STATEMENT OF
THOMAS O'TOOLE, M.D.
ACTING ASSISTANT UNDER SECRETARY FOR HEALTH FOR CLINICAL SERVICES
VETERANS HEALTH ADMINISTRATION (VHA)
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
ON
PENDING LEGISLATION

May 21, 2025

Chairman Moran, Ranking Member Blumenthal, and other Members of the Committee, thank you for inviting us here today to present our views on several bills that would affect VA programs and services. Joining me today is Mr. Kenneth Smith, Acting Executive Director of Education Services, Veterans Benefits Administration (VBA), and Mr. Phillip Christy, Acting Principal Executive Director and Chief Acquisition Officer, Office of Acquisition, Logistics, and Construction.

S. 214 Monetary Enhancement for Distinguished Active Legends Act of 2025 (MEDAL Act of 2025)

Section 2 of this bill would state Congress' findings regarding the Medal of Honor.

Section 3(a) of the bill would amend 38 U.S.C. § 1562(a) to increase the codified monthly special pension rate payable to Medal of Honor recipients from $1,406.73 to $8,333.33, subject to periodic cost-of-living adjustments.

Section 3(b) of the bill would amend the same section of law to codify the monthly special pension rate payable to surviving spouses of Medal of Honor recipients—currently identical to the Veteran rate—at $1,406.73, subject to periodic cost-of-living adjustments.

VA supports this bill, subject to amendments and the availability of appropriations.

VA concurs with the findings of Congress in section 2 that Medal of Honor recipients have earned a substantial increase to monthly special pension rates in recognition of their gallantry and intrepidity at the risk of life above and beyond the call of duty. Additionally, VA notes that the Department of Defense has raised concerns that need to be addressed. VA welcomes the opportunity to meet with the Department of Defense and the committee to provide technical assistance and edits to the bill.

Under current law, the monthly pension rate payable to a surviving spouse is unquantified but identical to the codified monthly pension rate payable to a Veteran. Under both current law and the proposed bill, these rates will be increased by the same percentage as any annual cost-of-living adjustments made to benefit amounts payable under title II of the Social Security Act.

At present, because of prior cost-of-living adjustments to the codified amount, the monthly pension rate payable to both Veterans and surviving spouses is $1,712.94. VA notes, however, that section 3(b) would codify a specific monthly pension rate of $1,406.73 for surviving spouses that is lower than that which they currently receive. Thus, the current bill would effectuate a reduction in special pension payable to surviving spouses.

Additionally, the proposed codified monthly rate for Medal of Honor special pension payable to surviving spouses ($1,406.73) is below the current monthly rate for Dependency and Indemnity Compensation (DIC) of $1,653.07, effective as of December 1, 2024. VA highlights this because 38 U.S.C. § 1562(a)(2)(C) does not allow a surviving spouse to receive both Medal of Honor special pension and DIC simultaneously. As a result of the proposed bill, DIC would become the greater monetary benefit. Surviving spouses would therefore be forced to choose between more monetarily valuable but less prestigious DIC benefits and more prestigious but less monetarily valuable Medal of Honor special pension benefits.

VA suggests amending the Medal of Honor monthly pension rate in section 3(b)(2) of the proposed bill from $1,406.73 to $1,712.94 to ensure Medal of Honor special pension would reflect current payment rates and be the greater benefit for a surviving spouse entitled to both DIC and Medal of Honor special pension. Furthermore, VA notes that this recommendation would be accurate only if the bill is enacted by November 30, 2025, because current Medal of Honor monthly special pension rates will be subject to any cost-of-living increase put into effect on December 1, 2025, pursuant to 42 U.S.C. § 401.

VA does not have a cost estimate for this bill.

S. 219 Veterans Health Care Freedom Act

Section 2(a) of this bill would require VA, acting through the Center for Innovation for Care and Payment (CICP), to carry out a pilot program in a minimum of four Veterans Integrated Service Networks (VISN) to improve the ability of eligible Veterans to access hospital care, medical services, and extended care services through the "covered care system." Section 2(b) would provide that VA would have to furnish such care and services at VA medical facilities, as well as at health care providers under the Veterans Community Care Program (VCCP) and eligible entities or providers that have entered into a Veterans Care Agreement (VCA, under 38 U.S.C. § 1703A). Section 2(c) would provide that eligible Veterans participating in the pilot program could elect to receive care or services at any provider in the covered care system. Section 2(d) would

require each eligible Veteran participating in the pilot program to select a primary care provider in the covered care system; this provider would be responsible for coordinating with VA and other health care providers with respect to care and services furnished to the participating Veteran and referring the Veteran to specialty care providers in the covered care system. VA would have to establish systems as appropriate to ensure a primary care provider can effectively coordinate the care and services furnished to a Veteran under the pilot program. Section 2(e) would allow eligible Veterans participating in the pilot program to select any specialty care provider in the covered care system from which to receive specialty care. VA could designate a specialty care provider as the Veteran's primary care provider if VA determined such a designation was in the health interests of the Veteran. Section 2(f) would allow participating Veterans to select a mental health care provider in the covered care system from which to receive mental health care. Section 2(g) would require VA to furnish to participating Veterans' information on eligibility, cost sharing, treatments, and providers to allow Veterans to make informed decisions.

Section 2(h)(1) would require VA to carry out the pilot program during a 3-year period beginning on the date that is 1 year after the date of enactment. Section 2(h)(2) would amend 38 U.S.C. § 1703(d) to add a new paragraph that would provide that, beginning on the date that is 4 years after the date of enactment, Veteran eligibility for VCCP would no longer be based on the existing five statutory eligibility criteria; instead, VA would have to furnish care and services to covered Veterans under the same conditions as articulated in section 2 of this bill (meaning Veterans could choose any provider from whom to receive care). The bill would also amend 38 U.S.C. § 1703A(a)(1) to add a new subparagraph (E) that would state that the requirements in law that care or services can only be furnished under this section when such care or services are not feasibly available from a VA facility or through a contract or sharing agreement would not apply with respect to furnishing care and services under this section beginning on the date that is 4 years after the date of enactment. Finally, section 2(h)(2)(C) would require VA, beginning on the date that is 4 years after the date of enactment, to furnish care and services to Veterans under chapter 17 of title 38, U.S.C., at VA medical facilities, regardless of whether the facility is in the same VISN as the VISN in which the Veteran resides.

Section 2(i) of the bill would require VA, on a quarterly basis for the first 2 years following enactment, to submit to Congress a report on the implementation of the pilot program; one of the reports would have to include a description of the final design of the pilot program. On an annual basis, beginning 1 year after the final quarterly report described above and ending on the date of the conclusion of the pilot program, VA would have to submit to Congress a report on the results of the pilot program.

Section 2(j) would authorize VA, in consultation with Congress, to prescribe regulations to carry out this section. Section 2(k) would state that no additional funds would be authorized to be appropriated to carry out this section, and the amendments made by this section. Section 2(l) would define various terms. The term "covered care system" would mean each VA medical facility, health care provider specified under

38 U.S.C. § 1703(c), and an eligible entity or provider that has entered into a VCA. The term "eligible veteran" would mean a Veteran who is enrolled in VA health care under 38 U.S.C. § 1705. The terms "hospital care," "medical services," and non-Department facilities" would have the meanings given those terms in 38 U.S.C. § 1701.

VA supports many of the principles in the bill but has significant concerns with specific provisions.

We support many of the principles in this bill. We appreciate that the bill's eligibility criteria would be simple to administer by making every enrolled Veteran in the pilot program eligible to participate. We also appreciate the bill would proceed in a phased approach, which could allow VA to incorporate lessons learned before national deployment. Further, we appreciate the bill's recognition of the importance of care coordination for Veterans receiving community care.

