directors exercise inconsistent oversight—and this is leading to another question—leading to major disparities in quality of care and leadership across the VISNs?

Mr. CASE. We have found disparity in oversight by VISN directors, largely attributable, we see often, in the fact they do not have clear definitions of what their responsibilities are and what their

duties are. This is not just VISN directors. It goes to all leadership, mental health directors at the VISN level.

Once the responsibilities and duties are clarified, then I think they will be in a position to move forward.

Mr. SELF. Do you attribute this to lack of leadership at the VA leadership level to a Secretary administrative level, or is it they have too much autonomy at the VISN director level? Again, leading to another question.

Mr. CASE. Yes. How the VA got itself in the situation is probably a long story. Autonomy can work if there is standardization of duties at the highest level, at the VISN level, and those duties are clear. As it exists right now, there is not that clarity for VISN leaders to act on their duties.

Mr. SELF. Okay. Let me go to the EHR, because—and I realize it probably is not in the core mission of this hearing. Is it not true, from the OIG perspective, that we cannot get to a clear EHR solution because of the customization at the VISN level? Is that a true statement or not?

Mr. CASE. That could be part of it, and it is probably part of it. There are many reasons, though, why EHR is in the state it is in at the present time.

Mr. SELF. The ethics violations. We covered, oh, probably all the way from sexual to the bonuses, those scandals that I referred to, to what would you owe that?

Mr. CASE. That depends on the instance that we are trying to address. Sometimes it is personal malfeasance. It boils down to that. Other times, malfeasance is allowed to go on. It just varies, and it is individualized. That is why our reports are very specific, focused, and practical.

Mr. SELF. In the last couple of seconds, Mr. Radway, do you track instances where VISN leadership intervenes—no. Do you identify cases where interference allows people to be transferred as opposed to held accountable? Quickly.

Mr. RADWAY. We do not track whether people are transferred. We just track whether the VISN leaders, if they are the deciding official, implement the recommendation for discipline or not.

Mr. SELF. Okay. Thank you. I yield back and recognize Mr. Conaway.

Mr. CONAWAY. Thank you.

Mr. SELF. Dr. Conaway. I apologize.

Mr. CONAWAY. Well, thank you for that. I appreciate that. Thank you, Mr. Chairman.

Thank you, lady and gentlemen, for presenting yourself to us today. Hopefully we, working together, can bring about the necessary improvements to ensure that the VA meets the demands of the American people and certainly the desires of our veteran community to receive first-rate service at the VA.

I would like to follow up, however, on a question that was just raised about ethics and to raise a concern about the President's actions upon—in office with respect to EOs.

My notes say here that among the recisions that the President made changed the ethics commitments by executive branch personnel and others with respect to gifts and the like.

Have any recent changes in the administration impacted the ethics rules governing the highest reaches in the VA? That is either for Mr. Case or Mr. Sherman. I will help out that way.

Mr. SHERMAN. Well, I think when President Trump came in, he rescinded the ethics pledge for appointees in the government, and significantly weakened those rules, making it easier for appointees to accept gifts and to move back and forth between the private sector and the public sector.

Certainly, I would be concerned about conflicts of interest, you know, undermining the efficacy of service that the American people, including our veterans, get from their government.

Mr. CASE. From the IG perspective, we will look at issues that are raised to us, and we will investigate those and do reports. We do investigate those, but we do not address broad policy issues, and we do not address in a significant way what is the result of those policy issues until we have specific requests to go and look at specific instances. That is basically are people meeting standards. That is how we operate in doing our reports.

Mr. CONAWAY. I thank you for that. I just have to say that these ethics rules are intended to ensure that the vendors who work for the VA, you know, public money is being spent there. If someone is getting gifts or not behaving appropriately with respect to awarding contracts and overseeing those because of gifts, then we are going to see waste and we are going to see, as we have seen, unfortunately, throughout the VA, serious problems with implementing the systems for everything from getting appointments, the Electronic Medical Record (EMR) which you just mentioned, and many other things in the reports that we have gotten that have looked at cost overruns and the inability to get these critical systems implemented and online.

Mr. Radway, again, thank you for being here. Can you describe how the OAWP improved the quality of investigative work over the last 4 years during the Biden-Harris administration, and have improvements been made, not been made?

You noted here that there are a number of investigations under the current authorities that have led to more than 5,000 people being removed from their jobs for various infractions.

Can you describe the—how the OAWP process has worked with respect to quality of investigations?

Mr. RADWAY. Sure, Congressman. A lot of it has to do with hiring the right people. I hired skilled 1810 administrative investigators who—many of whom are retired military or retired law enforcement and are on their second career.

We instituted standard operating procedures, based on the Council of the Inspectors General on Integrity and Efficiency Investigative Standards, and we modelled those standards for our investigation. We have given our folks training, and we established the Investigative Attorneys Division, which ensures that our reports are legally sufficient and our recommendations are legally supportable.

Mr. CONAWAY. That is all I have.

Mr. Sherman, can you talk about the—regarding the reinstatement of Schedule F by the current administration, how will this executive order create a VA that is more prone to corruption versus

one that prioritizes accountability and the well-being and care of veterans?

Mr. SHERMAN. Well, certainly weakening Civil Service protections makes it easier to fire government workers, nonpartisan government workers, when they report misconduct by the political leadership of the agency.

It makes it less likely that people will report misconduct, and it makes it more likely that the Civil Service is subject to partisan pressure, which is exactly what we do not want our veterans to experience when they come to the government for help.

Mr. CONAWAY. Well, with the time I have, I just want to say that we need a professionalized Civil Service and not people who are amateurs coming in there on political appointments that are not accountable to their mission but, rather, to the appointing authority.

Thank you, Mr. Chairman.

Mr. SELF. I recognize Mr. Ciscomani.

Mr. CISCOMANI. Thank you, Mr. Chairman.

Our ultimate duty here on the committee is to ensure veterans come first and not senior executive bureaucrats. It is one thing to be able to say that and then another to act on that.

Arizona is, sadly, the epicenter of what can go wrong when oversight is not taken seriously, as we saw in 2014. It was referred to that earlier today as well.

While we seek to ensure the VA is effective, we also have worked to create great public, private, and VSO partnership programs to fill the void in the community in Arizona as a result of what happened.

One example is the Be Connected program that for years has partnered with VA to ensure veterans are able to access the resources and benefits they have earned. While ensuring these partnerships continue, I want to make sure recent events in Arizona, such as a veteran passing away in the parking lot of the Phoenix Medical Center or a physician improperly administering care to veterans cease to occur.

Now, when we—Mr. Radway and Mr. Case, this will be going to you on the issue and the topic of the senior executive staff improper bonus pay.

Last Congress, it was discovered—and in this area I would like you to please provide some insight as well as getting into the OIG's work.

Last Congress, it was discovered Senior Executive Service (SES) pay bonuses were paid despite the purpose of these dollars being allocated for frontline healthcare workers who are day in and day out serving our veterans.

What is the VA doing to, one, regain trust; two, ensure this does not happen again; and, three, how do you plan to continue oversight of work with the new administration, given its Presidential memo regarding additional accountability for SES employees?

Mr. RADWAY. Congressman, in response to the IG report on critical skills incentives, or CSIs, our office was tasked with conducting an investigation into that episode, issued a 165-page report to the Secretary with recommendations for disciplinary and nondiscipli-

nary action, including policies and procedures that would prevent that from reoccurring.

Most of our recommendations to date have been implemented. We have not seen any issues of reoccurrence brought to our attention, but if they were we would certainly investigate those, as appropriate.

Mr. CASE. We have received a response to our recommendations, asking that they have been closed, from the VA That came on January 10th. The closure of recommendations and whether the VA has met the action plans they put forward is not a binary process. It is not a yes or no process.

Oftentimes it requires a discussion with VA as to what they have done, have they done enough, and see what their response is. We are analyzing those right now. From our perspective, I think some of those could probably be closed, but I think others are going to require this ongoing discussion as to what has been done and is it sufficient to meet the action plan of the recommendations.

Mr. CISCOMANI. What about my last part of the question regarding the new administration giving the Presidential memo regarding additional accountability for SES employees? How does that play into what you just explained?

Mr. CASE. Yes. When we do our work, we hold VA to standards, and those standards could include legislation, regulation, VA policies, clinical policies. Whatever it is that we are trying to investigate we hold them to standards, and if they come up short on those standards, then that would be part of our report, our findings, and we will make recommendations and then follow up to see if the action plans are implemented in the way that meets those recommendations. This would be part of that process, sir.

Mr. CISCOMANI. We are running out of time here, but just moving on, one of the major concerns is the number of times I have seen individuals resign while under investigation as well in an attempt to avoid accountability to their actions or for actions of those they oversee as well. That happened repeatedly. It was mentioned by the chairman in terms of how many of those we saw in this committee.

How does this impact accountability and the investigation processes?

Mr. RADWAY. It does happen, sir. It does not impact the investigation itself. We are continuing to close out our investigation. I am going to defer to Ms. Therit to speak about the consequences of that.

Ms. THERIT. Congressman Ciscomani, two things that I would offer. One is we do have authority under 5 USC 3322 to annotate personnel records when someone resigns under an investigation. I will tell you that authority is very limited to certain circumstances, and we cannot use it broadly.

I know later this month we have a legislative hearing, and we are looking forward to sharing some views that we have on more things that we can do to approve accountability at the VA.

Mr. CISCOMANI. I am interested in participating and helping in any way on that.

Mr. Chairman, I think that whenever someone saves themselves from any consequences by resigning, that is an accountability problem.

Thank you.

Mr. SELF. Mr. Kennedy.

Mr. KENNEDY. Thank you. Thank you all for your testimony. Thanks for your service to our great country.

Dr. Upton, I understand that you have been involved in improving the care in the community program of the Buffalo Medical Center. Are you fully read into the OIG report and what was found in that report and what has been recommended for the Buffalo VA Medical Center in the fall?

Dr. UPTON. Thank you, Congressman.

As a healthcare provider myself, this was mentioned earlier, as well as some of the works nationally, we need to make sure that when veterans are referred for care, that it happens timely and in a high quality way. Certainly that was the challenge, you know, the significant concern we heard in Buffalo.

I will say when that concern came to us, our under secretary for health very swiftly pulled a team of experts together from various disciplines to go to Buffalo directly, as you know, sir, and really look at all aspects of the issue there, from process to education to staffing to ensuring the right reviews are occurring of leadership as well.

Mr. KENNEDY. You are familiar?

Dr. UPTON. I am very familiar, yes.

Mr. KENNEDY. Excellent. Well, thank you.

The under secretary came up at my invitation, and we had a very productive meeting with the leadership of the staff at that hospital, and one of the issues that came up was a lack of staffing.

Through what you have read in the OIG report and in order to achieve the OIG recommendations, do you believe that it is important that the staff is hired to a level that is necessary to provide the service to our veterans?

Dr. UPTON. I do, Congressman.

Mr. KENNEDY. The VA is currently under a hiring freeze, is it not?

Dr. UPTON. We are complying with the, you know, orders from the administration, but we have received a number of exceptions for important critical roles within the healthcare delivery system.

Mr. KENNEDY. What is the VA doing to get more hires at the Buffalo VA specifically to help the veterans get the care that they need?

Dr. UPTON. I know that the current leadership at the Buffalo VA, as well as the VISN, are taking that very seriously, and I would be happy to follow up with you directly, Congressman, on the specific hiring in various key areas there.

Mr. KENNEDY. Well, it is important that the hiring is up to a level that the hospital and the system functions.

When the fork in the road email went out, there was a department of VA memo that stated that there were approximately 1,900 plus jobs that were rescinded and 716 job postings that were removed from USAJobs. Those are positions that are effectively providing service to our veterans, are they not?

Dr. UPTON. We are absolutely committed to hiring all the key positions we need, Congressman, and were able to repost a large number of those.

Mr. KENNEDY. I understand what you are saying, but I would like to know precisely how. Buffalo VA is indicative of what is happening around the country. If there is a hiring freeze in place, and what we are hearing, not only in my district but across the country, is that there are individuals that are being put on performance improvement plans, there are people that are on probation that are being cut without explanation, and are those positions being hired?

It sounds to me and others that we are hearing from, again, my constituents that we are blowing a hole in the staffing levels at not only the Buffalo VA and the Buffalo network, VA network, but across the country.

Can you speak to that?

Dr. UPTON. I will say that we are absolutely committed to hiring key staff, and I agree with you, Congressman. It is so important that we bring the staff in to serve veterans. The specifics of Buffalo in the network I would be happy to follow up with you with, but I certainly understand your concern.

Mr. KENNEDY. How can we be confident that the VA network across the country is being staffed appropriately when, in fact, there have been jobs that have been rescinded, offers that have been rescinded, and postings that have been removed, thousands of jobs and postings, and, you know, there are reports of individuals, again, being put on performance improvement plans that ultimately we know is the first step toward termination, and individuals that are currently in a probationary hiring period that are being terminated without cause?

Dr. UPTON. I will say we are going to stay laser focused as a health administration to hire all the employees that we can and follow all accordant directives and guidance, but we are laser focused on bringing the critical healthcare workers we need, Congressman.

Mr. KENNEDY. I would like you to, please, provide in writing to this committee, this subcommittee a hiring chart of exactly what is happening, where the hirings are, where the staffing levels are open, and all of which have transpired since the fork in the road memo went out.

I yield back. Thank you.

Mr. SELF. Mr. Moylan.

Mr. MOYLAN. Thank you, Chairman Self and Ranking Member Ramirez. I would like to thank the subcommittee for the opportunity to speak on behalf of the veterans of Guam who have been some of the most dedicated and selfless members of our Nation's armed forces.

Now, despite Guam having the highest enlistment rate per capita in the United States and one of the highest concentrations of veterans, our island has consistently been left behind when it comes to access to resources and benefits they deserve from the VA under the previous administration.

There is an ongoing discrepancy between the number of veterans reported by the government of Guam and those recognized by the VA. This is likely due to the VA's reliance on the number of vet-

erans registered without considering the need for increased outreach and support to those who have not been connected to the system.

We know that our veterans in Guam have sacrificed so much in service to this Nation. It is our responsibility to ensure that they are not left behind simply because they live in geographically isolated territory.

The failure of the VA to provide adequate staffing, oversight, and resources for Guam's veterans under the previous administration is a situation that demands immediate correction.

Today's hearing is a crucial step in ensuring that the brave men and women of Guam who have served our country are no longer neglected. We must take action to provide the support and services they have earned.

For my first question, Dr. Upton, Guam currently falls under the VA Pacific Island's healthcare system which services the largest geographic region in the country. How does VHA determine resources, allocations for its facilities and the territories which face unique challenges in accessing Federal resources and services?

Dr. UPTON. Thank you, Congressman.

I want to echo how important it is that we serve the veterans of Guam and appreciate their service. As you mentioned, Guam is part of that particular VISN network, and we look at the veteran population, the services they need, the location of various facilities, as well as in VA and in the community.

I would be happy, Congressman, to sit down with you and that VISN leadership to talk about the needs in Guam from the healthcare perspective. I know that, you know, it sounds like we can do better. They need support, and I would be happy to work with you.

Mr. MOYLAN. The next question will be for Mr. Radway. How much oversight exists when issues arise in Guam and the other territories? How often are visits conducted, and how does the VA address these matters?

Mr. RADWAY. I can only speak to oversight of the senior leaders. I do not have numbers for you on how many investigations we have had in Guam. I can certainly get those numbers for you, Congressman. If we receive allegations, we would treat those just the same and investigate them just as we would any other VISN or facility.

Mr. MOYLAN. All right. Thank you.

Last question. Ms. Therit, a consistent issue brought forth by my constituents is how does the VA decide where staffing is needed? How is the annual review conducted to determine if staffing needs to be increased?

Ms. THERIT. Congressman Moylan, thank you for that question.

In terms of the staffing resources and models that the Veterans Health Administration uses, those are assessed on an ongoing basis. We publish data on a recurring basis. On a monthly basis, we publish a public-facing report that looks at staffing levels. Then on a quarterly basis, we report it on the Mission Act 505 section with respect to our vacancies and our staffing levels.

Where those staffing levels need to be adjusted, I think as Dr. Upton mentioned, that local leadership will work with their VISN leadership to make sure that they are getting the resources and the

budget and the allocations that they need to ensure that the services are being provided in a timely and high quality manner. Those assessments are ongoing.

If there are any circumstances that you want to discuss specifically in your area, I am glad to take a closer look at that with the VHA HR team.

Mr. MOYLAN. I appreciate your time and you all coming and testifying before the subcommittee. I thank you very much.

Mr. Chairman, thank you.

Mr. SELF. Thank you.

I want to thank the witnesses for coming today for your candor, for your willingness to come, and to the VA for providing the witnesses, the expert that they have.

We need to ensure the VA has good governance. Veterans are getting the quality care that they deserve and they have earned, to quote several members from this side. Absolutely, that is imperative. That starts with ensuring that all employees are held accountable. Leadership culture matters.

Restoring accountability remains a top priority of this committee, and I am speaking for the chairwoman. We all look forward to continuing to ensure that VA remains committed to this goal. We all look forward to the leadership of Secretary Collins, and I believe that we will see a dramatic difference

Ranking Member Ramirez, closing comments.

Ms. RAMIREZ. Thank you, chairman.

I also want to echo the sentiments from the chairman now. We are really incredibly thankful for you to be here today.