However, we have some concerns with many of the specific provisions in this bill. We note that the general model of eligibility proposed in this bill would depart significantly from the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (VA MISSION Act; P.L. 115-182), which VA and the Committee worked hard to enact, implement, and improve. We are aware of the Committee's interest in advancing the Veterans' Assuring Critical Care Expansions to Support Servicemembers (ACCESS) Act of 2025 (S. 275). As VA previously stated to this Committee, VA strongly supports the intent of the Veterans' ACCESS Act of 2025, and we appreciate the Committee's willingness to work together on this bill to improve it. The Veterans' ACCESS Act of 2025 is an important step in reaffirming VA's commitment to providing timely access to care and prioritizing Veterans. VA believes enacting the Veterans' ACCESS Act of 2025 would be a better way of ensuring Veterans can receive care from community providers as it builds upon and improves the VCCP established by the MISSION Act instead of replacing it altogether. Some amendments proposed by S. 219 would be difficult to enact in conjunction with the amendments proposed in S. 275.

In terms of our specific concerns with this bill, we offer the following.

Section 1703A authorizes VA to enter into VCAs and use VCAs in limited circumstances. These limitations were established because VCAs are not subject to general contracting requirements under the Federal Acquisition Regulations and the VA Acquisition Regulations. Section 1703A is an authority for how VA purchases care. The principal statute through which Veterans are authorized to receive community care is 38 U.S.C. § 1703, which established the VCCP. The proposed amendments to § 1703A would undo the limitations Congress established to ensure that VCAs are used on a limited basis when conventional procurement options are not available. Further, this bill would expand the scope of § 1703A to control both the authorization of care and the purchasing of care as well, duplicating the VCCP authority under section 1703. VA may use VCAs for individuals other than Veterans, and this bill would seemingly expand their

eligibility to elect to receive non-VA care in ways that are not contemplated by current statute and regulation. We recommend against changes to § 1703A.

The bill's efforts at modifying 38 U.S.C. § 1703, the VCCP authority, could create ambiguity that could have unintended effects on Veteran eligibility for community care. Specifically, the bill would reverse all existing criteria for community care eligibility except for permissive eligibility upon the determination by VA that a medical service line is not providing care that complies with VA's standards for quality (under 38 U.S.C. § 1703(e)). Further, prohibiting additional appropriations to carry out the amendments made by this bill would create the risk of a shortfall of funding if demand for community care increased. In such a situation, VA would be forced to delay care for Veterans when funds cease to be available.

The bill would amend § 1703(d) to require VA to furnish care and services to covered Veterans "with the same conditions on the ability of the veteran to choose health care providers" as provided for in this bill. However, those "conditions on the ability of the veteran to choose health care providers" are not well-defined. For example, section 2(c) would provide that eligible Veterans participating in the pilot program could elect to receive care "at any provider in the covered care system;" however, section 2(d)(2) would require the primary care provider of the eligible Veteran to coordinate with VA and other providers in the covered care system and refer Veterans to specialty care providers as clinically necessary. In this context, it is unclear whether the primary care provider issuing the referral determines which provider sees the patient or whether the patient determines which provider sees the patient. It seems likely that designated primary care providers, particularly those who are not VA employees, are unlikely to know how to make referrals within the "covered care system," and our contracts are not structured in a way to permit them to do so (except in limited circumstances where a bundled set of services has been authorized). If a non-VA provider were selected as the primary care provider, this could make care coordination by VA difficult, which could jeopardize patient care and limit VA's ability to ensure proper care is being authorized and furnished. Moreover, § 1703(a) would remain unchanged, and paragraph (2) of that subsection requires VA to coordinate the furnishing of care, while paragraph (3) of that subsection states that care and services can only be provided upon VA's authorization. It is not clear that VA could structure the pilot program consistent with these requirements.

There are several elements of VA care that are subject to additional restrictions or eligibility criteria such as dental or domiciliary care. Therefore, allowing Veterans to select their own provider could produce significant complications in verifying that such care is statutorily authorized. If enacted, Veterans could choose certain providers for certain care, and receive a referral for that care, before VA could determine whether or not the Veteran was eligible for such care. This could produce confusion and frustration for Veterans and providers.

We also note that the language allowing Veterans to elect to receive care outside their home VISN is unnecessary. This currently happens today in many situations,

particularly when Veterans are located along the border of two VISNs. Further, in the pilot program phase of this authority, it is unclear how this would affect a Veteran's ability to elect to receive care from a VISN that is not participating. Similarly, it is unclear whether this is intended to authorize additional beneficiary travel payments when Veterans elect to receive care at a different location. We note the bill would not alter VA's authority to furnish beneficiary travel payments, which are generally limited only to the nearest VA facility.

VA believes certain provisions would raise particular risks to VA and has some concerns regarding the contracting that would be required to implement this bill, and VA would appreciate the opportunity to discuss these further with the Committee.

The bill also refers to carrying out a pilot program through CICP, but it is not clear if this is intended to mean that the pilot program would involve a waiver request submitted to Congress for approval and otherwise subject to the limitations set forth in 38 U.S.C. § 1703E. Section 1703E(g)(2) generally prohibits VA from expending more than $50 million in any fiscal year (FY) in carrying out pilot programs. This proposal would almost certainly exceed that amount. It also is not clear that this proposal would meet the requirements of § 1703E(a)(3)(B), which requires VA to test payment and service delivery models to determine whether such models create cost savings for the Department. The pilot program proposed in this bill seems unlikely to do so.

The bill's reporting and briefing requirements under section 2(i) would represent additional administrative expense for the Department. Section 2(j), which would authorize VA, in consultation with Congress, to prescribe regulations, is ambiguous as to its intended effect. VA would need regulations to implement the pilot program, and it would need to promulgate regulations to reflect the changes that would be made to § 1703. However, this provision of the bill seems to condition VA's prescribing of regulations to only what is done in consultation with Congress. During the drafting and development phase of the rulemaking process, much of the work is considered pre-decisional and deliberative in nature. Section 2(g) would require VA to furnish to eligible Veterans' information on cost sharing, but other than VA copayments, there are no cost shares associated with care for VA enrollees. It is unclear if this reference is meant to authorize VA to impose additional cost shares or not.

Regarding extended care services, VA generally requires Veterans receiving nursing home care (whether in a VA community living center, a state nursing home, or a community residential center) to receive their primary care from the institutional providers to ensure there is no duplication of services and to avoid fragmentation of care. By including extended care services within the scope of this bill, the language could create situations where such care cannot be coordinated effectively, increasing the risk of adverse outcomes for Veterans.

VA also notes for the Committee's awareness that DoD providers would be among those participating Veterans could select under the bill language. If a sufficient

number of Veterans selected DoD providers for their source of care, this could put an unsustainable added workload on them.

VA notes that the MISSION Act was enacted almost 7 years ago and has been in effect for almost 6 years. VA supports the underlying intent of this bill but believes amending and expanding the MISSION Act through the Veterans' ACCESS Act of 2025 is a better path forward.

VA does not have a cost estimate for this bill but is concerned that this could have a significant effect on demand, which could also disrupt access to community care in participating markets. When combined with the prohibition on the authorization of additional appropriations, this puts VA's ability to carry out the VCCP and furnish Veterans community care in a difficult position.

S. 506 Coordinating Care for Senior Veterans and Wounded Warriors Act

Section 2(a) of this bill would require VA, in consultation with the Secretary of Health and Human Services (HHS), to carry out a pilot program to coordinate, navigate, and manage care and benefits to covered Veterans. Section 2(b) would state that the purposes of the pilot program would be to improve access to health care services for covered Veterans at VA medical facilities, from providers under the VCCP, from providers who have entered into a VCA, and from Medicare providers. Additional purposes would include improving outcomes and the quality of care received by covered Veterans, lowering the costs of care received by covered Veterans, eliminating gaps in care and duplication of services and expenses for covered Veterans, and improving care coordination for covered Veterans (including coordination of patient information and medical records between providers). Section 2(c) would require VA to carry out the pilot program through the CICP and in not less than four VISNs with a large number of covered Veterans and varying degrees of urbanization. Section 2(d) would require VA to assign each covered Veteran participating in the pilot program a case manager responsible for developing an individualized needs assessment for such Veteran and a care coordination plan with defined treatment goals. Case managers would be responsible for assisting such Veterans in accessing needed services and navigating the VA health care system and the Medicare program. Section 2(e) would require VA, in designing the pilot program and to the extent practicable, to use existing models (including value-based care models) used by commercial health care programs to improve access, health outcomes, quality, and customer experience while reducing per capita costs. Section 2(f) would require VA, to the greatest extent practicable, to contract with private sector entities carrying out commercial health care programs for assistance in designing, implementing, and managing care and benefits under the pilot program, including care coordination. If VA determined that such contracts were not practicable, it would have to provide notice and other information to Congress. Section 2(g) would require VA to track a number of metrics under the pilot program. Section 2(h) would provide that the pilot program would last for 3 years from its commencement. Section 2(i) would require VA submit quarterly reports (for 2 years, beginning from the date of enactment) to Congress on the development, implementation, results, and design of the pilot program, including information on the

tracked metrics under subsection (g). Not later than 1 year after the last quarterly report, and annually thereafter for the duration of the pilot program, VA would have to submit to Congress a report on the results of the pilot program; not later than 180 days before the termination of the pilot program, VA would have to submit to Congress a final report that includes VA's recommendation for whether the pilot program should be extended or made permanent. Section 2(j) would define the term "covered veteran" to mean a Veteran who is enrolled in both the Medicare program and the system of annual patient enrollment under 38 U.S.C. § 1705.

VA supports the intent of this bill, subject to amendments, but cites concerns.

VA supports the intent of this bill to improve care coordination and benefit alignment for Veterans who are enrolled in both VA health care and Medicare. Veterans dually eligible for these programs often experience fragmented care, duplicative billing, and confusion navigating their benefits. We share the Committee's goal of improving access, reducing administrative burden, and ensuring that Veterans receive timely, coordinated care—whether through VA or Medicare. However, while we support the bill's objectives, VA has several concerns that we believe must be addressed to ensure effective implementation. First, the bill does not provide sufficient detail regarding how the pilot program would operate in practice. VA is already required to coordinate care under its statutory authorities—either when delivering care directly through VA facilities under 38 U.S.C. § 1710 or when furnishing care through community providers under 38 U.S.C. § 1703(a)(2). The bill's interaction with those authorities remains unclear. In addition, VA is currently required to administer an education program under section 7331 that informs Veterans about their health care options and how their VA benefits interact with other public and private insurance. This program would need to be amended for pilot participants to the extent the pilot affects coordination between VA and Medicare.

Second, while the bill outlines commendable goals, such as improving access to Medicare providers and lowering costs of care for Veterans, some of these outcomes may already be addressed under current law or may not be fully achievable without broader statutory changes. For example, most Medicare providers already meet eligibility requirements to participate in the VCCP under section 1703(c)(1). Moreover, the bill seeks to reduce costs to Veterans, but some cost-sharing is required by statute under both Medicare and VA programs. Veterans may be responsible for a copayment under one program or the other, and the bill does not alter these statutory requirements. The bill also references eliminating gaps and duplication in care, but it is unclear what specific gaps are being referenced or how the pilot would eliminate duplicative services without limiting Veterans' access to benefits under either program. VA also has concerns with the bill's approach to case management. The assignment of a dedicated case manager may duplicate existing efforts by VA's integrated care teams, including the work already performed by VA primary care providers and care coordinators. Veterans often already have individual care plans and needs assessments; requiring a separate case manager to create new ones may introduce redundancy rather than

added value. We also note that while the bill in subsection (b)(1) discusses coordination between various VA providers and facilities and "health care providers participating in the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.)". "Health care providers" is not a defined term in the Social Security Act, and "participating in Medicare" may have a different meaning than intended. It may be more appropriate to use more inclusive language like "providers, physicians or other practitioners, or suppliers that are enrolled or participating in the Medicare program" to capture a broader group of individuals, facilities, and entities that provide care to Medicare beneficiaries.

Finally, while we appreciate the bill's intent to use established models for measuring access, quality, outcomes, and Veteran experience, VA may determine that a new or tailored model would better serve the goals of the pilot. The bill requires use of existing models "to the extent practicable," but this could inadvertently limit VA's flexibility to adopt more appropriate evaluation frameworks. In addition, the reporting requirements, while important for transparency and accountability, would require significant resources—particularly in staffing, IT infrastructure, and data analytics—which may divert capacity from direct care unless additional funding is provided. VA also notes that concerns raised in our testimony on S.219 regarding community-integrated care pilots apply here as well.

VA has other technical edits on this bill, including amending section 2(i)(3) to only require VA to submit recommendations, if any, for whether the pilot program should be extended or made permanent.

VA does not have a cost estimate for this bill.

S. 585 Servicemember to Veteran Health Care Connection Act of 2025

Section 2(a) of this bill would create a new section 1705B in title 38, U.S.C., regarding registration in a pre-transition system and facilitation of enrollment in VA health care. This new section would require VA, not later than 180 days before the anticipated separation from the Armed Forces of a member of the Armed Forces, to automatically register the member in the pre-transition health care registration system. Such registration would have to consist of the entry of relevant information of such member into such system so as to facilitate and permit, at a future date, a final determination with respect to the enrollment of such member in VA health care if the member elects to enroll and is eligible to do so. Proposed section 1705B(b) would require VA, not later than 30 days after separation of a covered individual from the Armed Forces, or as soon as feasibly possible following such separation, to engage the individual to assist and facilitate the completion of the process for enrolling in VA health care and scheduling an initial primary care or other health appointment for the individual with VA if the individual is interested in such an appointment. VA would have to communicate through a combination of effective mechanisms, including by electronic means (through email and text message), paper mail, and by phone. In this subsection, the term "covered individual" would mean an individual who is eligible for or expected to

be eligible for enrollment in the patient enrollment system but who is not yet enrolled. Proposed section 1705B(c) would require VA, to the greatest extent feasible, to conduct timely outreach to members of the Armed Forces registered in the pre-transition health care registration system (in advance of their separation from the Armed Forces) and to explain what such registration means, what steps each member must take after separation to enroll (if eligible) in VA health care. VA would also have to explain what health care services are available through VA upon enrollment (including the general rules of eligibility) and services that may be available without enrolling (such as counseling for military sexual trauma, readjustment counseling, and others). VA would also need to explain the steps required to access services limited to enrollees and those available without regard to enrollment. Outreach would have to be conducted through a combination of effective mechanisms as described above. If an individual enrolls in VA health care, VA would have to contact the individual at least once during the first 180 days following such enrollment if the individual had not scheduled a primary care or other appointment with VA and offer to schedule an appointment if the individual was interested. VA could conduct this outreach as part of the Solid Start program or other processes. Proposed section 1705B(d) would define the term "pre-transition health care registration system" to mean an information technology or other system or systems in which VA enters or stores the relevant information of a transitioning member of the Armed Forces to facilitate and permit, at a future date, a final enrollment determination with respect to the enrollment of such member in VA health care. Section 2(a)(3) of the bill would make this subsection and its amendments take effect on the date of the enactment of the Act; it would further state the amendments would apply to any member of the Armed Forces who is anticipated to separate from the Armed Forces on and after the date that is 1 year after the date of enactment.

Section 2(b) would require VA, not later than 1 year from enactment, in consultation with the Department of Defense (DoD), to establish and implement an automated process to implement the pre-transition health care registration system required under the proposed section 1705B. VA would have to provide a briefing to Congress not later than 180 days, 1 year, and 2 years after enactment on the implementation of this process.

Section 2(c) would allow VA, in implementing these requirements and amendments, to integrate and coordinate such implementation with the Solid Start program or other processes as VA determined appropriate to ensure collaboration and coordination with relevant DoD programs. On and after the date that is 1 year after enactment, DoD would have to include an explanation of the pre-transition health care registration system required by the proposed section 1705B as part of the Transition Assistance Program.