This committee is going to be incredibly important over the next few weeks, over the next few years. We have to make sure that we use oversight and we use every authority in our power to ensure that we put our veterans first, that we ask hard questions, that we make sure that in everything we do, we are centering veterans and their families.

For many years, I got to shelter them. I fed them. I helped them find jobs. It is the work that I have done from a very young age—I know I look young, but that was almost 20 years ago.

I want to say that as I am thinking about and transitioning out of this hearing today, I am concerned that at no point during this hearing today we mentioned on this side—we certainly heard it from Mr. Sherman—but we did not address the removal of the VA's inspector general, Mike Missal.

Let me just say despite the fact that in this last Congress, Republicans relied on his testimony 22 times—let me repeat that. Republicans relied on his testimony 22 times. I have not heard anyone talk about his removal, and it does not surprise me, but it does not make it right.

I have said it once and I will say it again. Accountability for Members of Congress has to be one of our priorities.

The President made it very clear when he removed over a dozen qualified inspector generals, including the VA's former inspector general, Missal. From our own records, we can agree that Mr. Missal's work was apolitical. He did his job and held the VA to standards that ensured veterans were treated with dignity and got the care they earned.

Not once did my colleagues raise concerns or question Mr. Missal's integrity as they relied on his testimony. In fact, they thanked him for his transparency. They thanked him for his directness when discussing issues he and his staff uncovered at the VA. Yet now my Republican colleagues are silent, following their marching orders.

For a group of people fixated on qualifications, it seems like the only qualification that now matters is loyalty to the President or Musk.

Let us be real here. We cannot have an honest conversation about accountability at the VA without addressing Mr. Missal's removal, and that is why I want to make sure, Mr. Case, that you know and you hear this from me I am deeply concerned about reports that Elon Musk and his teenage intern team who are not government employees, at least I am not aware that they are, were at the VA central office earlier this week.

Look, I do not think they have legal authority to direct the people and the resources of the VA, and they do not have authority to access the VA data. This feels like an abuse of power.

I am going to be officially requesting the inspector general to initiate an investigation into this and report back to Congress as to whether Musk or his team were or are currently working at the VA, who they are meeting with, who is being discussed, what veteran data is being assessed, and whether that access is lawfully.

That is the responsibility that we have here, oversight and accountability. I look forward to working with you.

Mr. Chairman, I yield back.

Mr. SELF. Thank you, ranking member, and thank everyone for being here, and the audience included.

I ask unanimous consent that all members shall have 5 legislative days in which to revise and extend their remarks and include any extraneous material.

Hearing no objection, so ordered.

This hearing is now adjourned.

[Whereupon, at 3:18 p.m., the subcommittee was adjourned.]

A P P E N D I X

PREPARED STATEMENTS OF WITNESSES

Prepared Statement of Ted Radway

Good afternoon, Chairwoman Kiggans, Ranking Member Ramirez, and distinguished Members of the Subcommittee. Thank you for inviting us today to discuss the VA's efforts to improve accountability within the Department. Joining me today is Ms. Tracey Therit, Chief Human Capital Officer in VA's Office of Human Resources and Administration/Operations, Security, and Preparedness, and Dr. Mark Upton, Deputy to the Deputy Under Secretary for Health.

VA is committed to providing Veterans with the care and benefits they have earned through service to our country. Our Veterans and their families, caregivers, and survivors deserve nothing less. We and the more than 450,000 VA employees are devoted to this sacred duty and work diligently daily to fulfill this mission. Sometimes, even with the best intentions, the VA recognizes that the performance and actions of some VA employees, including some leaders, fall short of what we expect and what our Veterans deserve. When that happens, holding employees accountable is integral to effective, efficient management, and we take that responsibility seriously.

We look forward to working with the House and Senate Veterans Affairs Committees to strengthen our accountability policy, processes, procedures, training, and systems. Accountability starts long before we propose disciplinary actions; thus, VA continues to strengthen its employee relations, which supports its ability to hold employees accountable promptly and appropriately. In today's hearing, we welcome the opportunity to discuss our improvements to strengthen our accountability.

Office of Accountability and Whistleblower Protection

The Office of Accountability and Whistleblower Protection (OAWP) actively promotes and improves individual and organizational accountability across VA. We do this in several ways. While OAWP is most well-known for its investigations of senior leader misconduct and poor performance and of supervisor retaliation against whistleblowers, as the Office has matured, we have taken substantial steps to implement and operationalize the non-investigatory parts of our statute to help drive accountability in different ways.

First, we investigate allegations against VA senior leaders involving misconduct and poor performance; we also investigate allegations against all VA supervisors involving retaliation against whistleblowers who have made a protected disclosure. OAWP conducts these investigations using highly skilled professional 1810-series investigators under standard operating procedures modeled in part on the Council of the Inspectors General on Integrity and Efficiency Quality Standards for Investigations. The Investigations Division works hand-in-hand with our Investigative Attorneys Division (IAD), formed in 2022, which gives us complete independence from the VA's Office of General Counsel in conducting our investigations. The attorneys ensure investigations are properly scoped and within our statutory jurisdiction, all relevant issues and potential misconduct are identified, and the investigative conclusions and recommendations are legally supportable and appropriate.

After investigating 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 actions where appropriate. OAWP does not carry out those disciplinary actions. Instead, our report is issued to the appropriate VA official with the authority to propose and/or carry out those actions. If OAWP's recommended actions are not taken, or not taken within 60 days, OAWP reports the decision not to take the recommended action, along with the deciding official's reasoning, to the House and Senate Veterans Affairs committees.

Our work training our investigators, standardizing procedures, and forming the Investigative Attorneys Division has led to a remarkable turnaround in OAWP's productivity, success, and impact on individual accountability. For example, in fiscal year (FY) 2021, management took some action, or the employee retired or resigned,

on only 64% of our disciplinary recommendations. In FY23, that number increased to 100%. In FY24, we issued a record number of recommendations, and management has taken some action, or the employee retired or resigned in all but three (3) cases, or 92%. We may also issue non-disciplinary recommendations for relief or corrective action for the whistleblower, training, or policy modifications. Since FY21, management has consistently taken those non-disciplinary recommendations between 96% and 100% of the time.

The growth in investigative work quality and the resulting recommendations occurred while the volume of complaints coming to OAWP has increased yearly. The number of complaints increased by over 60% from FY21 to FY24 and 22% from FY23 to FY24 alone, to 3,305 complaints in FY24. This shows VA employees' trust in OAWP's ability to resolve complaints fairly and efficiently. A majority of complaints come in through our redesigned, user-friendly online portal, which allows whistleblowers to file reports anonymously and still track their complaints.

Despite the rapid increase in case volume, OAWP's efforts have dramatically reduced the time it takes us to close a case. In FY21, it took an average of 496 days to close a case that resulted in a written report of investigation. By contrast, in FY24, it only took an average of 122 days, **a greater than 75% reduction in time to close a case**. By comparison, according to its recent public filing, the Office of Special Counsel (OSC) closes 87% of its prohibited personnel cases in 240 days or less.[1]

By statute, OAWP also receives whistleblower disclosures that do not fall within its direct investigatory authority; for example, violations of law, rule or regulation, or gross mismanagement by a non-senior leader are referred to the appropriate VA organization to address potential problems and concerns. OAWP maintains oversight of those referrals, ensuring the investigations meet procedural requirements.

OAWP's success in fostering more significant reporting of wrongdoing and completing fair investigations promptly, resulting in recommendations that are acted on by VA management, drives greater individual accountability across the VA.

Beyond carrying out investigations, we also drive organizational accountability. By statute, OAWP provides advice, reports, and recommendations to the Secretary on all matters relating to accountability. In the past two years, this included providing the Secretary with eight reports on the VA's organization and efforts surrounding how we interact with and provide care to Veterans with Military Sexual Trauma, or MST. The eight reports contained 32 recommendations for VHA, VBA, and VA, all of which were concurred with, and more than half have already been implemented, with the rest scheduled for implementation in FY25 – driving greater organizational accountability and, more importantly, a better experience for our Veterans with MST. OAWP is also executing its statutory authority to confirm and review VA's implementation of recommendations from Office of Inspector General (OIG), Government Accountability Office (GAO), and the Office of the Medical Inspector (OMI), partnering with VA and those other oversight entities to identify repeated areas of concern, determine if VA is still implementing the closed recommendation, and identify any root cause solutions that might be scalable across the enterprise, thus identifying best practices to drive greater accountability and better service for our Veterans.

OAWP also launched Climate Reviews, on-site evaluations that include interviews and focus groups in addition to an anonymous all-employee survey that gives leadership insight into the whistleblower reporting environment at their facility and makes recommendations to improve that reporting culture to drive greater accountability and whistleblower protection.

OAWP also dramatically increased the data trend analyses it performs under its statute. It now shares that data, for example, with VISN leadership so they can identify and address any potentially problematic trends.

Finally, OAWP has expanded its training on whistleblower rights and protections, not just providing the bi-annual Training Management System (TMS) recorded training to all employees and annual TMS supervisor training but also providing live, in-person, or TEAMS training to a number of Administrations, VACO offices, VISN leadership teams, and individual facilities that have all reached out and requested we provide additional training. In FY24, OAWP provided approximately 226 of these supplemental training sessions.

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[1] Office of Special Counsel, Performance and Accountability Report for Fiscal Year 2024, January 7, 2025, at p. 29 (https://osc.gov/Documents/Resources/Statutory%20Reports%20and%20Notices/Performance%20and%20Accountability%20Reports%20(PAR/Performance%20Reports/FY%202024%20Performance%20and%20Accountability%20Report.pdf).

VHA as a High-Reliability Organization (HRO)

In 2019, the Veterans Health Administration (VHA) began a transformational modernization. Our transformation into a High-Reliability Organization (HRO) was central to this modernization. An HRO is an organization that experiences fewer than anticipated accidents or events of harm despite operating in highly complex, high-risk environments where even small errors can lead to tragic results. The Department empowers all staff to lead continuous process improvements within their workspaces. We created an environment where employees feel safe to report harm or near misses. This framework requires our leaders to focus on the why, not the who, when errors occur.

The work to become an HRO not only unleashed the incredible talent and commitment within our system to do great things but also underpins our efforts to strengthen the trust of Veterans and the American people in VA. We are committed to continuing to build on the great strides we made in improving safety and quality of care. In the most recent CMS Overall Hospital Quality Star Ratings, more than 58% of VA hospitals included received 4-or 5-star ratings compared to 40% of non-VA hospitals.[2] As Veterans Integrated Service Networks (VISNs) and VA Medical Centers (VAMCs) advance toward HRO maturity, leaders are applying an organization-wide commitment to Zero Harm by developing an even stronger safety culture featuring empowered, collaborative frontline teams supported by engaged leadership within a climate of trust and continuous improvement.

Office of Medical Inspector (OMI)

The Office of Medical Inspector (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 Veterans, VA employees and leadership, OAWP, OIG, Office of General Counsel, and Congress. Once a concern is identified, the Under Secretary for Health directs OMI to assemble and lead a team to initiate an investigation. 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 misconduct or poor performance by a senior leader 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 generally does not make specific recommendations related to discipline. Instead, it focuses on oversight and improvement of Veterans' health care.

Conclusion

VA is proud of its large, dedicated workforce, who work hard to carry out VA's great mission every day. The Department engages in continuous improvement of accountability to assess how to help identify and affect cultural improvements within the VA, hold employees accountable, and continue to work to protect whistleblowers. VA is committed to holding employees accountable, including taking disciplinary actions when necessary, and still celebrates VA's many accomplishments. Chairwoman Kiggans, Ranking Member Ramirez, and distinguished Members of the Subcommittee, we look forward to responding to any questions you may have.

Prepared Statement of David Case

Chairwoman Kiggans, Ranking Member Ramirez, and subcommittee members, thank you for the opportunity to discuss the efforts of the Office of Inspector General (OIG) to enhance VA's accountability and aid in its continuous improvement. The OIG's mission is to serve veterans and the public by conducting meaningful independent oversight of VA's services, programs, and operations. OIG staff execute this mission by conducting accurate, fair, and impactful audits, reviews, healthcare inspections, and investigations across the nation. For fiscal year (FY) 2024, the OIG produced 316 oversight publications with 1,106 recommendations to VA for corrective action. Our personnel made nearly 250 arrests, fielded more than 34,000 contacts to our hotline, and testified before congressional committees on 14 occasions, as well as conducted nearly 200 briefings to members of Congress and their staff. Our work has resulted in a monetary impact of more than $6.8 billion for that 12-month period. This would not have been possible without the funding and other sup-

[2] https://www.Medicare.gov/care-compare/

port we receive from Congress. We are also grateful to the veterans service organizations from whom we regularly solicit concerns and the many VA personnel and other stakeholders who bring to our attention a wide range of problems with VA programs and operations.

Integral to every OIG effort is intense scrutiny of the effectiveness of leadership and the quality management of VA operations that makes the most efficient use of taxpayer dollars. In a department the size of VA, with the nation's largest integrated public healthcare system, an aging infrastructure, and massive information technology (IT) modernization efforts, the OIG must remain vigilant to all risks to veterans, their families, and survivors. This requires the use of sophisticated data analytics and modeling; being responsive to hotline contacts and other allegations of misconduct; and rigorous and continuous oversight. OIG staff monitor programs and operations for breakdowns in processes; noncompliance with mandates; failures to provide quality health care; and deficiencies in the delivery of benefits and services. In addition, the OIG advances accountability by conducting an expansive range of administrative and criminal investigations that include, fraud, waste, and abuse of authority.

OIG leaders have testified before this subcommittee and other congressional committees many times in the past about enhancing accountability at VA.[1] There are several recurring themes and deficiencies that remain unchanged. These key elements of accountability are routinely identified by OIG staff and shared with VA leaders across the enterprise to encourage positive change and efficiencies within their respective programs and operations. OIG recommendations that focus on even 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.

This testimony focuses on five components of accountability identified by the OIG as often lacking within VA programs and operations, and highlights several illustrative oversight reports:

1. Strong governance and clarity of roles and responsibilities
2. Adequate and qualified staffing to carry out those duties
3. Updated IT systems and effectual business processes to support quality healthcare delivery, accurate and timely benefits, and efficient operations
4. Effective quality assurance and monitoring to detect and resolve issues
5. Leadership that fosters responsibility for actions and continuous improvement

The OIG appreciates the work VA personnel—the vast majority of whom work under challenging conditions and are committed to continuous improvement—do every day on behalf of veterans. Despite these efforts, the OIG regularly identifies instances of misconduct, broken systems, confusing and conflicting governing policies or guidance, and inefficiencies or missteps in implementing programs. Given the importance of VA's mission, every individual at VA should feel a responsibility to identify and report risks and any resulting problems, and then take action to address the underlying causes and mitigate the chances for future occurrences. To underscore the need for personnel to report potential crimes and issues that put veterans, VA employees, and resources at risk, the Senator *Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act* recently codified the requirement that all new VA employees receive training on how to report and cooperate with OIG staff.[2] Ensuring employees and leaders understand their duty to report and remediate problems is meant to foster a culture of accountability across VA.

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. Offices in administrations can be responsible for developing policy, but not for implementing or overseeing it. For example, financial officers in different administrations within VA do not report to the VA chief financial officer.

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[1] Recent OIG testimony to Congress can be accessed here.

[2] Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act, Pub. L. No. 118–210 § 501.

Two recent OIG reports serve as examples of how leaders did not act on known issues, resulting in delays in patients receiving health care. Last fall, the OIG published the results of a healthcare inspection regarding community care consult (referral) appointment scheduling practices. It examined delays for patients with serious health conditions who received community care through referrals from the VA Western New York Healthcare System in Buffalo.[3] The OIG found the system's community care staff did not timely schedule patients' radiation therapy and neurosurgery appointments, which resulted in delays in providing care and, in some cases, caused or increased the risk of patient harm. In particular, had there not been the delay in scheduling, and eventual cancellation of community care radiation therapy to treat a patient's cancer-related pain, efforts could have been made to alleviate that pain and improve the quality of life in the patient's final months. The Buffalo healthcare system and its community care leaders did not resolve the scheduling delays, despite advocacy by care providers and staff. The OIG found healthcare system leaders relied on inaccurate assurances from their community care managers that urgent, high-risk patient care consults were reviewed and prioritized, even as they received ongoing alerts about care concerns regarding those patients. The healthcare system and community care leaders' inactions were inconsistent with VA's stated commitment to the principles and values of high reliability organizations, as they failed to consistently focus on patients, get to the root causes of concerns, and predict and eliminate risks before causing patient harm. The OIG made two recommendations to the Veterans Integrated Service Network (VISN) director related to the healthcare system leaders' response to patient concerns and oversight of community care; and two recommendations to the Buffalo system's director related to establishing community care policies aligned with Veterans Health Administration (VHA) standards, as well as the disclosure of an adverse event (which has now been completed).[4]

Following an OIG analysis of VHA data, our healthcare inspectors reviewed the VA Loma Linda (California) Healthcare System's high use of community care providers for primary care, the impact, and system leaders' related oversight of VA outpatient clinics.[5] The OIG found that a new contractor responsible for the healthcare system's five non-VHA-operated community-based outpatient clinics experienced challenges staffing them. As a result, system leaders paused enrollment of new patients at all five of these clinics. VHA-operated clinics were unable to absorb the additional patients leading to an increase in the system's use of community care providers for primary care. Further, the system's community care office was not able to timely process the consults and schedule community appointments. The OIG did not identify any patients who experienced poor outcomes as a result. However, the lack of a formal oversight structure for non-VHA-operated clinics, turnover in the system's leadership positions, and the new contractor together created a vulnerability in the management of primary care services provided at the system's clinics. The OIG's three recommendations to the system director are unimplemented at this time. They focus on monitoring primary care staffing and panel sizes (the number of patients assigned), timeliness of community care consult processing, and oversight of all the system's clinics.

ADEQUATE AND QUALIFIED STAFFING TO CARRY OUT 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 workforce accountability, as is instilling that sense of responsibility in new hires.

As for persistent shortages, VA is not alone. Medical systems across the country are facing challenges in finding and retaining qualified personnel. The OIG is required by law to annually identify clinical and nonclinical VHA occupations with the largest staffing shortages within each VHA medical center.[6] The FY 2024 review, the 11th and most recent that the OIG has conducted, found that 137 of 139 sur-

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[3] VA OIG, *Leaders Failed to Address Community Care Consult Delays Despite Staff's Advocacy Efforts at VA Western New York Healthcare System in Buffalo*, September 27, 2024.

[4] VA has 18 VISNs across the nation—a regional network of care in which each VISN oversees VHA local healthcare facilities in their assigned area. An adverse event disclosure happens when a healthcare provider informs a patient or their family when a medical error or unexpected complication occurs during treatment that resulted in harm.

[5] VA OIG, *Increased Utilization of Primary Care in the Community by the VA Loma Linda Healthcare System in California*, April 23, 2024

[6] VA Choice and Quality Employment Act, Pub. L. No. 115–46, 131 Stat. 958 (2017).

veyed VHA facilities reported at least one severe occupational staffing shortage.[7] The total number of their reported severe shortages was 2,959, a 5% decrease from FY 2023, when facilities reported 3,118 total shortage occupations. Every year since 2014, the medical officer and nurse occupations have been identified as severe shortages, with the designations of medical officer as a severe occupational shortage generally decreasing since FY 2018. Following staffing increases in FYs 2022 and 2023, the nurse occupation was reported as a shortage by fewer facilities in FY 2024. Psychology was the most frequently reported clinical severe occupational staffing shortage in FY 2024, by 61% of facilities (85 of 139). Facilities also reported custodial worker and medical support assistance as the most frequent nonclinical shortage occupations, the same as for FYs 2022 and 2023.

An OIG review published last week highlights the impacts of insufficient staffing and hiring delays at the Joseph Maxwell Cleland Atlanta VA Medical Center's contact center for appointment scheduling. Callers experienced long hold times that led to abandoned phone calls.[8] Significantly, the facility's leaders were not attentive to concerning call center performance metrics, such as wait times and abandonment rates. The report also identified that the VISN had not been using available data to determine if its own call center was properly staffed.

In addition to addressing staffing shortages, VA should also ensure its existing personnel are equipped and prepared to do their jobs. The OIG has published numerous reviews over the last few years that examined whether staff at the Veterans Benefits Administration (VBA) were sufficiently trained for their duties.[9] For example, VBA uses the VA Schedule for Rating Disabilities (the rating schedule) to determine monthly compensation to eligible veterans for service-connected disabilities based on documented medical severity. In 2021, updates were made to the rating schedule for the musculoskeletal body system. The OIG performed a review to assess the effectiveness of VBA's implementation of the rating schedule changes for hip and knee replacements. The report on the review's findings, published in February 2024, found an estimated 38% of claims had an improper payment during the review period.[10] VBA paid an estimated $3.3 million in total improper payments for hip and knee replacement claims during that same period—including both underpayments and overpayments for these claims.VBA concurred with the OIG's four recommendations.[11] VBA has since provided sufficient documentation for the OIG to close its recommendations to supplement training on the rating schedule updates, including how to apply the changes to help ensure claims processors' comprehension.

The importance of a well-trained workforce to implementing VA's major initiatives cannot be overstated. Signed into law in August 2022, the PACT Act dramatically expanded access to VA health care and benefits for millions of veterans exposed to toxic substances.[12] The OIG assessed whether VBA staff processed PACT Act claims for presumptive disabilities in accordance with applicable laws and procedures before denying them—recognizing the potential impact on eligible veterans if claims were improperly denied. The OIG review team found errors resulting in unnecessary payments for examinations and medical opinions, as well as underpayments to veterans. A VBA leader told the OIG team that some claims processors said that information came at them quickly and there were too many changes. They further stated

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[7] VA OIG, *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages Fiscal Year 2024*, August 7, 2024.

[8] VA OIG, *Atlanta Call Center Staffing and Operational Challenges Provide Lessons for the New VISN 7 Clinical Contact Center*, January 30, 2025. The three recommendations to the VISN director and the recommendation to the facility director are not yet implemented. The OIG will begin to follow up with VBA for progress on the recommendation's implementation on or about May 1, 2025. At quarterly intervals commencing 90 calendar days from the date of the report's issuance, the OIG sends a follow-up 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.

[9] See, e.g., *VA OIG, Rating Schedule Updates for Hip and Knee Replacement Benefits Were Not Consistently Applied*, February 21, 2024; VA OIG, *VBA Needs to Improve Accuracy of Decisions for Total Disability Based on Individual Unemployability*, July 17, 2024; VA OIG, *Veterans Are Still Being Required to Attend Unwarranted Medical Reexaminations for Disability Benefits*, March 16, 2023; *VA OIG, VBA Could Improve the Accuracy and Completeness of Medical Opinion Requests for Veterans' Disability Benefits Claims*, September 7, 2022.

[10] VA OIG, *Rating Schedule Updates for Hip and Knee Replacement Benefits Were Not Consistently Applied*, February 21, 2024. The OIG team reviewed a random sample of 112 in-scope claims from a universe of about 3,200 claims for convalescence for hip or knee replacements or resurfacing, received and decided from February 7, 2021, through August 31, 2022.

[11] There were two other recommendations that address issues unrelated to quality assurance and training.

[12] Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022, Pub. L. No. 117–168.

the implementation of PACT Act legislation was very challenging, but VBA did the best it could given the circumstances. In an interview, the former Compensation Service quality assurance rating review chief stated PACT Act guidance changed repeatedly after the initial rollout. Further, the chief stated VBA hired many new employees to process the most complex claims, which, combined with the changing guidance, may have caused confusion when regional office staff were working these claims and resulted in errors. VBA concurred with the OIG's two recommendations to update the claims processing manual to clarify when examinations and medical opinions are needed and to continue to develop tools to aid claims processors in determining when they are needed and to evaluate their effectiveness. The OIG has issued other reports on implementation of the PACT Act and will continue to monitor VA's implementation of the legislation.[13]

EFFECTIVE IT SYSTEMS AND BUSINESS PROCESSES TO SUPPORT QUALITY HEALTH CARE, ACCURATE AND TIMELY BENEFITS, AND EFFICIENT OPERATIONS

VA is modernizing numerous significant systems that are critical to its operations. However, as detailed in multiple proactive reports, the OIG identified breakdowns 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. These have typically included weaknesses in planning, insufficient stakeholder engagement, failures to promptly fix known issues, and program management or coordination deficiencies. The results have been long delays, billions of dollars in over-budget costs, low user acceptance, and gaps in functionalities that make it more difficult for VA personnel to do their jobs. In some cases, the modernization efforts have put patients, beneficiaries, and resources at greater risk for harm or loss. The OIG understands the tremendous complexity 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, their families, caregivers, and survivors.

The Electronic Health Record Modernization (EHRM) program is probably the largest contract in VA history and critical to continued patient safety and care at VHA. Since April 2020, the OIG has released 22 oversight publications on VA's rollout of its electronic health record system that identify critical missteps and lack of remediation.[14] Of the 93 recommendations issued to date, 32 have not yet been implemented—with eight open for more than three years. The open recommendations include VA minimizing the number of required mitigation strategies healthcare providers must use when the system goes live, determining whether veterans' appointments are being scheduled correctly, and addressing unresolved issues that could hinder the system from resolving major performance incidents and outages. Unless VA more effectively manages all affected offices and contractors, IT solutions will continue to be delayed, more cost overruns will occur, and the risk to patients and VA operations will increase.

Although VA lifted the June 2022 EHRM rollout pause, users of the new system continue to raise issues that the system hinders the delivery of prompt, high-quality patient care. Moreover, VA has not adequately addressed open OIG recommendations focused on the need to develop a reliable, high-quality schedule for future rollouts, in addition to the many other open EHRM recommendations. The effects on staff, workload, and the risks for errors are also concerning. In March 2024, the OIG reported that an error in the system led Columbus (Ohio) facility staff to not complete the minimum scheduling efforts following a missed appointment for a patient who later died by drug overdose.[15] The OIG team determined that for sites using the new electronic health record system, VHA required fewer patient contact attempts following missed mental health appointments. Essential to implementing and budgeting this multibillion-dollar effort, VA needs a high-quality, reliable, integrated master schedule to ensure all tasks are properly accounted for and fully completed. A 2022 OIG audit found, however, that this foundational master schedule had significant weaknesses, including missing tasks, no baseline schedule, and no

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[13] VA OIG, *VBA Provided Accurate Training on Processing PACT Act Claims but Did Not Fully Evaluate Its Effectiveness*, January 15, 2025; *VA OIG, Staff Incorrectly Processed Claims When Denying Veterans' Benefits for Presumptive Disabilities Under the PACT Act*, December 3, 2024.

[14] OIG reports may be found on the website at *All Reports*. *A list of EHRM* reports can be found by searching on the key word "EHRM".

[15] VA OIG, *Scheduling Error of the New Electronic Health Record and Inadequate Mental Health Care at the VA Central Ohio Healthcare System in Columbus Contributed to a Patient Death*, March 21, 2024.

risk analyses, meaning VA cannot offer reliable assurances on timelines and costs.[16] That schedule has still not been completed at this time. The OIG will continue to conduct oversight on VA's plan to begin deployment operations next year in Michigan.

VA's delivery of education benefits to veterans is also tied to a new IT system. In 2024, the OIG reported on VBA's delays and increased costs in transitioning to the Digital GI Bill platform.[17] Unclear contract requirements and unrealistic expectations led to delays. In addition, the project's integrated master schedule was not updated consistently due to the lack of an overall schedule that tracked external dependencies. Poor communication between VBA and the contractor contributed to critical scheduling failures that caused delays and increased costs. VBA later renegotiated the original contract, more than doubling the cost to $932 million. The OIG made three recommendations, all as yet unimplemented, to the then under secretary for benefits to increase the chances of successful implementation under the new contract through improved monitoring, regular communication with the contractor to ensure a consistent and updated master schedule, and strategies to address critical path failures.

There are many other IT modernization efforts that are also interdependent and have had significant stalls, setbacks, or stops. These include financial and supply chain management—also the subject of myriad OIG oversight reports.

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, high-quality services and benefits to eligible veterans and their families. Ineffective 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.[18]

In September 2024, the OIG testified to this subcommittee and its full committee about issues at the Hampton VA Medical Center in Virginia.[19] For each of the last three years (2022–2024), the OIG published healthcare inspections of the Hampton facility that substantiated concerns related to clinical care.[20] In the most recent 2024 report, there were unaddressed clinical care concerns involving the facility's then assistant chief of surgery.[21] The facility leaders at the time 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 errors when determining whether changes were needed to the assistant chief of sur-

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[16] VA OIG, *The Electronic Health Record Modernization Program Did Not Fully Meet the Standards for a High-Quality*, Reliable Schedule, April 25, 2022.

[17] VA OIG, *VBA Needs to Improve Oversight of the Digital GI Bill Platform*, August 28, 2024.

[18] In March 2018, the OIG reported on deficiencies within the VHA personnel suitability program, concluding that neither VA nor VHA effectively governed the background investigation process to ensure requirements were met at medical facilities nationwide. VA OIG, Audit of the Personnel Suitability Program, March 26, 2018. In September 2023, the OIG reported on similar deficiencies during a follow-up audit of VHA's personnel suitability program. VA OIG, *VA's Governance of Its Personnel Suitability Program for Medical Facilities Continues to Need Improvement*, September 21, 2023. These prior audits identified issues that could affect the entire VA enterprise, prompting the OIG to audit the background investigation process for VBA and the National Cemetery Administration staff and determine whether investigation actions were completed on time and recorded reliably. The OIG determined there were problems at every step of the process, making four recommendations, all still open, to the under secretaries of benefits and memorial affairs. VA OIG, *VBA's and NCA's Personnel Suitability Programs Need Improved Governance*, September 30, 2024.

[19] VA OIG, *Statement of Inspector General Michael J. Missal before the House Committee on Veterans' Affairs, September 10, 2024*; VA OIG, Statement of Jennifer Baptiste, MD, before the House Committee on Veterans Affairs, September 24, 2024.

[20] 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 (multiple healthcare providers did not appropriately manage abnormal test results for this patient and staff and leaders did not initiate or submit patient safety reports or peer reviews); 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 (facility leaders were unaware until the OIG inspection and the facility lacked oncology care controls due to missing/ineffective cancer committee, tumor board, and cancer registry); VA OIG, *Mismanaged Surgical Privileging Actions and Deficient Surgical Service Quality Management Processes at the Hampton VA Medical Center in Virginia*, July 23, 2024.

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

gery's clinical privileges.[22] Leaders also did not report the assistant chief to the state licensing board. Failing to report providers may result in medical facilities within and outside of VHA hiring providers who do not meet generally accepted standards of clinical practice. These leaders also lacked a basic understanding of the quality assurance processes that support the delivery of safe health care. These three reports collectively uncovered issues with care coordination, communication, quality of care, administrative and clinical oversight, quality assurance, and overall employee engagement. The identified deficiencies contributed to increased risks to patient safety and adverse outcomes.

In their oversight work, 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.

LEADERSHIP THAT FOSTERS RESPONSIBILITY FOR ACTIONS AND CONTINUOUS IMPROVEMENT

The OIG published a report that was featured in congressional hearings and the national media on senior executives in VA's central office being improperly awarded $10.8 million in critical skills incentives authorized by the PACT Act. It uncovered weaknesses in VA's governance, leadership, and accountability, with excessive deference to both VHA and VBA leaders by individuals responsible for providing necessary checks and balances.[23] The PACT Act authorized VA to award critical skill incentives to only those staff who possessed a high-demand skill or skill that is at a shortage. As detailed in OIG testimony before this committee in June, officials at multiple levels across VA did not ensure their actions met the requirements and intent of the law and did not successfully escalate concerns to then Secretary McDonough.[24] VA concurred with the OIG findings that the awards were inconsistent with the PACT Act and VA policy and that VA's internal controls were ineffective to prevent the improper awards. The OIG continues to monitor VA's progress in implementing these recommendations until sufficient evidence is provided to enable closure.

Other oversight work has revealed that VA leaders at every level often do not get the information they need to make effective decisions. Some also do not take necessary and prompt action, while others struggle to create a workplace in which every employee feels they can and should report problems. The frequent turnover in key positions or the long-term use of acting positions exacerbates these challenges.

In 2024, the OIG released three reports on the VA medical facility in Aurora, Colorado, also describing the kind of accountability failures that every facility leader should be vigilant in preventing. The OIG's first report found that key senior leaders created an environment in which a significant number of clinical and administrative service and section leaders and frontline staff felt intimidated, deeply disrespected, and dismissed.[25] For example, staff feared that speaking up or offering a difference of opinion to the Peer Review Committee 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

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[22] 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.

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

[24] VA OIG, *Statement of Inspector General Michael J. Missal before the House Committee on Veterans' Affairs*, June 4, 2024.

[25] 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. One of seven recommendations has been closed.

from relevant leaders and staff.[26] These problems were allowed to persist because VISN leaders did not fulfill their own required oversight of the medical center.[27] The third report found that telemetry medical instrument technicians were not properly monitoring patients and that staff did not properly enter a Joint Patient Safety Report following a patient's death.[28]

As to work that is forthcoming that illustrates the OIG's commitment to enhancing VA accountability, OIG teams are finishing work on the conditions and contributing factors to the FY 2024 supplemental request by VBA and the multibillion dollar shortfall in VHA's budget for FY 2025.[29] In accordance with the governing statute, the OIG will publish these reviews before March 19, 2025.[30] VA's ability to accurately forecast its administration and staff office budgets, and then properly execute appropriated funds, is dependent on adhering to the foundational elements of accountability.

CONCLUSION

The OIG has experienced that the overwhelming number of VA leaders and personnel are committed to serving veterans, their families, and caregivers, as well as answering the call for assistance from their local communities in times of crisis. They often have to navigate obstacles and overcome challenges to make certain that patients receive prompt high-quality care and that veterans and other eligible beneficiaries receive the compensation and services they are owed. Unfortunately, the OIG has found that VA has struggled with the foundations of accountability, including strong governance and clarity of roles and responsibilities; adequate and qualified staffing; updated IT systems and effectual business processes; effective quality assurance and monitoring; and leadership that fosters responsibility for actions and continuous improvement. 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.

Chairwoman Kiggans, Ranking Member Ramirez, and members of the Subcommittee, this concludes my statement. The OIG looks forward to working with you and this Congress to advance VA's delivery of care and services to veterans, their families, and caregivers. I would be happy to answer any questions you may have.