Section 2(d) would require VA to make enrollment in VA health care, including pre-transition health care registration under the proposed section 1705B, a simple and streamlined process for all transitioning members of the Armed Forces and Veterans. This process would need to facilitate access to and utilization of VA services to which the individuals are entitled, ensure such individuals have a healthy and smooth

transition out of the Armed Forces and into civilian life, to support their mental and physical health, and to reduce, to the greatest extent possible, Veteran suicide. VA would need to continuously monitor, improve, and modernize this process.

Section 2(e) would require VA to proactively conduct outreach to transitioning and recently transitioned members of the Armed Forces to assist them in enrolling in VA health care; proactively and regularly engage with enrolled Veterans to offer assistance in accessing VA health care; proactively and regularly engage with Veterans who may not be eligible to enroll in VA health care but may be eligible to access certain VA health services; proactively engage with Veterans from traditionally under-represented groups; and engage with Veterans who are eligible but not enrolled in VA health care and offer information and assistance regarding the steps to facilitate enrollment.

Section 2(f) would amend 38 U.S.C. § 8111(f), which requires VA and DoD to submit to Congress a joint report on health care coordination and sharing activities under such section, to require VA and DoD to report on information about the registration of members of the Armed Forces in the pre-transition health care registration system under proposed section 1705B.

Section 2(g) would require VA, in consultation with DoD and not later than 1 year after enactment, to submit to Congress a report on the feasibility and advisability of permitting transitioning members of the Armed Forces (including those on separation leave), while still on active duty, to receive at least one no-cost health care appointment at a VA facility. Not later than 1 year after the date of enactment, VA, in consultation with DoD, would also have to submit to Congress a report assessing VA's efforts regarding the pre-transition health care registration system; assessing any challenges experienced by VA in receiving timely and reliable information from DoD and other Federal or non-Federal entities regarding the separation of members from the Armed Forces; identifying an individual in the Senior Executive Service within VA that is coordinating (or will coordinate) all VA programs relating to improving the registration and enrollment of transitioning or transitioned members of the Armed Forces in VA health care; and describing how such individual manages or will manage various programs across VA.

Section 2(h) would establish a rule of construction that nothing in this section could be construed to require any member of the Armed Forces, former member of the Armed Forces, or Veteran to use any VA service or to enroll in VA health care.

VA supports the intent of this bill, subject to amendments and the availability of appropriations.

VA supports the overall intent of the proposed legislation as it would simplify the enrollment process for transitioning Service members and increase the number of Veterans who have access to health care. Veterans are most at risk for suicide and other adverse events in the year following discharge from the military. Those who are connected to VA for health care fare better than those who are not connected to VA.

This is especially true for those most at risk for poor outcomes, who might not be inclined to seek out help on their own but would attend appointments if they were scheduled. While the bill would not automatically enroll Veterans, it would put Veterans first and facilitate easier access to their earned benefits.

VA has some concerns with the specific language in the bill. For example, the bill would require VA to automatically pre-register all members of the Armed Forces at least 180 days before their anticipated separation. The term "Armed Forces" is defined in 38 U.S.C. § 101 to include the National Guard and members of the Reserve components. However, if such individuals have not satisfied the minimum active-duty requirements set forth in 38 U.S.C. § 5303A, they would not generally be eligible to enroll in VA health care (or access most VA benefits). Additionally, some individuals may have an anticipated separation date based on a disqualifying discharge from service; such individuals would generally be barred from eligibility under 38 U.S.C. § 5303. The bill would still require VA to collect and pre-register these individuals.

Additionally, the pre-transition health care registration system would have to consist of the entry of "relevant information…so as to facilitate and permit, at a future date, a final determination with respect to the enrollment of such member". See proposed § 1705B(a)(2). However, VA cannot make a final enrollment determination absent the individual's DD-Form 214. VA would have to interpret the phrase "relevant information" to mean "available information" at the time of such registration. Similarly, VA may require income information to determine eligibility, which VA could obtain from other Federal databases (such as maintained by the Internal Revenue Service (IRS) or Medicare); however, the IRS and VA would require additional authority to connect to those resource to verify eligibility without placing additional burdens on the transitioning Service member. Moreover, some information (such as preferred facility) could only be gathered with the input of the applicant. VA would also need to know at which facility to register the new Veteran, and this would require the input of the separating Service member. Further updates to TAP and other DoD data sharing may also be required.

VA also notes the effective date provision in section 2(a)(3) is unclear. The bill states that the amendments and the subsection would take effect on the date of enactment and apply to any member of the Armed Forces who is anticipated to separate on and after the date that is 1 year after the date of enactment. However, section 2(b)(1) provides VA up to 1 year from enactment, in consultation with DoD, to establish and implement an automated process to implement the pre-transition health care registration system. Read together, presumably VA would be required to manually implement the pre-transition health care registration system, but this could be labor- and resource-intensive. VA recommends providing sufficient time to establish an automated process and having the requirements in the proposed section 1705B apply from that date forward. We do note that the automated process would require significant updates to IT systems, which would require additional resources. Given these concerns, the timeline for implementation is insufficient.

Finally, because the pre-registration would occur automatically, there is a high risk that records will remain open, potentially for years, with no clear resolution. Generally speaking, individuals must apply for benefits, and if they do not complete an application with a certain period of time, VA can consider such claims as abandoned. The bill, however, would provide no such mechanism, so VA would presumably need to retain these records for at least the lifetime of the transitioning Service member. This could create additional (perhaps unnecessary) privacy risks, increase VA's administrative costs, and increase the potential for errors regarding information records. We recommend the bill clearly set forth a timeline for VA's record retention period.

VA has a few technical comments on the bill and would appreciate the opportunity to share these with the Committee. Similar to our discussion of S. 506, VA recommends amending section 2(g) to only require VA to submit recommendations, if any, for changes in law and legislative action.

VA does not believe the bill would result in a significant change in enrollment or utilization rates given current efforts to enroll transitioning Service members. However, VA would require additional staff and resources to facilitate this type of engagement for all separating Service members and to provide the reports required by this bill. Mandatory and discretionary costing have not been evaluated at this time.

S. 599 Driver Reimbursement Increase for Veteran Equity Act of 2025 (DRIVE Act of 2025)

This bill would amend 38 U.S.C. § 111, which authorizes VA to provide beneficiary travel benefits, in two principal ways. First, it would amend subsection (g), which currently permits VA to adjust the mileage reimbursement rate for eligible individuals to be equal to the mileage reimbursement rate for the use of a privately owned vehicle by Government employees on official business when a Government vehicle is available. The amended text would require VA ensure the mileage rate is equal to or greater than the mileage reimbursement rate for the use of a privately owned vehicle by Government employees on official business when no Government vehicle is available; it would also make a conforming amendment to 38 U.S.C. § 111(a). Second, it would require VA, when VA exercises the authority under 38 U.S.C. § 111 to make any payments, to take such actions as may be necessary to ensure an allowance based on mileage paid under § 111(a) is paid not later than 90 days after the date on which a request for such allowance is properly submitted to VA in accordance with such regulations as VA may prescribe.

VA does not support this bill.

VA is committed to delivering Veterans the health care and benefits they have earned. Recognizing that transportation can be a barrier for many Veterans in accessing timely and necessary medical care, VA has developed a range of robust programs to facilitate transportation for Veterans. These initiatives are designed to meet the diverse needs of Veterans and ensuring that no Veteran is left without options. VA

operates a number of programs designed to meet the transportation needs of Veterans, including:

- Veterans Transportation Service (VTS): The Veterans Transportation Service (VTS), operated under the authority of 38 U.S.C. § 111A(a) and 38 C.F.R. part 70, subpart B) offers a network of safe and reliable transportation options for Veterans. VTS provides door-to-door service through a fleet of vehicles at many VA medical centers. This service is particularly valuable for Veterans with disabilities or those who need additional assistance.
- Highly Rural Transportation Grants (HRTG): The Highly Rural Transportation Grant program (which would be amended by S. 784 and S. 827, discussed below) awards funds to eligible organizations to provide transportation services to Veterans in highly rural areas. These grants support efforts to bring Veterans from underserved, remote regions to VA medical facilities, enhancing their ability to receive care.
- Volunteer Transportation Network (VTN): The Volunteer Transportation Network, supported by the Disabled American Veterans (DAV) organization, and operated under the authority of 38 U.S.C. § 111A(b), mobilizes volunteers to provide free transportation to Veterans. These dedicated volunteers use their personal vehicles or VA-provided vehicles to ensure Veterans can attend their appointments without worrying about travel logistics or costs.
- Shuttle Services and Interfacility Transfers: Many VA medical centers provide limited transportation between VA facilities, including community-based outpatient clinics, or between different locations within a single VA campus. These shuttles help expand access by assisting Veterans and other eligible individuals who may require assistance in accessing VA facilities.

VA's beneficiary travel program (authorized by 38 U.S.C. § 111 and 38 C.F.R. part 70, subpart A) provides mileage reimbursement to eligible individuals traveling to and from locations for compensation and pension examinations, vocational rehabilitation and counseling, and health care. This program is essential in mitigating travel costs, particularly for eligible individuals residing in rural or remote areas. Currently VA reimburses mileage at the amount of $0.415 per mile. This bill would raise that amount to a minimum of $0.70 per mile, as that is the rate currently established by the General Services Administration (GSA) as of January 1, 2025.

According to the Government Accountability Office (GAO) report, "VA Health Care: Additional Assessments of Mileage Reimbursement Data and Veterans' Travel Costs Needed" (GAO-24-106816; May 2024), the current mileage reimbursement rate of 41.5 cents per mile, set by Congress in 2010, covers the cost of fuel for Veterans traveling 25 miles or more round-trip. Additionally, VA's beneficiary mileage rate is almost double the standard mileage rate set by the IRS for tax-deductible expenses. As of December 19, 2024, the IRS standard mileage rate for medical travel was 21 cents per mile (IR-2024-312). Maintaining the current rate allows VA to allocate resources more effectively across a range of transportation initiatives that benefit a broader segment of the population of eligible individuals, including Veterans.

VA does not have a cost estimate for this bill, but by increasing the mileage reimbursement rate for all Veterans and eligible individuals, this bill would significantly increase costs for health care and the Medical Disability Examination Office program; it also would increase mandatory costs for the Veterans Benefits Administration (VBA).

S. 605 CHAMPVA Children's Care Protection Act of 2025

This bill would amend 38 U.S.C. § 1781 to allow a child to be eligible to receive medical care benefits under VA's Civilian Health and Medical Program (CHAMPVA) until the age of 26. VA's CHAMPVA program is primarily for dependent spouses and children of certain Veterans, provided they do not qualify for DoD's TRICARE program for dependents. In the absence of a CHAMPVA-specific definition, CHAMPVA relies on the definition of "child" that is codified in 38 U.S.C. § 101 and applicable to other VA benefits available to a child. Generally speaking, a child reaches the age of majority when the child attains 18 years of age. Some exceptions exist, namely for a child who, before attaining the age of majority, became permanently incapable of self-support, or who after reaching the age of majority is pursuing a course of instruction at an approved education institution up until the age of 23 years.

VA does not support this bill.

VA is not subject to the Patient Protection and Affordable Care Act (PPACA) as CHAMPVA is not a health insurance plan. Rather, it is a medical care benefit grounded in statute. No provision of the PPACA amends the title 38 definition of "child" which states that the age of majority is 18. Because CHAMPVA operates like a health insurance plan, there has been a lot of confusion and disputes over who can be covered.

This bill would extend a child's eligibility for CHAMPVA up until the age of 26, thereby aligning the age criterion for CHAMPVA eligibility with that applicable to health insurance dependent care coverage. It would, however, be a greater benefit than found in plans covered by the TRICARE Young Adult Program because this extended eligibility would be regardless of a child's marital status.

CHAMPVA is required by law to provide medical care to CHAMPVA beneficiaries in the same or similar manner as that which is provided to TRICARE dependents, and subject to the same or similar limitations as TRICARE. TRICARE provides premium based (to offset the cost to DoD) extended medical coverage for a young adult up until the age of 26 (provided the child is unmarried and meets certain other requirements such as ineligibility for employer-sponsored health insurance based on the young adult's own employment). Nonetheless, an unmarried child between the ages of 18 and 23 who is pursuing a course of instruction at an approved educational institution is eligible for CHAMPVA medical benefits only up until the child's 23rd birthday. VA believes this benefit coverage up to age 23 is sufficient for our beneficiary population. VA is also

concerned that the bill would require resources that could otherwise be used to support patient care.

The Department does not currently have a cost estimate for this bill, but by providing coverage to dependents up to the age of 26 under CHAMPVA, this bill would significantly increase costs for VHA.

S. 635 Veterans Homecare Choice Act of 2025

Section 2 of this bill would amend 38 U.S.C. § 1703 in two ways. First, it would amend subsection (c), which defines eligible entities and providers for purposes of the VCCP, to include any nurse registry, including any registered nurse, licensed practical nurse, certified nursing assistant, home health aide, companion, or homemaker furnishing services through a nurse registry. Second, it would define the term "nurse registry" in a new subsection (q)(3) to mean a person that satisfies any applicable state licensure requirement and that procures, or attempts to procure, contracts or other agreements on behalf of registered nurses, licensed practical nurses, certified nursing assistants, home health aides, companions, or homemakers under which such individuals can provide health care-related or assistive services and receive compensation for such services.

VA supports this bill, subject to amendments and the availability of appropriations.

VA supports efforts to increase the number of qualified providers under the VCCP; however, this bill's addition of nurse registries under § 1703(c) would likely have no significant effect on the VCCP because nurse registries already can be an eligible entity or provider. Any entity or provider that wants to participate in the VCCP must enter into an agreement with VA (or a third-party administrator) to furnish covered health care services and comply with the terms of that agreement and any applicable laws and regulations. Being an eligible entity or provider does not mean that such entity or provider is participating under the VCCP.

VA understands that some state laws (such as Florida) require providers in a nurse registry to be independent contractors that have agreements directly with the patient. It is unclear how VA would contract with the registry instead of the provider and still provide protections to Veterans with billing issues from independent contractors. This could present complications that would make the attempted inclusion of nurse registries, at least as described in this bill, more difficult.

The requirement that a nurse registry be a person that "satisfies any applicable state licensure requirement" could raise concerns that such persons would not meet the same standards required by other providers. Licensure requirements can vary greatly by state, and a state's requirement for nurse registry license alone may not provide enough oversight of these providers. Florida law, for example, appears to preclude any such oversight, where it states that "A nurse registry may not monitor, supervise,

manage, or train a registered nurse, licensed practical nurse, certified nursing assistant, companion or homemaker, or home health aide referred for contract under this chapter." *See* 2024 Florida Statutes, § 400.506(19). In this case, VA contracts would need to provide additional requirements to ensure patient safety that may be uniquely applicable to these registries.

We also have several technical concerns with the bill. The term "companion", for example, is undefined, and the intended effect of its inclusion is unclear. Additionally, the term "nurse registry" is defined to mean a person, while we believe in most situations the registry would be an entity. Further, a person or entity that "procures, or attempts to procure, contracts or other agreements on behalf" of nurses or other providers could potentially include a much broader category of organizations than is intended—labor unions or employment companies, for example, would seem to fit this description. Finally, the term "health care-related or assistive services" is undefined, and these may include services that are not hospital care, medical services, or extended care services (which is all that can be provided under the VCCP pursuant to § 1703).

VA does not have a cost estimate for this bill.

S. 649 Guard and Reserve GI Bill Parity Act of 2025

This bill would amend 38 U.S.C. § 3301(1)(B) to expand eligibility criteria for those who are on active duty to include active-duty service as defined in 10 U.S.C. § 101(d), inactive-duty training as defined in 10 U.S.C. § 101(d), or annual training duty. Under 10 U.S.C. § 101(d), the term "active duty" is defined as those individuals who are on full-time duty in the active military service of the United States including full-time training duty, annual training duty, and attendance, while in the active military service, at a school designated as a service school by law or by the Secretary of the military department concerned.