Prepared Statement of Donald Sherman

Chairwoman Kiggans, Ranking Member Ramirez, and members of the Subcommittee, thank you for the opportunity to testify regarding accountability at the U.S. Department of Veterans Affairs (VA).

The Department of Veterans Affairs is a large agency with a similarly large and important mission. The care, benefits and support veterans receive through the VA is the fulfillment of a promise that our nation makes, and must continue to make, to those who serve and protect our country. My family includes veterans who served in World War II, the Korean War and in the Marines as well as the Army. My grandfather proudly worked for many years at the VA in his hometown of Tuskegee, Alabama, made famous by the Tuskegee Airman. On behalf of myself and my organization, Citizens for Responsibility and Ethics in Washington (CREW), I thank our nation's veterans and military families for their service and sacrifice for our country.

In order to meet its critical mission, the VA plays many roles. It is one of the largest federal agencies in the government with functions including administering pensions, insurance and home loans for veterans, providing survivor support for veterans' families and running the Veterans Health Administration, the largest integrated healthcare network in the United States. It is incumbent upon Congress and

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[26] 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. All recommendations remain open.

[27] 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.

[28] VA OIG, *Failures by Telemetry Medical Instrument Technicians and Leaders' Response at the VA Eastern Colorado Health Care System in Aurora*, August 13, 2024. Five of the six recommendations remain open.

[29] 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. However, by July 2024, VHA estimated that it would need an additional $12 billion in FY 2025 for medical care. By November, that request was modified to $6.6 billion.

[30] The Veterans Benefits Continuity and Accountability Supplemental Appropriations Act, 2024, Pub. L. No. 118–92 § 104.

the president to ensure that the VA does not falter in fulfilling its mission. It is equally important to acknowledge that managing such complex systems is a daunting task. It is therefore perhaps unsurprising that the VA has experienced challenges across multiple administrations, Republican and Democratic. The inherent risks and challenges associated with operating a large agency make ensuring robust oversight and accountability absolutely critical.

As the members of this Committee know well, the VA's Office of Inspector General (OIG) has consistently played a key role in providing oversight to help the VA fulfill its mission and to ferret out waste, fraud and abuse in the agency. For decades under both Republican and Democratic administrations, the OIG has issued numerous reports and recommendations to improve the VA's operations, including 189 open VA OIG reports in 2020 during the final year of President Trump's first term and 197 open VA OIG reports in 2016 during the final year of President Obama's administration.[1]

Inspector General (IG) Michael Missal led VA OIG for more than eight years.[2] Mr. Missal was confirmed by the Senate in April 2016 after being favorably voted out of the Republican led Senate Veterans' Affairs Committee and unanimously voted out of the Republican led Senate Homeland Security and Governmental Affairs Committee.[3] Mr. Missal's confirmation was "urge[d]" by Chairman Ron Johnson so that the VA OIG could have "permanent, independent leadership."[4] The Chairman of the House Veterans' Affairs Committee at the time, Rep. Jeff Miller, expressed relief at Mr. Missal's confirmation, saying that he was "glad" that the Senate "finally confirmed a permanent" IG.[5]

In fiscal year 2024 alone, former VA Inspector General Missal's office issued "a total of 316 reports and 1,106 recommendations" and made a monetary impact of nearly $6.8 billion amounting to "a return on investment of $28:1" for every dollar spent on the inspector general's oversight.[6] And those savings still pale in comparison to the extraordinary work that VA OIG did to address veteran suicides and improve health outcomes for veterans and military families throughout the many years of Mr. Missal's leadership of the office.[7] That impact is priceless. Inspector General Missal's leadership of OIG garnered bipartisan approval for independent and vigorous oversight of the agency across the Obama, Trump and Biden administrations.[8] As the Military Times noted, Mr. Missal released numerous reports critical of VA

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[1] Department of Veterans Affairs Office of Inspector General, Semiannual Report to Congress Issue 76 (Apr. 1, 2016 to Sept. 30, 2016), https://www.vaoig.gov/sites/default/files/document/2023–08/VAOIG-SAR–2016–2.pdf; Department of Veterans Affairs Office of Inspector General, Semiannual Report to Congress Issue 84 (Apr. 1, 2020 to Sept. 30, 2020), https://www.vaoig.gov/sites/default/files/document/2023–08/vaoig-sar–2020–2.pdf).

[2] Council of the Inspectors General on Integrity and Efficiency (CIGIE), Inspector General Historical Data (July 25, 2017) https://www.ignet.gov/sites/default/files/files/IG%20History%20(PAS)%20-%207–25–17.pdf; Department of Veterans Affairs, Staff Biographies: Inspector General Michael J. Missal (last accessed Feb. 4, 2025) https://department.va.gov/staff-biographies/michael-j-missal/.

[3] PN897, 114th Cong. (2016), https://www.Congress.gov/nomination/114th-congress/897; Council of the Inspectors General on Integrity and Efficiency (CIGIE), Inspector General Historical Data, (July 25, 2017) https://www.ignet.gov/sites/default/files/files/IG%20History%20(PAS)%20-%207–25–17.pdf; Department of Veterans Affairs, Staff Biographies: Inspector General Michael J. Missal (last accessed Feb. 4, 2025) https://department.va.gov/staff-biographies/michael-j-missal/.

[4] Press Release, Senate HSGAC, Johnson, Committee Unanimously Approve Michael Missal For VA Inspector General, Jan. 21, 2016 https://www.hsgac.senate.gov/media/reps/johnson-committee-unanimously approve-michael-missal-for-va-inspector-general/.

[5] Press Release, House Veterans' Affairs Committee, Miller Statement on Senate Confirmation of VA Inspector General, Apr. 20, 2016, https://veterans.house.gov/news/documentsingle.aspx?DocumentID=876.

[6] Department of Veterans Affairs Office of Inspector General, Semiannual Report to Congress Issue 92 (Apr. 1, 2024 to Sept. 30, 2024 https://www.vaoig.gov/sites/default/files/document/2024–11/semiannual__report__to__congress__issue__92.pdf.

[7] Department of Veteran Office of Inspector General, September 2024 Highlights (Sept. 24, 2024) https://www.vaoig.gov/sites/default/files/document/2024–10/monthly__highlights__september__2024.pdf.

[8] See e.g., @SenatorTester, X (Feb. 16, 2022, 5:47 PM), https://x.com/SenatorTester/status/1494081013940641793; Press Release, Boozman, Hassan Introduce Bipartisan Legislation Requiring Mandatory Whistleblower Training for VA Employees, Office of Senator John Boozman (July 23, 2021) https://www.boozman.senate.gov/public/index.cfm/2021/7/boozman-hassan-introduce-bipartisan-legislation-requiring-mandatory-whistleblower-training-for-va-employees; @SenCapito, X (July 31, 2020, 1:32 PM), https://x.com/SenCapito/status/1289252668695748609; and Press Release, Inspector General to Investigate Reports of "Wait Lists" at Colorado VA Facility, Senate HSGAC (Oct. 16, 2020), https://www.hsgac.senate.gov/media/reps/inspector-general-to-investigate-reports-of-wait-lists-at-colorado-v a-facility/.

officials during President Trump's first term as well as President Biden's term in office.[9]

Despite that staggering impact, Mr. Missal is not here today to testify about his oversight of the VA OIG during President Biden's tenure because President Trump unceremoniously fired him last month along with more than a dozen other independent agency inspectors general.[10] The firing of IG Missal came just days after Chairman of the Senate Committee on Veterans' Affairs Jerry Moran stated: "We work closely with the inspector general at VA... I find him valuable both to me and to this committee, and he should be valuable to the Department of Veterans Affairs." [11]

Although it is beyond my expertise to opine on the state of VA's mission-specific operations, the mere existence of these reports highlights the value of robust oversight to ensure accountability at the VA. Without the work of the inspector general and the cooperation of past administrations, the waste, fraud, abuse and operational challenges identified in some of these reports and recommendations may never have come to light. And the efforts that administrations have taken to implement and correct these recommendations to better support our nation's veterans and military families likely would never have been possible. That includes efforts to address over 266,000 reports of potential wrongdoing, waste, abuse or inefficiencies received through the VA OIG hotline over the last eight fiscal years covering the Trump and Biden administrations.[12] During the first Trump and Biden administrations combined, the VA OIG's work resulted in cost savings with an estimated total monetary impact of over $40 billion.[13]

Inspectors general are critical to improving government agencies' efficiency in serving the American public and investigating fraud. In the nearly 50 years since the first inspector general positions were established, these officials have provided critical independent oversight that improved the integrity of our government. Crucially, inspector general terms were not designed to be tied to that of the president, because they provide oversight and accountability regardless of political party or who sits in the Oval Office. I am proud to have worked cooperatively with inspectors general and their staff during my tenure in the House, Senate and executive branch. At a time when there is a low global trust in government, the role of inspectors general is more important than ever to rebuild and strengthen that public trust.[14] Under both Presidents Trump and Biden, CREW has consistently pressed for Inspector General vacancies to be filled and advocated for strong independent oversight of federal departments and agencies.[15]

During President Trump's first term, my organization identified at least 25 actions taken by him to undermine the inspector general community, including firing two permanent IGs, removing three acting IGs without any clear justification and appointing four IGs to dual roles thus limiting their ability operate independently – a critical aspect of the IG role.[16] During his first term, President Trump also suggested that he would prevent the Special Inspector General for Pandemic Recovery from communicating with Congress about administration misconduct and obstruction, thus attempting to stifle Congress' constitutional oversight role.[17] These attempts to politicize IG offices undermined their independence, thus hindering their

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[9] Leo Shane III, *VA, DOD oversight questioned after Trump inspector general firings, Military Times* (Jan. 27, 2025), https://www.militarytimes.com/news/pentagon-congress/2025/01/27/va-dod-oversight-questioned-after-trump-inspector-general-firings/.

[10] *Id.*

[11] *Id.*

[12] These figures were calculated by CREW using reports *available at* "All Reports," Department of Veterans Affairs Office of Inspector General, https://www.vaoig.gov/reports/all.

[13] *Id.*

[14] OECD Survey on Drivers of Trust in Public Institutions – 2024 Results: Building Trust in a Complex Policy Environment, OECD, July 12, 2024, https://doi.org/10.1787/9a20554b-en.

[15] *President Biden should fill vacant inspector general and ethics roles*, CREW (Aug. 7, 2024), https://www.citizensforethics.org/legal-action/letters/president-biden-should-fill-vacant-inspector-general-an d-ethics-roles/; Donald K. Sherman, *12 Federal agencies still do not have permanent inspectors general*, CREW (Sept. 23, 2020, https://www.citizensforethics.org/reports-investigations/crew-investigations/12-inspector-general-vacancies/.

[16] Donald K. Sherman, *Trump's war on watchdogs and what Congress can do about it*, Citizens for Responsibility and Ethics In Washington (June 15, 2020), https://www.citizensforethics.org/reports-investigations/crew-reports/trumps-war-on-watchdogs-and-what-congress-can-do-about-it/.

[17] Charlie Savage, *Trump Suggests He Can Gag Inspector General for Stimulus Bailout Program*, The New York Times (Mar. 27, 2020), https://www.nytimes.com/2020/03/27/us/trump-signing-statement-coronavirus.html.

ability to identify waste, fraud and abuse. They were rightfully condemned by lawmakers on both sides of the aisle.[18]

Also critical to the mission of providing excellent care for our nation's veterans is the support of a strong, well-trained and experienced civil service to carry out the important mission of the department. Supporting veterans through the implementation of federal programs requires agencies to be staffed by individuals with a thorough understanding of statutory and regulatory schemes, institutional knowledge of the history of the programs, familiarity with relevant stakeholders inside and outside government, and substantial technical expertise. That is what the career civil service provides. Sometimes lost in the discussion about the civil service is that veterans make up 30% of the federal civilian workforce,[19] 53% of whom are disabled.[20] Attacks on the federal civil service is an attack on veterans. Right now, veteran unemployment stands at 2.8%, but that number could rise with efforts to weaken civil service protections and reduce the size of the federal workforce.[21]

Our merit-based system is critical to the government's ability to continue operating effectively, and is thus crucial to the protection of the health and welfare of America's veterans. The merit-based civil service system was created to replace its predecessor, the spoils system, under which, politicians would put in place political cronies [22] who often lacked the knowledge or expertise to fulfill their jobs in positions of power.

The first Trump administration sought to upend the merit-based civil service by implementing an executive order referred to as "Schedule F," which would have stripped employment protections away from thousands of career civil servants. Had Schedule F not been rescinded, independent civil servants could have been replaced with political loyalists who likely would have prioritized blind obedience over following the law, leading to a government more prone to corruption.

During President Trump's first term in office, the VA was specifically targeted by efforts to upend the civil service. In 2017, President Trump signed the VA Accountability and Whistleblower Protection Act into law.[23] Although the bill was ostensibly aimed at making it easier to remove government managers, in actuality the law was used to target low-level workers and retaliate against whistleblowers.[24] Between June 2017 (the month the bill was passed) and March 2018, 1,700 low level VA employees were removed from their positions, including housekeepers and food service workers, many of whom may have been veterans themselves.[25] An investigation by ProPublica found that whistleblowers and people who had filed discrimination complaints were among those fired. In 2018, the VA OIG reported significant staff shortages in the Veterans Health Administration, with high staff turnover being one

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[18] Press Release, Grassley Leads Bipartisan Call to Safeguard Inspector General Independence Following ICIG Removal (Apr. 8, 2020),https://www.grassley.senate.gov/news/news-releases/grassley-leads-bipartisan-call-safeguard-inspector-general-independence-following; Alexander Bolton and Laura Kelly, S*enate Republicans demand answers from Trump on IG firing*, The Hill (May 18, 2020), https://thehill.com/homenews/senate/498425-senate-republicans-demand-answers-from-trump-on-ig-firing/.

[19] Office of Personnel Management, Employment of Veterans in the Federal Executive Branch (Fiscal Year 2021), https://www.opm.gov/fedshirevets/hiring-officials/ved-fy21.pdf.

[20] *Id*.

[21] Department of Labor, Veteran Unemployment Rates (Jan. 10, 2025), https://www.dol.gov/agencies/vets/latest-numbers.

[22] *See "Spoils System,"* Encyclopedia.com; Machine Politics, PBS, https://www.pbs.org/wgbh/americanexperience/features/presidents-unity-garfield/; Gabe Lezra and Diamond Brown, FAQ: *The conservative attack on the merit-based civil service*, CREW (Jan. 25, 2024), https://www.citizensforethics.org/news/analysis/faq-the-conservative-attack-on-the-merit-based-civil-service/.

[23] S. 1094, 115th Cong. (2017), https://www.Congress.gov/bill/115th-congress/senate-bill/1094.

[24] Jasper Craven, *At the VA, a Law Meant to Discipline Executives is Being Used to Fire Low-Level Workers*, The Nation (May 10, 2018),https://www.thenation.com/article/archive/at-the-va-a-law-meant-to-discipline-executives-is-being-used-to-fi re-low-level-workers/; Department of Veterans Affairs Office of Inspector General, Failures Implementing Aspects of the VA Accountability and Whistleblower Protection Act of 2017 (Oct. 24, 2019), https://www.vaoig.gov/sites/default/files/reports/2019–10/VAOIG–18–04968–249.pdf .

[25] Jory Heckman, *VA reinstated 100 employees fired under widely challenged law, paid $134M to hundreds more*, Federal News Network (Oct. 29, 2024),https://Federalnewsnetwork.com/workforce/2024/10/va-reinstated–100-employees-fired-under-widely challenged-law-paid–134m-to-hundreds-more/; Isaac Arnsdorf, *The Trump Administration's Campaign to Weaken Civil Service Ramps Up at the VA*, ProPublica (Mar. 12, 2018),https://www.propublica.org/article/veterans-affairs-the-trump-administration-campaign-to-weaken-civil-service-ramps-up; Craven, *Supra* note 24.

of the top causes of the shortages.[26] These firings were so egregious that the VA paid roughly $134 million to the 1,700 former VA employees who had been wrongfully fired as part of a settlement it reached with the American Federation of Government Employees.[27] Yet, despite this successful legal challenge, the Trump administration and its allies indicated that the VA's system should be replicated across all federal agencies.[28]

As unprecedented, damaging, and in some cases illegal, as President Trump's actions were toward inspectors general and the civil service during his first term, what we have seen unfold in recent days is on an entirely different scale. If these attacks continue, they will harm all Americans, including our veterans.

On the day President Trump was sworn in, he signed a series of executive orders, including one essentially reinstating Schedule F.[29] In a separate executive order, President Trump implemented an immediate and broad hiring freeze across the government,[30] reportedly causing chaos for certain vacancies at the VA.[31] VA employees and applicants rightfully questioned the impact of the hiring freeze on vital care and services provided by the VA.[32]

President Trump's broadside attack against the government hasn't been limited to hiring – his administration is also taking aim at across the board government funding, including funding for programs that are designed to protect and support our veterans. Last week, the Acting Director of the Office of Management and Budget issued a memorandum, requiring every federal agency to pause "all activities related to obligation or disbursement of all Federal financial assistance, and other relevant agency activities that may be implicated by [President Trump's] executive orders."[33] According to reports, 44 separate financial assistance programs related to veterans were temporarily suspended while the department reviewed them to see if they were in compliance with OMB's funding freeze.[34] Although they were exempted from the freeze after they were reviewed, those included veterans' suicide prevention, homelessness, job training and nursing home support programs.[35] The memo, which was halted by two federal court judges who heard legal challenges to the rule, was later rescinded by the administration. In one of the judicial opinions, a federal district court judge wrote, "For many, the harms caused by the freeze are non-speculative, impending, and potentially catastrophic."[36]

President Trump's actions aimed at the civil service have produced, and will continue to cause, untold ripple effects across departments and agencies which will likely lead to complications, waste and opportunities for abuse. That is why oversight and accountability is needed now more than ever. Yet, within his first week in office, President Trump fired inspectors general and members of their staffs across 17 different federal agencies, including VA Inspector General Missal, who members of Congress from both sides of the aisle have lauded for his oversight work during both Democratic and Republican administrations.[37]

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[26] Department of Veterans Affairs Office of Inspector General, OIG Determination of Veterans Health Administration's Occupational Staffing Shortages (FY2018), https://www.vaoig.gov/sites/default/files/reports/2018–06/VAOIG–18–01693–196.pdf.

[27] Heckman, *supra* note 25.

[28] Arnsdorf, *supra* note 25.

[29] *Office of Personnel Management, Memorandum from Acting Director Charles Ezell to Heads and Acting Heads of Departments and Agencies on Guidance on Implementing President Trump's Executive Order, Restoring Accountability To Policy-Influencing Positions Within the Federal Workforce* (Jan. 27, 2025), https://www.opm.gov/policy-data-oversight/latest-memos/guidance-on-implementing-president-trump-s-executive-order-titled-restoring-accountability-to-policy-influencing-positions-within-the-federal-workforce.pdf

[30] The White House, *Executive Order entitled Hiring Freeze* (Jan. 20, 2025), https://www.whitehouse.gov/presidential-actions/2025/01/hiring-freeze/.

[31] Jory Heckman, *VA reinstates job offers to health care hires, but some still in limbo amid hiring freeze*, Federal News Network (Jan. 27, 2025),https://federalnewsnetwork.com/veterans-affairs/2025/01/va-reinstates-job-offers-to-health-care-hires-but-some-still-in-limbo-amid-hiring-freeze/.

[32] *Id*.

[33] Memorandum from Matthew Vaeth to Heads of Executive Departments and Agencies, Office of Management and Budget (Jan. 27, 2025),https://www.documentcloud.org/documents/25506361-omb-memo-on-Federal-aid-freeze/.

[34] Leo Shane III, *VA benefits won't be halted under White House funding freeze order*, Military Times (Jan. 29, 2025), https://www.militarytimes.com/news/pentagon-congress/2025/01/29/va-benefits-wont-be-halted-under-white-house-funding-freeze-order/.

[35] *Id*.

[36] Lindsay Whitehurst, *Judge in nation's capital extends block on Trump administration federal funding freeze*, AP News (Feb. 3, 2025),https://apnews.com/article/trump-federal-grants-loans-funding-freeze-court–1bc457d8e333dd8a8f374572ea33 927c.

[37] Campaign Legal Center., *The Significance of Firing Inspectors General: Explained* (Jan.31, 2025) https://campaignlegal.org/update/significance-firing-inspectors-general-explained; Leo

President Trump defended the firing of the inspectors general, saying that "it's a very common thing to do."[38] That is not the truth. The only precedent for such a mass firing of IGs by an incoming president after the passage of the Inspectors General Act of 1978 was the firing of 15 IGs by President Ronald Reagan in 1981 – an act met by strong disfavor, which was only eased when President Reagan re-nominated several of the removed IGs.[39]

As Hannibal Ware, the Chairperson of the Council of the Inspectors General on Integrity and Efficiency, publicly acknowledged, "IGs are not immune from removal. However, the law must be followed to protect independent government oversight for America."[40] Within the last 20 years, Congress has passed two laws with bipartisan support to prevent the precise type of action President Trump just took.[41] The Inspector General Reform Act of 2008, which established a requirement that Congress be notified in writing no later than 30 days before removal or transfer of an IG,[42] and the Securing Inspector General Independence Act of 2022, provisions of which became law as part of the James M. Inhofe National Defense Authorization Act for Fiscal Year 2023, added a requirement that Congress be given a detailed account of the justification for the removal of an inspector general and the inspector general remain in place for 30 days while Congress considers that justification.[43]

The firings of the IGs by President Trump were made all the more concerning because President Trump failed to follow the law and provide the legally required 30-day notice and case-specific reasons for removal, as Chairman Chuck Grassley and Ranking Member Dick Durbin of the Senate Judiciary Committee recently noted in a letter to President Trump.[44] The fact that these inspectors general appear to have been fired without cause suggests that they may have been fired to stifle oversight of the new administration and raises questions about whether the next inspector general will be a partisan loyalist or simply fired on the president's political whim. Will anyone filling these posts actually conduct robust oversight? How can a federal employee stripped of their employment protections by Trump's executive orders feel comfortable going to a potential Trump loyalist hand-picked to serve as IG to blow the whistle on waste, fraud or abuse? These are important questions that I urge Congress to address.

It is critical that the VA has a permanent IG that has the expertise and institutional knowledge to provide continuity in the oversight work directed at addressing critical long-term challenges at the Department. For instance, the VA Office of Inspector General under Missal, conducted in-depth work reviewing healthcare staffing shortages, patient safety concerns, inadequate clinical care, as well as veterans'

Shane III, *VA, DOD oversight questioned after Trump inspector general firings*, Military Times (Jan. 27, 2025), https://www.militarytimes.com/news/pentagon-congress/2025/01/27/va-dod-oversight-questioned-after-trump-inspector-general-firings/; **Fired Inspectors General Raise Alarms as Trump Administration Moves to Finalize Purge**, The New York Times (Jan. 27, 2025),https://www.nytimes.com/2025/01/27/us/politics/trump-inspectors-general-fired.html); *See e.g., VA, DOD oversight questioned after Trump inspector general firings*, Military Times (Jan. 27, 2025) https://www.militarytimes.com/news/pentagon-congress/2025/01/27/va-dod-oversight-questioned-after-trump-inspector-general-firings/; *See e.g.*, House Committee on Veterans Affairs Minority, *Press Release: Ranking Member Takano's Statement on Trump's Late-Night Purge of 12 Inspectors General* (Jan. 25. 2025), https://democrats-veterans.house.gov/news/press-releases/ranking-member-takanos-statement-on-trumps-late-night-purge-of–12-inspectors-general.

[38] Manu Raju, Alayna Treene, Morgan Rimmer and Annie Grayer, *Trump fires inspectors general from more than a dozen federal agencies*, CNN (Jan. 25, 2025),https://www.cnn.com/2025/01/25/politics/trump-fires-inspectors-general/index.html.

[39] Congressional Research Service, *Removal of Inspectors General: Rules, Practice, and Considerations for Congress* (Updated January 25, 2025) https://crsreports.congress.gov/product/pdf/IF/IF11546.

[40] Council of the Inspectors General on Integrity and Efficiency (CIGIE), *Statement from Hon. Hannibal Ware, Chairperson of the Council of the Inspectors General on Integrity and Efficiency* (Jan. 25, 2025) https://www.ignet.gov/sites/default/files/files/CIGIE%20Statement%20—%201__25__2025.pdf

[41] Roll Call 661 for Bill Number: H.R. 928 Inspector General Reform Act of 2008 (Sept. 27, 2008) https://clerk.house.gov/Votes/2008661 ; Cosponsors Securing Inspector General Independence Act of 2021 https://www.congress.gov/bill/117th-congress/senate-bill/587/cosponsors.

[42] Public Law No: 110–409 (Oct. 14, 2008).

[43] Public Law No: 117–263 (Dec. 23, 2022).

[44] Letter from Senate Judiciary Chairman Chuck Grassley and Ranking Member Dick Durbin to President Donald J. Trump (Jan. 28, 2025),https://www.judiciary.senate.gov/press/rep/releases/grassley-durbin-seek-presidential-explanation-for-ig-dismissals (citing Pub. L. 117–263 The "President "shall" communicate to Congress in writing 30 days before removing or transferring an IG from office the "substantive rationale, including detailed and case-specific reasons" for the removal or transfer).

suicide risk and prevention.[45] It is important for veterans and military families that IG oversight in these areas continues unabated. Although VA Deputy IG David Case has been made acting IG, having an acting IG is a far cry from having a properly vetted and Senate-confirmed official serving in that role. As Senator Grassley has noted, permanent IGs are critical because "[e]ven the best acting Inspector General lacks the standing to make lasting changes needed to improve his or her office."[46] Moreover, an acting IG may not have the experience necessary, nor feel adequately empowered, to take sensitive and problematic issues to the Secretary or Congress as Inspector General Missal did when he confronted then-VA Secretary David Shulkin, in 2018, with allegations of the Secretary's own unethical conduct, including the improper acceptance of gifts and the misuse of agency resources.[47] Or like Mr. Missal's office did in May 2024 when it issued a report finding that the Biden VA erroneously awarded $10.8 million in recruitment and retention bonuses to senior executives, leading to an effort by then-Secretary McDonough to recoup those funds.[48]

To an administration that claims to value monetary efficiency in government, I would argue that firing inspectors general actually hinders efficiency and results in monetary waste. Mr. Missal's ouster certainly did not benefit any veterans or military families. Instead, attacking the IG and the civil service does a disservice to veterans and makes the VA more susceptible to waste, fraud and abuse.

Thank you. I am happy to answer your questions on ways to foster accountability at the VA and ensure our veterans and military families can get the help, care and support they deserve.

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[45] *See e.g.*, Department of Veterans Affairs Office of Inspector General, *Deficiencies in Inpatient Mental Health Suicide Risk Assessment, Mental Health Treatment Coordinator Processes, and Discharge Care Coordination* (Dec. 18, 2024),https://www.vaoig.gov/reports/national-healthcare-review/deficiencies-inpatient-mental-health-suicide-risk-assessment; Department of Veterans Affairs Office of Inspector General, Inadequate Staff Training and Lack of Oversight Contribute to the Veterans Health Administration's Suicide Risk Screening and Evaluation Deficiencies (Dec. 18, 2024), https://www.vaoig.gov/reports/national-healthcare-review/inadequate-staff-training-and-lack-oversight-contribute-veterans; Department of Veterans Affairs Office of Inspector General, *Mismanaged Surgical Privileging Actions and Deficient Surgical Service Quality Management Processes at the Hampton VA Medical Center in Virginia* (July 23, 2024),https://www.vaoig.gov/reports/hotline-healthcare-inspection/mismanaged-surgical-privileging-actions-and-deficient.

[46] Andrew Ackerman,*Maloney Named Interim SEC Inspector General*, Wall Street Journal (Jan. 27 2012), https://www.wsj.com/articles/SB10001424052970204573704577187443078314650.

[47] Department of Veterans Affairs Office of Inspector General, Administrative Investigation – VA Secretary and Delegation Travel to Europe (Feb. 14, 2018),https://www.vaoig.gov/sites/default/files/reports/2018–02/VAOIG–17–05909–106.pdf.

[48] Department of Veterans Affairs Office of Inspector General, VA Improperly Awarded $10.8 Million in Incentives to Central Office Senior Executives (May 9, 2024), https://www.vaoig.gov/reports/administrative-investigation/va-improperly-awarded–108-million-incentives-central-office; Eric Katz, *Lawmakers blast VA over executive bonus scandal, but secretary declines to offer any heads*, Government Executive (June 4, 2024), https://www.govexec.com/pay-benefits/2024/06/lawmakers-blast-va-over-executive-bonus-scandal-secretary-declines-offer-any-heads/397095/.

STATEMENTS FOR THE RECORD

Prepared Statement of Government Accountability Project

MR. CHAIRMAN:

Thank you for the opportunity to submit written testimony on the Department of Veterans Affairs (VA)'s Office of Accountability and Whistleblower Protection (OAWP). I serve as Legal Director of the Government Accountability Project (GAP), a non-profit, non-partisan whistleblower support and advocacy organization. I hope this testimony will provide additional context for matters not considered in the February 6 hearing. summarizes issues Government Accountability Project previously testified on four times in the previous hearings by this Committee.

GAP has engaged in aggressive oversight of whistleblower rights at the Department of Veterans Affairs (DVA) during the last two administrations. When I first testified in 2019, 10 DVA whistleblowers were 40% of my 25-client reprisal docket. The worst offender was the agency's whistleblower protection office, the Office of Accountability and Whistleblower Protection. During the Biden administration, the new OAWP chief resolved all the OAWP reprisal cases in an even-handed manner, and administratively instituted significant reforms that this Committee unanimously sought to institutionalize in the H.R. 8510, the Strengthening Whistleblower Protection at the Department of Veterans Affairs Act. At the end of this testimony, we recommend that this committee try again to codify the key reforms it approved previously.

HISTORY OF WHISTLEBLOWER RETALIATION

The DVA long has been the Executive branch's worst agency with respect to whistleblower retaliation. GAP's 40% rate of DVA whistleblowers compared to the rest of the government is consistent with that of the U.S. Office of Special Counsel. To illustrate from our clients, misconduct that whistleblowers were retaliated against for exposing included——

- gross mismanagement that led to multi-year waiting lists for patients who needed immediate care for life threatening conditions;
- lying to patients that they would receive timely care while concealing the secret waiting lists;
- sabotaging corrective action for waiting lists through unqualified, buddy system contracts;
- breakdown of the suicide prevention program;
- breakdown of the program to treat spinal cord injuries; and
- bribery that led to contamination of the water supply at a facility.

These examples are representative of a DVA pattern of betraying its mission to promote its own self-interest. It was encouraging, however, that whistleblower reprisal complaints to GAP dropped sharply during the last Administration.

THE OFFICE OF ACCOUNTABILITY AND WHISTLEBLOWER PROTECTION

The OAWP had a disastrous birth, with GAP receiving more whistleblowing disclosures and retaliation complaints from its staff than the rest of the Department. The Office was not producing results, as all the cases summarized above sought and failed to receive help. In particular, OAWP employees blew the whistle on mission breakdowns such as——

- gagging its own employees despite being a whistleblower protection agency;
- lacking enforcement authority due to veto authority for the agency General Counsel to veto actions;
- canceling its effective mentoring mediations program; and

• canceling counseling services that had assisted over 1,000 DVA employees.

Again, we were encouraged that the recent OAWP chief, Mary Donohue, had significant success turning the agency around. All the whistleblower retaliation complaints were resolved on fair terms. OAWP obtained its own counsel. The mentoring and counseling programs were restored.

While the progress was welcome, our organization and others have advocated that the improved practices be institutionalized through statutory requirements. We recommend that any further remedial legislation include the following:

1. **Independent Counsel for OAWP:**
By statute, OAWP must have independent legal counsel free from VA Officer of General Counsel (OGC) oversight. While OAWP attorneys now exercise significant autonomy, OGC retains control over disciplinary decisions. True structural independence must be codified.

2. **Transfer of Investigative Authority to the Office of Special Counsel (OSC):**
OAWP lacks enforcement power. Unlike OSC, it cannot litigate to enforce corrective action. Instead, it can only make recommendations VA officials routinely ignore. If OAWP retains investigative authority, Congress must grant it enforcement power to ensure real consequences for retaliation.

3. **Protection Against Retaliatory Licensing Board Referrals:**
DVA officials often circumvent whistleblower protections by referring employees to state licensing boards, effectively blocklisting them from their profession. This practice must be explicitly prohibited to prevent career-ending retaliation.

4. **Increased Transparency in OAWP Oversight:**
OAWP has improved its public reporting, but gaps remain. Unlike OSC, OAWP does not disclose its assessments of agency corrective actions. Congress should require parity with OSC's transparency standards, ensuring full oversight and public accountability.

5. **Mandatory Whistleblower Navigators:**
An early administration eliminated whistleblower counseling services, leaving employees to navigate a complex system alone. OAWP has reinstated a navigator function, but Congress should codify this as a permanent, mandatory service.

6. **Institutionalized Alternative Dispute Resolution (ADR):**
A prior OAWP mediation program successfully resolved whistleblower disputes without litigation. However, this initiative was discontinued. Congress should restore and mandate a no-fault ADR program to provide an alternative to prolonged legal battles.

7. **Tracking and Reporting Compliance with Recommendations:**
OAWP claims that 95% of its recommendations are accepted, but there is no data on whether they are implemented. Agencies frequently accept recommendations without acting on them. Congress should require annual reports on compliance and enforcement actions.

These reforms are necessary to ensure that OAWP serves its intended purpose: protecting whistleblowers and upholding accountability at the VA. While recent leadership changes have improved the agency's responsiveness, structural safeguards are essential to prevent regression.

Government Accountability Project remains committed to supporting these efforts and is on call however we can be helpful. Thank you for your time and attention to this matter.

Prepared Statement of American Federation of Government Employees, AFL-CIO

Chairman Kiggans, Ranking Member Ramirez, and Members of the Subcommittee:

The American Federation of Government Employees, AFL–CIO (AFGE) and its National Veterans Affairs Council (NVAC) appreciate the opportunity to submit a statement for the record on today's hearing titled "VA First, Veteran Second: The Biden-Harris Legacy." AFGE represents more than 750,000 federal and District of Columbia government employees, 310,000 of whom are proud, dedicated Department of Veterans Affairs (VA) employees. These include front-line providers at the Veterans Health Administration (VHA) who provide exemplary specialized medical and mental health care to veterans, the Veterans Benefits Administration (VBA) workforce responsible for the processing veterans' claims, the Board of Veterans' Appeals (Board) employees who shepherd veterans' appeals, and the National Ceme-

tery Administration Employees (NCA) who honor the memory of the nation's fallen veterans every day.