The bill would also amend 38 U.S.C. § 3301(1)(C) by expanding the eligibility criteria for those with active-duty service as a member of the Army National Guard or Air National Guard. Currently, such individuals are limited to those with service described in § 3301(1)(C) with full-time service: (i) in the National Guard of a State for the purpose of organizing, administering, recruiting, instructing, or training the National Guard, or (ii) in the National Guard under 32 U.S.C. § 502(f) when authorized by the President or the Secretary of Defense for the purpose of responding to a national emergency. The amendment would now define "active duty" to include: (i) full-time service in the National Guard of a State for the purpose of organizing, administering, recruiting, instructing, or training the National Guard, (ii) full-time service in the National Guard when performing full-time National Guard duty as defined in 32 U.S.C. § 101, which includes the Army National Guard and the Air National Guard, and (iii) full-time service in the National Guard when performing active duty, as defined in 32 U.S.C. § 101.

Currently, Guard and Reserve service is only creditable for the Post-9/11 GI Bill benefit if it's service in very limited circumstances: on active duty under a call or order to

active duty under §§ 688, 12301(a), 12301(d), 12301(g), 12301(h), 12302, 12304, 12304a, or 12304b of title 10 or section 712 of title 14; or in the case of a member of the Army National Guard of the United States or Air National Guard of the United States full-time service in the National Guard of a State for the purpose of organizing, administering, recruiting, instructing, or training the National Guard; or in the National Guard under section 502(f) of title 32 when authorized by the President or the Secretary of Defense for the purpose of responding to a national emergency declared by the President and supported by Federal funds.

The proposed legislation would be effective 1 year after the date of enactment. The amendments would apply to service performed on or after September 11, 2001.

Finally, the time limitation under 38 U.S.C. § 3321(a) for using VA education benefits acquired from the expansion of eligibility for Reserve and National Guard members by this bill would apply as if the amendments had been enacted immediately after the enactment of the Post-9/11 Veterans Educational Assistance Act of 2008 (P.L. 110-252).

VA will provide views on S. 649 to the Committee at a later date.

A cost estimate is not available at this time.

S 778 Lactation Spaces for Veteran Moms Act

This bill would add a new 38 U.S.C. § 1720M to require, not later than 2 years after enactment, that each VA medical center (VAMC) contain a lactation space. It would clarify that nothing in this section would authorize an individual to enter a VAMC or portion thereof if that individual is not otherwise authorized to enter. It would define the term “lactation space” to mean a hygienic place, other than a bathroom, that is shielded from view, free from intrusion, accessible to disabled individuals, contains a chair and a working surface, is easy to locate, is clearly identified with signage and is available for use by women Veterans and members of the public otherwise authorized to enter a VAMC to express breast milk.

VA supports this bill, subject to amendments and the availability of appropriations.

Since 2010, Federal agencies have been required to provide employees with a private space, permanent or temporary, that is shielded from view and free from intrusion from coworkers and the public, to allow employees to express breast milk for up to 1 year after the birth of the employee’s child. We have supported the acquisition and installation of breastfeeding pods in our facilities, and we have encouraged facilities to develop and dedicate lactation spaces for Veterans and members of the public. Access to dedicated lactation spaces supports Veteran health and well-being and fosters trust in VA.

While we support the goal of this bill, we have some concerns with the legislative text as written. As noted before, we fully support ensuring lactation spaces are available in our facilities. The need to retrofit and renovate facilities would require a longer time period for compliance. Our biggest impediment is simply the lack of space in existing facilities. In this context, we fully support the intent of this legislation, and we would like to work with the Committee to determine how VA can meet the intent of this bill.

VA does not have a cost estimate for this bill.

S. 784 Rural Veterans Transportation to Care Act

This bill would amend section 307 of the Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163; 38 U.S.C. § 1710, note), as amended, which requires VA to establish a grant program to provide innovative transportation options to Veterans in highly rural areas. The bill would amend this authority to include rural areas as well. It would also make county Veterans Service Organizations and Tribal organizations eligible to be awarded a grant. It would amend the maximum amount of a grant under this section from $50,000 to $60,000 and would provide an exception to this threshold if the recipient is required to purchase a vehicle to comply with the requirements of the Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. § 12101 et seq.) in carrying out this section; in these cases, the maximum grant amount would be $80,000. The bill would replace the current definition of highly rural in section 307 with definitions for the terms rural and highly rural, which would have the meanings given those terms under the Department of Agriculture Rural-Urban Commuting Areas coding system. Finally, the bill would authorize to be appropriated such sums as may be necessary to carry out section 307 and remove the current language authorizing the appropriation of $3,000,000 each for FY 2010 through 2022.

VA supports this bill, subject to amendments and the availability of appropriations.

Lack of transportation in rural and highly rural areas is a well-known barrier to access to care. VA wants to ensure that Veterans living in rural and highly rural areas have access to transportation for their VA-authorized medical care and supports use of this grant program. We do have some recommendations to improve the bill and further improve access to care for rural Veterans. The current definition of highly rural in section 307 makes grants under this authority available only to applicants in 25 states. Expanding the scope of this grant to include rural, in addition to highly rural, areas and additional eligible recipients who serve Veterans in these areas would increase the impact of this program and would allow more eligible Veterans the opportunity to receive medical care that they may not otherwise receive.

VA recommends several changes to the bill. First, the bill would authorize a total award amount of $80,000 if a grantee needed to purchase a vehicle to comply with the ADA. Instead, VA recommends allowing such grantees to receive up to $60,000 (the same as other grantees) to operate the program, and an additional $80,000 for the

purchase of a vehicle. This would allow interested parties who need to purchase a vehicle compliant with the ADA to do so to implement or continue a grant-funded program. Without this additional support, the high-cost of purchasing an ADA-compliant vehicle may dissuade eligible applicants from applying for a grant or from continuing their grant program. Second, we recommend including specific authority for VA to establish limitations regarding the purchase of new vehicles, including the frequency of vehicle purchasing and the number of vehicles that can be purchased by each grantee. This would provide VA clear authority to establish reasonable limitations to ensure proper use of taxpayer funds.

VA would be pleased to provide additional technical assistance to this bill to address these recommendations.

VA does not have a cost estimate for this bill.

S. 800 Precision Brain Health Research Act

Section 2 of this bill would amend section 305 of the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (P.L. 116-171; 38 U.S.C. § 1712A, note), which generally requires, in subsection (a), VA to develop and implement an initiative (the Precision Medicine for Veterans Initiative) to identify and validate brain and mental health biomarkers among Veterans with specific consideration for certain conditions. Specifically, the bill would include among the list of conditions repetitive low-level blast exposure, dementia, and other brain conditions as VA considers appropriate. The bill would further amend this section of law to require VA to work with DoD to establish a data-sharing partnership between the two Departments. The partnership would have to be stored in the open platform already required by law. The data supplied by DoD would have to include all relevant data, Department-wide, collected through the U.S. Armed Forces, the U.S. Special Operations Command, and the Long-Term Impact of Military-Relevant Brain Injury Consortium Chronic Effects of Neurotrauma Consortium maintained by the Defense Health Agency. It would also add five new subsections at the end.

Proposed subsection (f) would require VA, in carrying out the Precision Medicine for Veterans Initiative to conduct specific types of research. First, VA would have to conduct a big-data assessment of the clinical and non-clinical interventions that are illustrating positive outcomes for patients within VA with likely low-level repetitive blast injuries, including a categorization of military occupational specialties, and units, known to experience higher levels of low-level repetitive blast injuries. Second, VA would have to conduct not fewer than two large-scale implementation studies of research-proven interventions within VA for patients with likely low-level repetitive blast injuries, including a categorization of military occupational specialties, and units, known to experience higher levels of low-level repetitive blast injuries. Third, VA would have to conduct a translational research study on the use of growth hormone replacement therapy on the improvement of cognitive function, quality of life, brain structure, and other negative symptoms on patients within such health system with likely low-level repetitive blast

injuries. Finally, VA would have to conduct not fewer than four large-scale quality improvement studies on improving the diagnosis and care of Veteran patients with likely low-level repetitive blast injuries.