With this firsthand and front-line perspective, we offer our observations on the problems the Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017 has caused front-line VA Employees. Specially, AFGE has long objected to the VA's use of 38 U.S.C. 714 (§ 714) of the law and how it has harmed hardworking and dedicated employees. Additionally, through this experience AFGE is also aware of the failure of VA leadership to hold managers accountable under other provisions of the law. AFGE has supported efforts to amend the law to restore fairness to VA employees and encourages the committee to restore basic fairness to the VA workforce.

Background

Public Law 115–41, the Department of Veterans Affairs Accountability and Whistleblower Protection Act (Accountability Act or Act), was signed into law on June 23, 2017. At the time of its passage, supporters claimed the Act was intended to simplify and expedite the disciplinary process at VA so that it could better hold bad employees accountable. The Act is divided into two parts, Title I, which established the Office of Accountability and Whistleblower Protections (OAWP) and Title II, which governs Accountability and Adverse Actions for Senior Executives, VA Employees, and Supervisors disciplinary procedures. Within Title II, the bill enacted 38 U.S.C. § 714 which changed the following disciplinary procedures for bargaining unit employees (38 U.S.C. § 713 is for managers):

- Required management to make a final decision within 15 business days of proposing an adverse action (i.e., suspension of more than 14 days, demotion, or removal);
- Reduced the time period for an employee to respond to proposed adverse action to 7 business days;
- Reduced the time period for an employee to appeal the final adverse action;
- Lowered the standard of proof necessary to sustain an adverse action before a third party, such as arbitrators and the Merit Systems Protection Board (MSPB), from preponderance of the evidence to substantial evidence;
- Prevented third part adjudicators from mitigating the penalties assigned by VA.

Oversight

Since the Act's enactment, there has been robust oversight over the Act's implementation, and its effect on the workforce in multiple venues:

Congressional Oversight

The House Veterans' Affairs Committee held an oversight hearing in July 2018 before the Committee on Veterans' Affairs entitled "*The VA Accountability and Whistleblower Protection Act: One Year Later.*" [1] The committee's goal was to address problems caused by the VA's implementation of the Act. In his opening statement, then-Ranking Member Mark Takano addressed the VA's penchant to use the Act to disproportionately discipline rank and file employees as opposed to supervisors and other management officials stating: [2]

> "[Of] the 1,086 removals during the first five months of 2018, the majority of those fired were housekeeping aides...I also find it hard to believe that there are large numbers of housekeeping aides whose performance is so poor that it cannot be addressed. If that is truly the case, then it stands to reason that there are also management issues behind their poor performance. But of those 1,096 removals, only fifteen were supervisors which is less than 1.4%. Firing rank and file employees does nothing to resolve persistent management issues." He continued "it is not possible to fire your way to excellence."

AFGE also testified at this hearing citing how the law disproportionately harmed lower paid federal workers and not the managers who supervised them, and also further explained many of the structural problems with the law that continue to

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[1] *The VA Accountability and Whistleblower Protection Act: One Year Later: Before the H. Comm. On Veterans Affairs*, 115th Congr. (2018), https://republicans-veterans.house.gov/calendar/eventsingle.aspx?EventID=2212.

[2] *The VA Accountability and Whistleblower Protection Act: One Year Later: Before the H. Comm. On Veterans Affairs*, 115th Congr. (2018) (statement of Mark Takano, ranking member), https://republicans-veterans.house.gov/calendar/eventsingle.aspx?EventID=2212.

exist today.[3] AFGE has also commented on the Accountability Act and Whistleblower at other House Veterans' Affairs Committee hearings including before this subcommittee on May 19, 2021 at hearing titled "*Protecting Whistleblowers and Promoting Accountability: is VA Making Progress?*"[4] citing the problems with the current law and the need to pass reforms. AFGE also submitted a statement for the record before this subcommittee on March 9, 2023 discussing the problems with the 2017 accountability statute at a hearing titled "Accountability at VA: Leadership Decisions Impacting its Employees and Veterans."

Inspector General Investigation

In response to requests for an investigation from multiple legislators, the Office of Inspector General (OIG) highlighted VA's failure to properly implement the portion of the Act pertaining to whistleblower protection. The OIG issued a report, which explained, "in many instances, [OAWP] focused only on finding evidence sufficient to substantiate the allegations without attempting to find exculpatory or contradictory evidence."

Further, while VA front-line employees were being disciplined more often and more harshly under section 202 of the Accountability Act, the OIG report found that VA "struggled with implementing the Act's authority to hold executives accountable." OIG explained that despite statements from then-Secretary Shulkin, as of May 22, 2019, VA had only removed one covered executive employee under 38 U.S.C. 713, which addresses discipline for senior executives. Further, of thirty-five cases involving executives, VA mitigated the discipline of thirty-two.

The OIG investigation revealed unlawful whistleblower retaliation by OAWP itself, noting that after an OAWP employee made a whistleblower complaint, Executive Director O'Rourke instructed a subordinate to remove the employee. Finally, the OIG found that the VA did not comply with reporting and training requirements of the Act and failed to adequately report to Congress regarding the outcomes of disciplinary actions.

Freedom of Information Act

In an attempt to learn more about the VA's use of its authorities under the Accountability Act, on May 31, 2022, AFGE submitted a Freedom of Information Act (FOIA) Request to the VA. This request asked the VA to share, without violating the privacy of employees, the VA's use of Section 204 of the Veterans Affairs Accountability and Whistleblower Protection Act of 2017, 38 U.S.C. § 721, which authorizes the Secretary to issue an order, under certain circumstances, directing an employee to repay an award or bonus paid to the employee. This request covered the period from June 23, 2017, through May 31, 2022. In response to the AFGE's request, the VA responded on June 2, 2022, and stated that "This is a recently enacted VA policy and there are no responsive records." This is evidence that the VA has not utilized all of the tools at its disposal to hold employees accountable, and that the VA does not need additional tools for accountability.

Challenges in Federal Court

Since the enactment of the Accountability Act, the certain parts of the law have been challenged in federal courts, relating to the restrictions on the MSPB or third party adjudicators to mitigate a penalty. In *Sayers v. Dep't of Veterans Affairs*, the U.S. Court of Appeals for the Federal Circuit (Federal Circuit or Court) determined that, contrary to VA's contentions, the MSPB was permitted to review the penalty as well as the facts of a case under § 714. The Court explained that "[d]eciding that an employee stole a paper clip is not the same as deciding that the theft of a paper clip warranted the employee's removal." It is clear that prior to *Sayers*, the Agency promoted a limited review and harshly disciplined employees under § 714, often for similarly trivial acts.

The perceived inability to mitigate led judges to affirm decisions where even a single charge was proven by substantial evidence. Where the harshest available penalty, removal, was used liberally, this led to a loss of employee resources for the smallest of infractions. VA's rush to remove employees was clear in performance cases as well. As Administrative Judges believed they could not mitigate penalties, employees were removed for easily remedied performance failures.

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[3] *The VA Accountability and Whistleblower Protection Act: One Year Later: Before the H. Comm. On Veterans Affairs*, 115th Congr. (2018) (statement of AFGE National President J. David Cox). https://docs.house.gov/Committee/Calendar/ByEvent.aspx?EventID=108516.

[4] *Protecting Whistleblowers and Promoting Accountability: is VA Making Progress? Before the H. Comm. On Veterans Affairs Subcommittee on Oversight and Investigations*, 117th Congr. (2021) (AFGE Statement for the Record).

Another key element of the law examined by the courts is the elimination of the preponderance of the evidence standard, and the implementation of the new substantial evidence standard. In *Rodriguez v. Dep't of Veterans Affairs*, the Court held that the "preponderance of the evidence, rather than substantial evidence was the correct standard for management to apply at the administrative level in conduct cases under [§]714." [5] The Court explained that when determining whether conduct justified discipline under § 714, preponderance of the evidence was the correct evidentiary burden, and the MSPB's standard of review should be substantial evidence. Consequently, the Court found that VA had applied the wrong evidentiary standard in its § 714 conduct cases. The Court held in August 2021 that VA and MSPB must apply the *Douglas Factors* in deciding and reviewing the imposed penalty.[6]

By subjecting management's decisions to additional scrutiny, the Court demonstrated VA's overreach in its use of the Accountability Act. The use of § 714 has proven to have had its greatest impact on lower-level employees, compounding a staffing crisis while doing little to address systemic problems such as inadequate training and hostile managers. Thus, while the reviewing arbitrators, Administrative Law Judges, and Federal Circuit Judges have done much to curtail VA's broad interpretation of the law, the law itself must be amended if it is to accomplish its stated goal of improving systemic flaws in the Agency.

Furthermore, in the recent case *Richardson v. Department of Veterans Affairs*, the MSPB further limited the applicability of the law.[7] In *Richardson*, the MSPB ruled that an employee appointed under 38 U.S.C 7401(3), a "hybrid" Title 38/Title 5 employee, could not be terminated under § 714 as the text of 38 U.S.C. 7403(f)(3) dictated its reliance on "the procedures" of chapter 75 of Title 5.[8]

As a result of these and other legal rulings and determinations, the VA announced on March 5, 2023, that the VA will prospectively "cease using the provisions of 38 U.S.C. § 714 to propose new adverse actions against employees of the Department of Veterans Affairs (VA), effective April 3, 2023."

In the remaining 21 months of the Biden Administration, the VA reverted to using standard and well understood Title 5 discipline for employees covered by § 714, which provided discipline, including removal for VA employees, while simultaneously guarding the civil service protections of the dedicated VA workforce.

Suggested Reforms

Irrespective of the possibility that future VA Secretaries could reverse the Secretary's determination to cease using § 714, AFGE recommends two legislative changes to the Accountability Act:

Restore the Standard of Review to Preponderance of Evidence

38 U.S.C. § 714 established by the Accountability Act mandates that the MSPB uphold management's decision to remove, demote, or suspend an employee if the decision is supported by substantial evidence. While not defined in the law, management guidance defined substantial evidence as "relevant evidence that a reasonable person, considering the record as a whole, might accept as adequate to support a conclusion, even though other reasonable persons might disagree, or evidence that a reasonable mind would accept as adequate to support a conclusion."

Prior to the implementation of § 714, discipline based on unacceptable performance was considered under Chapter 43. Disciplinary actions to promote the efficiency of the service were considered under Chapter 75 of Title 5 of the United States Code. Under those chapters, a disciplinary action was upheld where substantial evidence demonstrated that the unacceptable performance took place under Chapter 43, and where a preponderance of the evidence demonstrated that the misconduct or performance took place under Chapter 75. The difference in the burdens of proof aligned with the differences in penalties, as Chapter 43 actions led to attempts to improve that performance whereas harsher penalties, to include immediate removal, were available for misconduct under Chapter 75.

As discussed in *Rodriguez v. Dep't of Veterans Affairs*, VA improperly read § 714 to mean that its burden of proof in justifying discipline was lowered to the substantial evidence standard. The Federal Circuit disagreed with the Agency's position, finding that the Agency conflated burden of proof and standard of review. Consequently, the Court found that the VA still had to meet the preponderance of the evidence burden of proof in its decision to discipline for conduct.

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[5] *Ariel Rodriguez v. Department of Veterans Affairs*, 8 F.4th 1290 (Fed. Cir.) (2021).
[6] *Stephen Connor v. Department of Veterans Affairs*, 8 F.4th 1319 (Fed. Cir.) (2021).
[7] Richardson v. Department of Veterans Affairs, Docket No. AT–0714–21–0109-I–1 (MSPB) (2023).
[8] *Id.*

Rodriguez clarified the difference between the burden of proof required of management, a preponderance of the evidence for conduct cases, and the standard of review by the MSPB, changed to substantial evidence under § 714. Even a proper reading of § 714, however, puts reviewers in a position they often have little choice but to rubber stamp VA's harsh penalties. Changing the standard of review to the preponderance of the evidence is necessary to ensure that VA reassumes the burden of proving that the claimed action occurred. Where an employee's job is on the line, VA's decisions should be held to a higher degree of scrutiny.

Restore the Authority to Mitigate Unreasonable Penalties

Connor v. Department of Veterans Affairs, spoke to the issue of mitigation. In that case, on appeal, the MSPB sustained only one of the 27 charges against the employee. On appeal to the Federal Circuit, the Agency argued it need not consider the *Douglas Factors* in § 714 proceedings.[9]

Under current statute established by § 714, the law provides that where the Agency's decision is supported by substantial evidence, the MSPB or an arbitrator may not mitigate the penalty. Thus, the MSPB or an arbitrator could only reverse an Agency decision it determined was unreasonable. MSPB had an extremely high rate of affirming Agency decisions even before the enactment of the Accountability Act. MSPB's affirmance rate of VA decisions was 83.7%, of the years recorded since, 2019 was the highest rate of affirmance at 89.44%. Few cases were mitigated prior to 2017, however, mitigation was available to reviewing entities, saving the time of sending back a case, causing needless delay.

The Accountability Act was promoted as enabling management to streamline the disciplinary process. VA's failure to use the right evidentiary standard and MSPB's inability to mitigate discipline caused many disciplinary cases to be returned to the Agency for time-consuming work and increased the time it took to process discipline.

AFGE strongly supports restoring the standard of review applicable to the Agency to the preponderance of the evidence and restoring the ability of reviewing bodies to mitigate penalties under § 714. Such changes would ensure fair determinations and streamline the disciplinary process.

Both of these recommendations would be enacted by passing H.R. 932, the bi-partisan "Protecting VA Employees Act."

Conclusion

AFGE thanks the House Veterans' Affairs Committee for the opportunity to submit a Statement for the Record for today's hearing. AFGE stands ready to work with the committee and the VA to address the workforce issues currently facing the department and find solutions that will enable VA employees to better serve our nation's veterans.

Prepared Statement of Disabled American Veterans

Chairman Bost, Ranking Member Takano and Members of the Committee:

Thank you for inviting DAV (Disabled American Veterans) to submit testimony for the record of this legislative hearing. As you know, DAV is a congressionally chartered and Department of Veterans Affairs (VA) accredited veterans service organization. We provide meaningful claims support free of charge to more than 1 million veterans, family members, caregivers and survivors. We are pleased to provide our views on the bills under consideration by the Committee.

H.R. 472, the Restore VA Accountability Act of 2025

DAV has consistently advocated for a culture of accountability within the VA, where VA employees are held to the highest standards of performance and conduct. We applaud the committee for its efforts to address longstanding issues within the VA and to ensure that federal employees are responsible for their actions. We concur that bad employees must be held accountable to ensure that the best federal employees are serving veterans; however, accountability must include due process principles, protecting the rights of employees, including veterans, who make up nearly 30% of VA's workforce.

H.R. 472, the Restore VA Accountability Act of 2025, makes several changes to the due process of appeals for employees at the VA. The Act would allow for expedited disciplinary actions for certain categories of VA employees based on substantial evidence of misconduct or poor performance. Specifically, the bill would remove

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[9] *Stephen Connor v. Department of Veterans Affairs*, 8 F.4th 1319 (Fed. Cir.) (2021).

the Performance Improvement Plan (PIP) requirement and the appellant's review by the Merit Systems Protection Board (MSPB).

Although the goal of the Restore VA Accountability Act is to increase accountability by streamlining the disciplinary process and ensuring that VA employees who do not meet performance standards or engage in misconduct can be held accountable more swiftly and effectively, DAV asks the committee to give careful consideration to our concerns, which may have an indirect impact on the high quality of care and benefits services provided to veterans.

DAV's major concern is the exclusion of the MSPB from the appeals process for federal employees. The MSPB has historically served as an independent and impartial body that reviews agency decisions and safeguards employees from arbitrary or unjust actions. By removing the MSPB from the appeals process, we risk depriving employees of a crucial avenue for redress and oversight.

Additionally, DAV has concerns with provisions that eliminate the necessity for PIPs before any disciplinary measures are taken. PIPs provide employees with a fair opportunity to address and correct performance issues before facing more severe consequences. Eliminating this critical step could lead to unjust disciplinary actions.

DAV wholeheartedly supports the Committee's commitment to accountability within the VA. However, striking a balance between holding civil servants accountable for their performance while maintaining the VA as an employer of choice for the best and brightest to ensure veterans receive the best care and timely services remains our priority.

We firmly believe that due process must not be compromised in pursuit of these goals, which has been reiterated within DAV's Resolution No. 138 that notes any bill enacted by Congress should include standards by which accountability can be measured while ensuring due process and fairness for VA employees subject to such standards.

H.R. 740, Veterans' ACCESS Act of 2025

The VA health care system is vital to millions of service-disabled veterans, offering comprehensive primary care and specialized programs tailored to their unique needs. While community care should be available as a supplement when the VA cannot provide timely, accessible, or high-quality care, it should not replace the VA's primary role in delivering and coordinating integrated care for enrolled veterans. The lack of expansion in the VA's capacity to meet the increasing demand for care has led to an over-reliance on external providers. The growing reliance on community care in recent years presents significant challenges to this comprehensive, evidence-based care model.

The VA MISSION Act of 2018 (P.L. 115–182) introduced a new process for integrating community care with the VA's hospital care, medical care, and extended care services, ensuring veterans receive the highest standards of care regardless of limitations within the VA health care system. The legislation aimed to expand access to non-VA care when necessary while strengthening the VA direct care system to meet the growing needs of enrolled veterans.

The Act established the Veterans Community Care Program (VCCP), setting wait time and travel distance standards. The goal was to ensure the VA maintained overall responsibility for veterans' care by coordinating their treatment and requiring community providers to meet the same quality standards as VA providers. Unfortunately, the VA has yet to implement the intended quality standards for non-VA providers or establish a robust care coordination program for veterans receiving both VA and community care.

The Act also included provisions to enhance the VA's internal capacity by improving the recruitment, hiring, and retention of qualified clinicians and addressing the longstanding neglect of the VA's aging health care infrastructure. Without sufficient infrastructure and capacity to meet the rising needs of veterans, the VA has turned increasingly to community care, which has seen more rapid growth than VA services. Despite significant increases in the VA's workforce over the past six years, the Department's health care infrastructure remains critically under-funded.

H.R. 740, the Veterans' Assuring Critical Care Expansions to Support Servicemembers (ACCESS) Act of 2025, aims to improve the provision of care and services under the VCCP and enhance veterans' health care with defined eligibility standards, mandatory notification of eligibility and denial of requests, consideration of veterans' care preferences, and extension of claim submission deadlines. It also seeks to streamline specialized mental health treatment programs with a standardized eligibility process and make improvements to the Mental Health Residential Rehabilitation Treatment Program (RRTP). The legislation also includes provisions to establish an interactive online self-service module for care, change requirements

for the Center for Care and Payment Innovation (CCPI), and mandate pilot programs and reports to ensure effective implementation.

The ACCESS Act stands to bring substantial changes to the VCCP, potentially impacting the VA's mission of delivering timely, high-quality, veteran-focused health care and services to enrolled veterans. As we move forward with proposed program changes, we believe that it is essential to appropriately balance the role community care plays in the VA's provision of specialized health care and support to our nation's ill and injured veterans.

The Independent Budget for fiscal year 2026–2027—coauthored by the DAV, Veterans of Foreign Wars and Paralyzed Veterans of America, calls on Congress to ensure that VA remains the primary provider and coordinator of care for veterans and that community care is available and accessible to veterans as needed to support and supplement VA care. With this background and context, DAV offers the following comments and recommendations regarding H.R. 740.

Section 101: Codification of Requirements for Eligibility Standards for Access to Community Care from the Department of Veterans Affairs

Section 101 of the bill would codify the minimum access standards for community care from the VA including all extended care services, except for nursing home care and mandate the VA to review these standards with an expanded stakeholder group and report to Congress triennially. Provisions in this section would prohibit telehealth appointments from fulfilling access standards if an in-person VA appointment is unavailable within the standards. It would also require that canceled VA appointments restart the wait time calculation from the original request date, and any deviations in wait time or distance agreed upon by a veteran and their provider must be documented and provided to the veteran and apply to all VA care and patients, whether new or established.

DAV has no concerns with codifying the eligibility standards for access to community care from VHA, while emphasizing the need for thorough and periodic reviews of these standards. However, we strongly recommend amending the provision that the Secretary shall not take into consideration the availability of telehealth appointments from the Department when determining whether the VA is able to furnish such care or services. We believe that a telehealth appointment should be considered as an option if agreeable with a veteran. Additionally, if a veteran is eligible and opts for an in-person community care appointment because VA only had a telehealth appointment available, that appointment in the community should be for an in-person appointment only. Telehealth services would have already been offered or provided by the VA under Section 105 of this act, which requires the VA to discuss telehealth with veterans as an option for care, both in the VA health care system and in the community, if telehealth is available, appropriate, and acceptable to the veteran.

We endorse the mandate in this section of the bill to document medical records and make them accessible to veterans through digital platforms such as VA.gov, email, and mobile text, except where veterans specifically request them and lack digital access.

Section 102: Requirement that Secretary Notify Veterans of Eligibility for Care under Veterans Community Care Program

Section 102 mandates the VA to promptly notify veterans of their eligibility for community care. To ensure clarity, we propose that the two-day notification requirement includes digital methods, as traditional mail may not meet the deadline. We recommend expeditious deployment of the External Provider Scheduling (EPS) system within the Community Care Network (CCN) to facilitate real-time scheduling when the VA cannot provide direct care or meet access standards, thereby enhancing more timely and effective communication and care coordination for veterans.

Section 103: Consideration of Veteran Preference for Care, Continuity of Care, and Need for Caregiver or Attendant

Section 103 of the Veterans ACCESS Act would require the VA to consider various factors when determining if it is in the best medical interest of a veteran to seek care in the community. These factors include the veteran's preference for when, where, and how to receive care, continuity of care, and the veteran's need or desire for a caregiver or attendant to accompany them.

We have concerns with the definition of veterans' preference for where, when, and how to seek hospital care, medical care, or extended care services. While we want the veteran's preference to be considered when determining the best option for care, the best medical interest including the distance to care, the frequency of care, and

the availability of appointments, should be the primary factors considered, as provided in the MISSION Act.

Section 104: Notification of Denial of Request for Care under Veterans Community Care Program

Section 104 mandates that if the VA denies a veteran's request for community care, it must provide the veteran with the reason for the denial and instructions for appealing the decision through the Veterans Health Administration's clinical appeals process. DAV has no concerns with this section. In fact, our benefits advocates stand ready to assist any veteran with filing a clinical appeal.

Section 106: Extension of Deadline for Submittal of Claims by Healthcare Entities and Providers under Prompt Payment Standard

Section 106 extends the deadline for health care entities and providers to submit claims for reimbursement for community care services from the current 180 days to up to one year after service, aligning with industry standards.

DAV has no concerns with this section, as it provides a more flexible timeframe for providers without compromising the timely processing of claims or the quality of care for veterans.

Section 202: Standardized Process to Determine Eligibility of Covered Veterans for Participation in Certain Mental Health Treatment Programs

Section 202 would require the VA to establish a standardized screening process to determine, based on clinical needs, whether a covered veteran satisfies criteria for priority admission to a covered residential rehabilitation treatment program (RRTP). As part of the evaluation process a veteran must be screened and admitted into a program within 48 hours if determined eligible for RRTP. Either a veteran or relevant health care provider can make the request for admission into a treatment program if they meet criteria for priority admission.

We recommend that the language in this section be amended to require that a VA clinician make the determination if the veteran meets the eligibility criteria for priority admission within 48 hours of the request.

We appreciate the provision in this section of the bill that requires non-department RRTP facilities to be properly licensed by a state and accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission.

Section 203: Improvements to Department of Veterans Affairs Mental Health Residential Rehabilitation Treatment Program

We appreciate that Section 203 includes requirements for the VA to develop a process for assessing the quality of specialized RRTP care delivered by both VA and non-VA providers, including the use of evidence-based treatments, cultural competency, clinical outcomes and oversight, and referral of billing practices.

The VA is advancing efforts to give veterans faster and simpler access to its mental health RRTPs, which provide around-the-clock support for substance use disorders, posttraumatic stress disorder, depression, and other mental health conditions common among veterans. Over 27,000 veterans were treated at VA RRTPs in fiscal year 2024, and we urge the department to increase its bed capacity to expand these critical services.

The VA's national RRTP conference in September 2024 underscored the high priority the VA is giving to fostering more timely access for veterans who need these programs. The VA is focused on implementing a new centralized screening process for each region. However, there are still limits to timely access to these specialized services, and we want to ensure veterans do not have barriers to accessing this life-changing care. Accountability and oversight are paramount to ensure facilities meet the quality of care standards, include veteran-centric programming, and demonstrate effective patient outcomes.

Section 301: Plan on Establishment of Interactive, Online Self-Service Module for Care

Section 301 mandates the VA to create an interactive, online self-service module to help veterans schedule appointments, track referrals, appeal care denials, and receive reminders for both VA and community care appointments.

DAV is supportive of this effort but suggests that alternative methods and adequate support be provided to bridge the digital divide and guarantee equitable access to care for all veterans, including those living in rural and remote communities.

Section 302: Modification of Requirements for the Center for Innovation for Care and Payment of the Department of Veterans Affairs and Requirement for Pilot Program

Section 302 would require the VA to establish and report to Congress on a three-year pilot program allowing enrolled veterans to access outpatient mental health and/or substance use services through community care network providers without referral or pre-authorization. This pilot program would be conducted in areas with varying degrees of urbanization, locations with high rates of veteran suicide, overdose deaths, calls to the Veterans Crisis Line, and long wait times for VA mental health and substance use disorder services. The VA would also be required to develop a care coordination plan with appropriate oversight and patient safety plans to monitor and support veterans participating in the pilot.

The bill requires development of robust metrics and measures to track and oversee the program's implementation, patient safety, and patient outcomes. Annual reports would be required to the Committee on Veterans' Affairs, detailing the number of participating veterans and health care providers, program effectiveness, costs, and other relevant matters.

We appreciate the intent behind the proposed pilot program aimed at improving access to outpatient mental health and substance use services for veterans. However, we have significant concerns about the bill's lack of a requirement for clinical authorization for such care from the VA.

While we fully support the goal of enhancing access to critical mental health and substance use services, the absence of a clinical authorization requirement raises serious questions about the quality and coordination of care. Clinical authorization is a key element in ensuring that veterans receive appropriate, evidence-based treatment that is tailored to their individual needs. Without this oversight, there is a risk of fragmented care, potential overuse or misuse of services, and the potential for insufficient monitoring of treatment outcomes.

The VA has a comprehensive understanding of veterans' unique health care needs and a robust system for coordinating care across the system. By bypassing clinical authorization, the bill may undermine the VA's ability to properly manage and oversee the delivery of care effectively. This could result in inconsistent treatment plans, gaps in care continuity, and ultimately, negative impacts on veterans' health outcomes.

We recommend that the bill be amended to include a requirement for clinical authorization from the VA for all services provided under the pilot program. This would ensure that veterans receive high-quality, veteran-centric, coordinated care that aligns with best practices and leverages the VA's expertise in managing veterans' health care and these specialized services. Incorporating this requirement will strengthen the program's effectiveness and safeguard the well-being of our veterans.

In conclusion, while we understand and support the intent of the pilot program, we urge the Committee to address the critical concern of clinical authorization. Ensuring that the VA retains a central role in authorizing and coordinating care will enhance the program's success and better serve our nation's veterans. We appreciate the opportunity to submit this statement and welcome further discussion on this important matter.

H.R. 1041, the Veterans 2nd Amendment Protection Act

and

Discussion draft to prohibit the VA Secretary from transmitting certain information to the Department of Justice for the NICS list.

The federal Gun Control Act of 1968, as amended, prohibits certain classes of persons from purchasing or possessing firearms and ammunition. One of the classes of prohibited persons are those who have been "adjudicated as a mental defective." A person may be "adjudicated as a mental defective" if a court, board, or commission finds that they are a danger to themselves or others.

Under the provisions of the Brady Handgun Violence Prevention Act of 1993, the Federal Bureau of Investigation (FBI) administers the National Instant Criminal Background Check System (NICS) that allows federally licensed firearms dealers to perform a required background check on potential buyers to ensure they are not prohibited from purchasing firearms and ammunition.

Historically, it has been the VA's policy to submit the names of all beneficiaries determined to be incompetent to the Attorney General for inclusion in NICS. However, incompetency within VA regulatory provisions (38 C.F.R. 3.353) defines a men-

tally incompetent person as someone who because of injury or disease lacks the mental capacity to contract or to manage his or her own affairs, including disbursement of funds without limitations. It does not address the requirement of a finding that they are a danger to themselves and others.

On March 15, 2024, VA announced that through the remainder of fiscal year 2024, VA would only report to the FBI NICS in instances when VA was aware that a mentally incompetent beneficiary had been found by a judicial authority to be a danger to themselves or others. While VA implemented this change and updated its electronic reporting, on March 11, 2024, VA stopped all weekly reporting to the NICS of mentally incompetent beneficiaries.

These bills focus on two main provisions that are essential to protecting veterans from unjust stigmatization and the loss of their Second Amendment rights without proper due process:

- The VA Secretary must notify the Attorney General that the basis for transmitting personally identifiable information of a beneficiary to the Department of Justice (DOJ) for use by NICS does not apply, or no longer applies, if such transmittal was solely based on a determination to pay benefits to a fiduciary.
- The VA Secretary shall not treat a person as having been adjudicated as a mental defective solely on the basis of requiring a fiduciary.

Additionally, the draft bill would require notification of lack of basis for the VA to have transmitted a veteran's information to the DOJ on or after November 30, 1993, for placement on the NICS solely on the basis of a determination by the VA to pay benefits to a fiduciary.

DAV supports these bills, to ensure that veterans are not unfairly stigmatized or deprived of their Second Amendment rights based on VA determinations without judicial oversight. Our veterans have dedicated their lives to defending the freedoms we hold dear, and it is our responsibility to safeguard their constitutional rights in return.

Discussion Draft, Student Veteran Benefit Restoration Act of 2025

Veterans have selflessly served our country, and it is our duty to ensure they receive the benefits they have earned. Unfortunately, some educational institutions have taken advantage of veterans, defrauding them of their well-deserved educational assistance.

This draft bill, the Student Veteran Benefit Restoration Act of 2025, would restore educational entitlements of those veterans who have fallen victim to fraudulent practices and would not be charged against their benefit entitlements. This includes periods when the institution was not approved or engaged in fraudulent activities. Additionally, educational institutions found guilty of fraud would be required to repay the VA Secretary any funds received fraudulently. This ensures that the burden of fraud is placed on the institutions rather than the veteran.

DAV supports this draft bill based on DAV Resolution No. 238, which calls for legislation that reduces and removes barriers to a service-disabled veteran continuing their education. We must ensure that we are protecting veterans and their hard-earned education benefits from fraud and deceptive acts.

Mr. Chairman, this concludes DAV's statement for the record.

Prepared Statement of Concerned Veterans for America

Statement for the Record

of

Nathan Anderson
Senior Advisor, Concerned Veterans for America

on

"VA First, Veteran Second: The Biden-Harris Legacy"

before the

Subcommittee on Health, House Veterans Affairs Committee

February 6, 2025

Thank you to Chairwoman Kiggans, Ranking Member Ramirez, and Members of the Subcommittee for the opportunity to submit this statement on behalf of Concerned Veterans for America (CVA). CVA is a grassroots network of thousands of veterans and military families dedicated to a freer and more secure America where every person is empowered to live their American dream. Our organization elevates veterans' unique perspectives in order to deliver people-empowering policy solutions, rooted in liberty-based principles, to the issues Americans face.

CVA's History in Veterans' Health Care Reform

Concerned Veterans for America has a thirteen-year track record as a leading advocacy organization for empowering veterans to seek the care that best meets their needs. CVA helped elevate the voices of VA whistleblowers who revealed that veterans had died while waiting for care on secret wait lists during the Phoenix VA scandal of 2014. In the aftermath of Phoenix, CVA also supported early reform efforts like the Veterans Access, Choice, and Accountability Act of 2014, which created the first options for veterans to seek care outside the VA. CVA also helped secure passage of the 2017 VA Accountability and Whistleblower Protection Act to change the personnel incentives that created the Phoenix scandal to begin with.

These early efforts culminated in the VA MISSION Act of 2018, which CVA helped shape and support in Congress. The legislation which passed with overwhelming bipartisan support, incorporated many of the recommendations of CVA's 2015 Fixing Veterans' Health Care Task Force—namely by creating the Veterans Community Care Program (VCCP).[1] 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.

Over the past four years, CVA has fought for additional congressional oversight as the Department of Veterans Affairs prioritized its bureaucratic interests over the well-being of veterans it exists to serve. Veterans have suffered because the VA has not properly followed the requirements of the MISSION Act, particularly when it comes to ensuring veterans have access to community care when eligible. This status quo has hurt veterans and must change under the new administration.

VA MISSION Act Implementation Failures Under the Biden-Harris Administration

During the Biden administration, the VA effectively picked and chose which portions of the MISSION Act it would follow in an effort to drive veterans to VHA facilities rather than offer community care alternatives, regardless of veteran preferences.

Despite its clear intent to offer veterans more control over their own health care, the MISSION Act made the mistake of giving the VA bureaucracy too much discretion to gatekeep community care access—instead of following the law, the Biden administration attempted to reduce community care usage as much as possible. The 119th Congress should learn from these mistakes and remove opportunities for bureaucratic meddling in veterans' health care choices in the future.

A Freedom of Information Act (FOIA) suit conducted by the Americans for Prosperity Foundation revealed that the VA undermined the MISSION Act's community care access standards and manipulated

[1] "Fixing Veterans Health Care: A Bipartisan Policy Task Force," *Concerned Veterans for America*, 2015. https://cv4a.org/wp-content/uploads/2016/01/Fixing-Veterans-Healthcare.pdf

wait time measurements which improperly reduced the number of veterans able to obtain community care referrals.[2]

Undermining Community Care Access Standards

As directed under the MISSION Act, the VA wrote the implementing regulations determining veterans' eligibility rules, or access standards, for community care. These access standards specify that when wait times at Veterans Health Administration (VHA) facilities exceed 20 days or a 30-minute drive from the veterans' residence for primary or mental health care, and 28 days or a 60-minute drive for specialty care, veterans are eligible for a community care referral.[3] The regulations also allow a veteran's VHA clinician to refer them to community care, regardless of wait or drive time, if he or she determines that doing so is in the veteran's best medical interest.