Proposed subsection (g) would require VA, not later than 60 days after enactment, to seek to enter into a contract with the National Academies of Sciences, Engineering, and Medicine (NASEM) under which NASEM would work in tandem with the Precision Medicine for Veterans Initiative on validation of brain and mental health biomarkers among Veterans and report to Congress, not less frequently than once every 2 years, on such work.

Proposed subsection (h) would require VA to conduct an assessment of all translational research studies in progress and planned under the Precision Medicine for Veterans Initiative, including the research that would be required under the proposed subsection (f). VA would have to submit a report to Congress on this assessment not later than 60 days after completing the assessment.

Proposed subsection (i) would require VA, not less frequently than once every 2 years, to submit to Congress a report on the Precision Medicine for Veterans Initiative; each report would have to include recommendations for immediate administrative and legislative action to improve the Initiative.

Proposed subsection (j) would authorize to be appropriated to VA $5 million for each of FY 2025 through 2034 to carry out the Initiative.

VA supports the intent of this bill, subject to appropriations, but cites concerns.

VA supports efforts to expand work in this critical research area involving sharing of research data, advancing brain health, blast exposure, and a potential treatment for specific Veterans adversely affected by their military service. However, we have concerns with codifying research approaches or methodologies, as this bill would do, and we note many of the research requirements of this bill could be conducted with current authority but would require additional resources. We would appreciate the opportunity to discuss current research efforts in this area and how legislation might support these. We also would appreciate the opportunity to discuss how this bill might affect eligibility for benefits more broadly under the Honoring our PACT Act of 2022 (P.L. 117-168). Some elements of this bill may be better suited to DoD being the responsible agency. Other elements, such as studying the use of growth hormone replacement therapy, may not be clinically appropriate.

Similar to prior discussions, VA recommends amending the reporting requirement to only require VA to make recommendations for legislation, if any, VA determines appropriate. VA has other technical edits as well; for example, the Long-

Term Impact of Military-Relevant Brain Injury Consortium Chronic Effects of Neurotrauma Consortium is not maintained by the Defense Health Agency

VA does not have a cost estimate for this bill.

S. 827 Supporting Rural Veterans Access to Healthcare Services Act

This bill, similar to S. 784, would amend section 307 of the Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 111--163; 38 U.S.C. § 1710, note), as amended, which requires VA to establish a grant program to provide innovative transportation options to Veterans in highly rural areas. S. 827 would amend this authority to make Tribal organizations and Native Hawaiian organizations eligible to be awarded a grant. It would permit VA to award up to an additional $25,000 in grant funds in the case of a county that has more than five communities that are off the road system. The bill would add a definition of "Native Hawaiian organization," which would have the meaning given that term in section 6207 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. § 7517), and a definition of "Tribal organization," which would have the meaning given that term in section 4 of the Indian Self-Determination and Education Assistance Act (ISDEAA) (25 U.S.C. § 5304). Finally, the bill would authorize to be appropriated such sums as may be necessary for FY 2025 through 2029 to carry out section 307 and remove the current language authorizing the appropriation of $3,000,000 each for FY 2010 through 2022.

VA supports the intent of this bill, subject to amendments and the availability of appropriations.

VA supports the intent of the bill but notes that the Department of Justice has raised serious concerns that need to be addressed. VA welcomes the opportunity to meet with the Department of Justice and the committee to provide technical assistance and edits to the bill. As noted earlier, S. 827 is similar to S. 784. VA's preferred revisions to section 307 of the Caregivers and Veterans Omnibus Health Services Act of 2010 are described in VA's testimony on S. 784. We understand the intent of S. 827, but we have some concerns with the additional grant amount language. We would welcome the opportunity to speak with the Committee to better understand the intended effect and then to propose changes to reflect that intent. Additionally, the draft bill defines Tribal organizations (TO) using the ISDEAA definition (25 U.S.C. 5304). While the definition of TO in the ISDEAA technically captures an Indian Tribe, to the extent that it includes the Tribe's governing body, there is some concern that it can cause potential confusion and/or pushback because the bill does not explicitly include/define Indian Tribe, which is defined separately in the ISDEAA. At minimum, the drafters may want to clarify the intent of the bill. If it is intended to also include Indian Tribes, the drafters may want to consider explicitly adding and separately defining Indian Tribe as defined in the ISDEAA.

VA does not have a cost estimate for this bill.

S. 879 Veteran Caregiver Reeducation, Reemployment and Retirement Act

Section 2 of the bill would amend 38 U.S.C. § 1781, which authorizes the CHAMPVA program, to allow VA to provide medical care under CHAMPVA to designated primary family caregivers eligible for CHAMPVA during the 180-day period following the removal of such designation unless the individual was dismissed from the program for fraud, abuse, or mistreatment. Notwithstanding any other provision of law, individuals would not be eligible during this 180-day period if they were entitled to hospital insurance benefits under Part A of the Medicare program during that period.

VA supports this section, subject to appropriations.

Primary family caregivers provide extensive and direct care and support for Veterans with service-connected disabilities; many often face significant constraints that limit their ability to maintain regular employment and, consequently, employer-sponsored health insurance. The 180-day extension of CHAMPVA benefits, as proposed in this bill, would allow these caregivers a necessary transitional period to seek alternative health coverage without facing an abrupt interruption in their medical care.

VA does not have a cost estimate for this section.

Section 3 of the bill would make several amendments to 38 U.S.C. § 1720G, which generally establishes the Program of Comprehensive Assistance of Family Caregivers (PCAFC) under subsection (a). Specifically, section 3(a) of the bill would add a new subsection (e) to § 1720G regarding employment assistance for individuals designated as a primary provider of personal care services under the PCAFC. VA would have to provide to such individuals reimbursement of fees associated with certifications or re-licensure necessary for such employment; no-cost access to VA training modules for purposes of gaining credit for continuing professional education requirements; and in consultation with DoD and the Department of Labor (DoL), access to employment assistance under DoD's Military OneSource program, DoL's Veterans' Employment and Training Service if they are eligible, and such VA programs as VA determines appropriate. Such individuals would have access to this assistance while participating in the PCAFC and during the 180-day period following the date on which the individual is no longer participating in the PCAFC, unless the individual was dismissed for fraud, abuse, or mistreatment. The maximum lifetime amount that could be reimbursed for an individual for fees associated with certifications or re-licensure necessary for employment would be $1,000.

Section 3(b) would amend the benefits available to primary family caregivers to allow VA to use agreements (instead of only contracts) for financial planning services (including retirement planning services) and legal services. It also would make such assistance available during the 180-day period following the date on which the primary

family caregiver is no longer participating in the PCAFC, unless the family caregiver was dismissed for fraud, abuse or mistreatment, such instruction, preparation, training, and support as VA considers appropriate to assist the caregiver in transitioning away from caregiving.

Section 3(c) would further amend the benefits that could be furnished through contracts or agreements to include assistance returning to the workforce upon the discharge or dismissal from the PCAFC unless the family caregiver was dismissed for fraud, abuse, or mistreatment.

Section 3(d) would expand the counseling available to family caregivers (not just the primary family caregiver) to include bereavement counseling and support following the death of the eligible Veteran.

Section 3(e) would require VA, in partnership with DoL and no later than 1 year after enactment, to complete a study on the feasibility and advisability of conducting a returnship program for individuals who are or were designated as a primary family caregiver to assist such individuals in returning to the workforce. Not later than 180 days after completing this study, VA would have to submit a report to Congress on the study.

Section 3(f) would require VA, not later than 1 year after enactment, to complete a study on barriers and incentives to hiring individuals who were primary family caregivers at VA facilities to address staffing needs. Within 180 days of completing this study, VA would have to submit a report to Congress on the study.

VA supports this section in general, subject to appropriations, but cites concerns.