Over the past four years, the VA repeatedly chose to ignore these rules and even issue contradictory internal guidance. VA training documents recommended that schedulers not inform veterans of their community care eligibility unless veterans directly asked for it.[4] On top of this, VA scheduling scripts instructed employees to actively try to dissuade veterans from choosing community care instead of VHA facilities.[5] Veterans who knew about and wanted community care nevertheless faced a variety of obstacles for access.

VA training documents obtained via FOIA revealed that officials added an an additional approval layer for community care requests. Despite appearing nowhere in the MISSION Act or its implementing regulations, the VA created a new standard for determining whether a veteran's community care request was "clinically appropriate," which in practice functioned as an additional opportunity to improperly deny referrals despite no legal basis for the VA to do so.[6]

What's more, the VA allowed its administrators to overturn clinicians' assessment of a veteran's "best medical interest" for community care referrals.[7] VA internal guidance even created carveouts where wait time access standards were simply ignored for scheduling purposes without the veteran's consent.[8]

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[2] For detailed overviews of the evidence obtained via FOIA, see: "Records Confirm VA's Use of Inaccurate Wait Time Numbers," October 21, 2021, Americans for Prosperity Foundation, https://americansforprosperity.org/blog/records-confirm-va-inaccurate-wait-time-numbers/, and "More Evidence the VA is Improperly Delaying or Denying Community Care to Eligible Veterans," January 28, 2022, Americans for Prosperity Foundation, https://americansforprosperity.org/blog/va-denying-delaying-care/

[3] CFR § 17.4040

[4] "Unless the patient requests to review their other eligibility, no additional [community care] eligibility is required to be reviewed other than wait time." See: "Standard MISSION Act Guidance: Patient Eligibility and Scheduling Reference Sheet," *Department of Veterans Affairs*, October 28, 2020, pg. 2. https://americansforprosperity.org/wp-content/uploads/2021/09/03-Mission-Act-Guidance-Oct.-2020.pdf

[5] "Referral Coordination Initiative Implementation Guidebook," Veterans Health Administration, *Department of Veterans Affairs*, March 10, 2021. https://americansforprosperity.org/wp-content/uploads/2021/09/Referral-Coordination-Initiative-Guidebook.pdf#page=62

[6] VA training flowcharts obtained via FOIA: https://americansforprosperity.org/wp-content/uploads/2022/01/21-06268-F_Responsive_Records_1-Part-1.pdf#page=347

[7] 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/

[8] For example, the VA's internal community guidebook, obtained via FOIA, included directives such as "For Veterans with a Return to Clinic order with CID greater than 20/28 days, the wait time standard is considered waived." This guidance is in direct contravention to MISSION Act eligibility access standards, under which only a veteran can waive community care wait time standards. "Office of Community Care Field Guidebook," Veterans Health Administration, *Department of Veterans Affairs*, August 21, 2021. https://americansforprosperity.org/wp-content/uploads/2022/01/21-06268-F_Responsive_Records_1-Part-1.pdf#page=198

In October 2021, the VA announced it was shutting down its Office of Community Care and the VA MISSION Act website, which offered information about community care eligibility (missionact.va.gov).[9] This decision damaged efforts to educate veterans on their community care options while the MISSION Act was still relatively new. The Concerned Veterans for America Foundation ultimately took it upon itself to recreate the archived website (under the URL vamissionact.com) to preserve this clearinghouse for community care information.

The VA's core mission is caring for veterans. The agency should aid veterans in accessing whatever care veterans feel best meets their individual needs, whether inside or outside of the VA. Instead, over the past four years, the agency has focused on protecting its narrow bureaucratic interests by obstructing the treatment options those who have served our country.

Wait Time Manipulation

One of the VA's more alarming efforts to undermine the MISSION Act has been its widespread use of improper wait time measurements in direct violation of its own regulations. The MISSION Act's access standards, listed under CFR § 17.4040, clearly state that wait times for the purposes of community care eligibility determinations are to be calculated from the veteran's "date of request" for an appointment to the date the veteran is able to receive treatment.

FOIA evidence confirmed that, in contravention of MISSION Act implementing regulations, the VA used obsolete "patient indicated date" (PID) wait time criteria—a measurement dating from the earlier 2014 Choice Act.[10] In practice, PID measurements were usually set by a scheduler sometime after the veterans' initial appointment request and could dramatically reduce the appearance of wait times for reporting and community care eligibility purposes. This broken wait time system—eerily reminiscent of the conditions that created the Phoenix VA scandal—was criticized by the Government Accountability Office for being too subjective and prone to manipulation.[11]

Case studies from Arizona, Montana, Kansas, Tennessee, and Illinois FOIA data reveal that improper PID wait time measurements excluded large portions of veterans who were legally eligible for community care under the MISSION Act's "date of request" framework.[12]

A Leadership Culture Hostile to Community Care

All of these MISSION Act implementation failures are easier to understand given the anti-community care tone regularly set by senior VA leadership throughout the Biden administration.

In a June 2022 hearing before the Senate Veterans' Affairs Committee, former VA Secretary Denis McDonough suggested that the increasing popularity of community care was potential grounds to tighten

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[9] "VA embarks on process to design new model to deliver seamless integrated care," *Department of Veterans Affairs*, October 5, 2021. https://news.va.gov/press-room/press-statement-va-embarks-on-process-to-design-new-model-to-deliver-seamless-integrated-care/

[10] See examples of VA training materials using PID wait time measurements in: ""More Evidence the VA is Improperly Delaying or Denying Community Care to Eligible Veterans," January 28, 2022, Americans for Prosperity Foundation, https://americansforprosperity.org/blog/va-denying-delaying-care/

[11] Comptroller General Gene Dodaro to Secretary Denis McDonough, *U.S. Government Accountability Office*, May 10, 2021. https://www.gao.gov/assets/720/714332.pdf

[12] For more information on how PID wait time calculations have restricted community care eligibility, see: "Delayed and Denied Care: Transparency and Oversight Needed for VA Wait Times," *Concerned Veterans for America*, February 2022. https://cv4a.org/wp-content/uploads/2022/02/22_298900_VAPolicyBriefingHandout.pdf

access to further restrict eligibility.[13]

In an August 2023 town hall, then-Under Secretary for Health, Dr. Shareef Elnahal, told VA staff that they needed to drive more veterans to seek treatment at the VHA, encouraging them to "press the easy button less" with community care referrals, instead offering every VA option first before allowing veterans to seek an alternative provider.[14]

The VA "Red Team" Report Targeting Community Care:
The VHA commissioned a "Red Team" report, released in March 2024, which identified the growing popularity of the Veterans Community Care Program as a threat to be countered.[15] Citing rising community care costs, the Red Team report was an effort to further operationalize Secretary McDonough's misgivings about the VCCP.

The Red Team recommended a messaging campaign to convince veterans that VA services are superior, despite survey data in the VA's FY 2024 budget request indicating higher veteran satisfaction in the community care network than at VA hospitals.[16] The report also suggested including telehealth availability in wait and drive time calculations to be able to claim shorter VHA wait times and remove more veterans from community care eligibility.

The Red Team also argued for restricting community care access for certain care specialties it considered greater cost drivers. These specialties included emergency care, mental health, cardiology, and oncology.[17] Routing a veteran in need of an ER visit, a cancer screening, or access to a mental health professional to a VHA facility, regardless of wait time or distance, is a clear example of putting the VA first and veterans' urgent health care needs last.

Finally, the Red Team recommended "repatriating" veterans from community care providers to VHA facilities.[18] This practice would have plainly put VA bureaucratic interests over veterans' stated health care preferences while causing harmful disruptions to veterans' continuity of care.

In practice, the Red Team's recommendations directly translated into performance incentives for Veterans Integrated Service Network (VISN) Directors to reduce community care usage. For example, the Referral Coordination Initiative Plan for VISN 16 (covering parts of Mississippi, Louisiana, Arkansas, Texas,

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[13] Patricia Kime, "VA Weighs Limiting Access to Outside Doctors to Curb Rising Costs," *Military.com*, June 15, 2022. https://www.military.com/daily-news/2022/06/15/va-weighs-limiting-access-outside-doctors-curb-rising-costs.html

[14] "Veterans Affairs Under Secretary for Health: Video," *Empower Oversight*, January 18, 2024 https://empowr.us/veterans-affairs-under-secretary-for-health-video/; See also: Tristan Leavvitt to Secretary Denis McDonough, *Empower Oversight*, January 18, 2024. https://empowr.us/wp-content/uploads/2024/01/2024-01-18-TL-to-VA-community-care_Redacted.pdf

[15] Kenneth Kizer, et. al., "The Urgent Need to Address VHA Community Care Spending and Access Strategies," "Red Team" Executive Roundtable Report, March 2024. https://empowr.us/wp-content/uploads/2024/04/VA-Red-Team-Executive-Community-Care-Roundtable-Report-post.pdf

[16] This data was not available in the VA's FY 2025 budget request. See: "FY 2024 Budget Submission: Supplemental Information and Appendices," *U.S. Department of Veterans Affairs*, pg. 20. https://www.va.gov/budget/docs/summary/fy2024-va-budget-volume-i-supplemental-information-and-appendices.pdf

[17] Kizer, et. al., "Red Team" Executive Roundtable Report, March 2024. https://empowr.us/wp-content/uploads/2024/04/VA-Red-Team-Executive-Community-Care-Roundtable-Report-post.pdf, pg. 10-11.

[18] Ibid. pg. 14-16.

Oklahoma, Missouri, Alabama, and Florida) specifically identified a "decrease in [community care] referrals" and an "increase in direct care consults" as key performance indicators.[19]

VA officials also falsely presented the Red Team's report as impartial and separate from the VA. Secretary McDonough insisted to Senator Cassidy before the Senate Veterans Affairs Committee that the Red Team report was an "independent look," a characterization repeated by opponents of community care in the press.[20] FOIA records suggest otherwise.

Documents obtained by the Americans for Prosperity Foundation reveal that VA employees drafted and edited the Red Team report, despite no indications of this in the publication itself. Before the report was published, VHA Chief of Staff Ryung Suh indicated that the VHA planned to use the report's recommendation "as an opening step for a broader strategy to include an Interagency Task Force to look deeper at the issues raised in the report" as well.[21] These records suggests that the Red Team process was designed to support the Biden-Harris white house's goal of reducing community care usage rather than providing a truly independent assessment.

Focus on Community Care Took Focus Off Larger Cost Drivers

The Red Team's cost concerns about community care are unfounded. Though the VA's FY 2025 budget request indicates that 40% of veterans' care was handled through community care in 2023, these costs only accounted for 24% of the VHA discretionary medical care budget, suggesting that community care is disproportionately cheaper per patient than VHA care.[22]

In emails about the Red Team report obtained via FOIA, the VA even acknowledges that community care use only accounted for 15% of the VHA growing expenses between FY 2019 and 2023.[23] In contrast, 74% of VHA's spending increases were due to the cost of VHA care and staffing expenses.[24]

Lessons for the 119th Congress:

The past four years of VA mismanagement has revealed that congressional oversight is only the start of compelling a VA bureaucracy intent on limiting veterans' access to health care options to fulfill its true mission.

Ultimately, Congress needs to take greater responsibility for writing clearer, more specific statutes, less open to violation through malicious agency interpretation. Congress' role is even more important considering the U.S. Supreme Court's decision last year in *Loper Bright Enterprises v. Raimondo*, 144 S. Ct. 2244 (2024), which overruled the 40-year-old *Chevron* deference regime. The VA—like any other

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[19] Darin Selnick, Testimony before the House Committee on Veterans' Affairs, Subcommittee on Health, December 17, 2024.
[20] See: Suzanne Gordon and Steve Early, "Is Denis McDonough a Slow Reader?" *The American Prospect*, May 14, 2024. https://prospect.org/health/2024-05-14-is-denis-mcdonough-slow-reader-veterans-affairs/
[21] Kevin Schmidt, "VA's Claim of an 'Independent' Red Team Report Falls Apart Under Scrutiny," *Americans for Prosperity Foundation*, November 25, 2024. https://americansforprosperityfoundation.org/vas-claim-of-an-independent-red-team-report-falls-apart-under-scrutiny/
[22] Community providers delivered for 40% of care to VA enrollees, as measured in Global Relative Value Units, see: "Table: Global RVUs for VA and Non-VA Facilities," FY 2025 Budget Submission: Volume I, Supplemental Information and Appendices, *Department of Veterans Affairs*, pg 43. For the share of community care outlays within overall VHA discretionary medical care outlays, see "Table: Medical Care Appropriations by Account Category, Recurring Expenses Transformational Fund, and Medical Care Collections." FY 2025 Budget Submission: Volume II, Medical Programs, *Department of Veterans Affairs*, pg. 29. https://www.va.gov/opa/docs/remediation-required/management/fy2025-va-budget-volume-ii.pdf
[23] Kenneth Kizer to Hillar Peabody, et. al. April 9, 2024, obtained via Freedom of Information Act by the Americans for Prosperity Foundation. See: https://americansforprosperityfoundation.org/wp-content/uploads/2024/10/24-14214-F.pdf Pg. 3.
[24] Ibid.

agency—can no longer expect reflexive judicial deference to its understanding of how VHA activities should be carried out. Courts—and, by extension, officials within the VA tasked with the adjudication of veterans' claims—will instead need to focus on statutory text.

In the immediate term, the end of *Chevron* will likely mean more cautious rulemaking. But it could also witness a shift to the use of guidance, especially in future administrations. In either case, Congress's re-assertion of Article I authority must go hand-in-hand with robust oversight of the VA's regulatory and sub-regulatory actions.

There are several concrete steps that Congress could take in this respect.

First, Congress should quickly act to codify existing community care access standards. Doing so would provide veterans with certainty of their future care options and prevent VA leadership in future administrations from attempting to tighten community care access standards without congressional approval. Congress should similarly codify VA wait time calculation criteria on a "date of request" to "date of appointment" basis, the common-sense standard used elsewhere, to remove the potential for bureaucratic manipulation.

Second, Congress should consider tightening its delegation of general rulemaking authority to the Secretary under 38 U.S.C. § 501, which previous administrations have liberally construed to the detriment of veterans.

Third, Congress should remain vigilant when the VA claims special technical expertise in the administration of congressionally created programs, as if such bureaucratic expertise can insulate agency action from legislative oversight or judicial review.

Finally, Congress could consider how it might revitalize the so-called "veteran's canon," which directs that any ambiguity in the law—whether statutory or regulatory—is to be resolved in favor of veteran beneficiaries. By regulating in line with this canon, the VA could simplify its bureaucracy, especially in complicated claims adjudications, and foster a regulatory apparatus that prioritizes veterans and advances their interests.

The Veterans' ACCESS Act

Fortunately, H.R. 740, the recently introduced Veterans' ACCESS Act of 2025, sponsored by House Veterans Affairs Committee Chairman Mike Bost, would address many of these deficiencies.[25] The bill would codify community care access standards, require the VA to notify veterans of their eligibility for the program, and mandate wait time calculation from the veteran's "date of request." The legislation also creates a pilot program allowing veterans to seek mental health care and substance use treatment, for which timely access is urgent, in the community without VA pre-approval.

Full Choice: The Veterans Health Care Freedom Act

The Veteran ACCESS Act's pilot program points toward a deeper lesson Congress should learn from the past four years of VA failures—the need for "full choice." The best way to remove opportunities for the

[25] "Veterans' ACCESS Act of 2025," Representative Mike Bost, *House Committee on Veterans Affairs*, February 2025. https://veterans.house.gov/uploadedfiles/veterans_access_act_of_2025.pdf

VA administrative meddling that violates the intent of Congress is to end the VHA's role as a gatekeeper for whether a veteran can choose to go to the VA or a community care provider to begin with.

H.R. 71, the Veterans Health Care Freedom Act, sponsored by Rep. Andy Biggs, would create a full choice pilot program that becomes permanent after a three-year trial in at least four VISNs.[26] This legislation would truly put veterans first in making the health care decisions that are best for their individual circumstances.

Conclusion

When speaking about veterans' health care, General Omar Bradley, the first administrator of the VA, noted, "we are dealing with veterans, not procedures; with their problems, not ours." Honoring America's promise to its veterans requires rededication to General Bradley's mindset. Unfortunately, over the past four years, VHA leadership lost sight of the fact that driving patients to its facilities alone is not its mission. Caring for veterans and improving their health outcomes should be the sole focus of the VA, regardless of where that care takes place.

Fortunately, by reclaiming its role in legislating from agencies and holding the VA accountable for systematically skirting the law, Congress can better serve veterans. Opportunities like the Veterans' ACCESS Act and the Veterans Health Care Freedom Act offer ready-made options for ensuring the mistakes of the past four years are not repeated in serving those who served our nation.

Sincerely,

Nathan Anderson
Senior Advisor | Concerned Veterans for America

[26] "Blackburn, Colleagues, Introduce Veterans Health Care Freedom Act," Senator Marsha Blackburn, January 24, 2025. https://www.blackburn.senate.gov/2025/1/issues/veterans/blackburn-colleagues-introduce-veterans-health-care-freedom-act