VA appreciates the Committee's interest in expanding support for caregivers of Veterans by offering assistance when they transition out of Caregiver Support Programs and into the workforce or retirement. VA also appreciates the ability to provide bereavement counseling after a Veteran dies, as this loss can be especially difficult for Family Caregivers who have dedicated their lives to caring for the Veteran.

VA supports some of the requirements under section 3; however, we do have concerns with certain provisions and would appreciate the opportunity to speak with the Committee to address them. We also recommend meeting with DoL as well.

VA does not have a cost estimate for this section.

Section 4 of the bill would require the Comptroller General to submit to Congress a report assessing VA's efforts to support family caregivers under the PCAFC in transitioning away from caregiving, either by assisting those individuals with retirement planning or returning to work.

VA defers to the Comptroller General on this section.

VA does not have a cost estimate for this section.

Section 5 of the bill would require VA, in consultation with the Department of the Treasury and the heads of other relevant entities, to submit to Congress a report on the feasibility and advisability of establishing an individual retirement plan (as defined in section 7701(a)(37) of the Internal Revenue Code of 1986, or similar retirement plans) for family caregivers under the PCAFC or permitting such family caregivers to join an already established pathway to retirement savings.

VA supports this section, subject to amendments.

Providing a pathway to retirement savings acknowledges the critical role that family caregivers play in the health and well-being of Veterans. It also demonstrates a commitment to supporting those who make substantial personal and financial sacrifices in the service of their loved ones. We appreciate the intent behind this section, but it would not grant VA any new authority. VA can already work with the Department of the Treasury and other entities to better understand the feasibility of establishing individual retirement plans for family caregivers under PCAFC. We would appreciate the opportunity to talk with the Committee about its intended outcomes here to determine if legislation is needed.

VA does not have a cost estimate for this section.

S. 1318 Fallen Servicemembers Religious Heritage Restoration Act

This bill would require the American Battle Monuments Commission (ABMC) to establish a program, known as the Fallen Servicemembers Religious Heritage Restoration Program, to identify covered members and to contact survivors and descendants of covered members. ABMC would carry out this Program during the first 10 FYs beginning after the date of enactment. During each of these FYs, ABMC would have to seek to enter into a contract with a non-profit organization under which such organization would have to carry out the purpose of the Program. Each contract would be for a period of 1 year and in the amount of $500,000 to the non-profit organization. ABMC would have to give priority in awarding these contracts to non-profit organizations that have demonstrated capability and expertise in carrying out such a program. There would be authorized to be appropriated $500,000 for each FY to ABMC. The term “covered member” would mean a deceased member of the Armed Forces who was Jewish and buried in a U.S. military cemetery located outside the U.S. and under a marker that indicates such member was not Jewish. The term “non-profit organization” would mean an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from taxation under section 501(a) of such Code.

VA defers to ABMC on this bill.

VA does not have a cost estimate for this bill.

S. 1320 Servicewomen and Veterans Menopause Research Act

Section 2 of the bill would define certain terms for purposes of this Act. Specifically, it would define the term “covered provider” to mean a provider employed by VA or DoD. The term “menopause” would mean the stage of a woman’s life when menstrual periods stop permanently and she can no longer get pregnant and that is not a disease state but a normal part of aging for women. The term “mid-life” would mean a life stage that coincides with the menopausal transition in women, which may be physical or emotional, encompasses the late reproductive age, which can begin at approximately 35 years of age, to the late post-menopausal stages of reproductive aging, which can extend to approximately 65 years of age, and often marks the onset of many chronic diseases. The term “perimenopause” would mean the time during a woman’s life when levels of estrogen fall un-evenly in a woman’s body and is also called the menopausal transition. The term “post-menopausal” would mean the stage of a woman’s life after a woman has been without a menstrual period for 12 months that lasts for the rest of a woman’s life and reflects a time when women are at an increased risk for osteoporosis and heart disease.

VA has no objection to this section.

This section would only define terms, and VA has no objection to these definitions. Bill sponsors should consider changing the term “Armed Forces” each place it occurs in the bill to “uniformed services (as such term is defined in section 101 of title 10, United States Code)”. Officers of the United States Public Health Service (USPHS) Commissioned Corps and NOAA Commissioned Corps do not fall under the term “Armed Forces”; however, USPHS officers and NOAA officers receive their care from Military Treatment Facilities and, once separated from Service, are considered veterans on the Federal level and are eligible to receive VA care in Veteran spaces. Therefore, it is appropriate to ensure all Servicewomen in each of the uniformed services benefit from the research described in this bill.

Regarding the bill overall, VA supports its efforts to advance research and care related to menopause, perimenopause, and mid-life women’s health among women who serve or have served in the Armed Forces.

VA does not have a cost estimate for this section.

Section 3(a) would require DoD, in coordination with VA, to evaluate: (1) the results of completed research related to menopause, perimenopause, or mid-life women’s health among women who are members of the Armed Forces or Veterans; (2) the status of such research that is ongoing; (3) any gaps in knowledge and research

on treatments, safety and effectiveness of such treatments, the relation of service in the Armed Forces to perimenopause and menopause, the effect of combat roles on symptoms relating to perimenopause and menopause (including exposure to burn pits, toxic chemicals, and perfluoroalkyl and polyfluoroalkyl substances (commonly known as PFAS)), and the impact of perimenopause and menopause on the mental health of women who are members of the Armed Forces or Veterans; (4) the availability of and uptake of professional training resources for covered providers relating to mid-life women's health with respect to the care, treatment, and management of perimenopause and menopausal symptoms, and related support services; and (5) the availability of and update of treatments for women who are members of the Armed Forces or Veterans who are experiencing perimenopause or menopause.

Section 3(b) would require DoD and VA to each submit a report to Congress, not later than 180 days after enactment, on the findings of the evaluation required by subsection (a), recommendations for improving professional training resources for covered providers, and a strategic plan that resolves the gaps in knowledge and research identified in the report and identifies topics in need of further research relating to potential treatments for menopause-related symptoms of women who are members of the Armed Forces or Veterans.

Section 3(c) would provide that, in carrying out activities under this section, DoD and VA would have to ensure that such activities minimize duplication and supplement, not supplant, existing information sharing efforts of HHS.

VA defers to DoD regarding section 3(a) and has no objection to sections 3(b) and 3(c).

VA does not have a cost estimate for this section.

Section 4 would express the sense of Congress that DoD and VA should each conduct research related to menopause, perimenopause, or mid-life health regarding women who are members of the Armed Forces or Veterans.

VA defers to Congress on this section.

VA does not have a cost estimate for this section.

S. 1383 Veterans Accessibility Advisory Committee Act of 2025

Section 2 of this bill would require VA, within 180 days of enactment, to establish an advisory committee (the Veterans Advisory Committee on Equal Access) to provide advice on matters related to accessibility of VA for individuals with disabilities. The bill sets forth conditions regarding membership, terms and vacancies, meetings, selection of a chairperson, duties (including providing advice and preparing reports), and

personnel and resource matters relevant to the committee. The committee would terminate on the date that is 10 years after enactment.

This committee would be subject to the provisions of the Federal Advisory Committee Act, 5 U.S.C., Ch. 10.

Section 3 of the bill would require VA, not later than 180 days from enactment (and before establishing the Veterans Advisory Committee on Equal Access) to either: (1) abolish a VA advisory committee that was not established by an Act of Congress and that is inactive; (2) consolidate two such advisory committees; or (3) submit to Congress a recommendation to abolish a VA advisory committee that was established by an Act of Congress and that is inactive.

VA supports this bill, subject to amendments and the availability of appropriations.

While there are several existing advisory committees that focus on disability accessibility to VA services, benefits, and facilities, this new committee would be fully focused on the issue of providing accessibility to individuals with disabilities. It is also important to stand up this committee as its own entity. Combining committees or merging committees would create serious efficiency concerns. It also may dilute the important work that the already established committee is doing. By creating and standing up this Veterans Advisory Committee on Equal Access, the members can be focused and committed on the sole issue of accessibility that they have been tasked with.

However, the proposed committee could be tasked with responsibilities that may duplicate existing efforts. For example, the committee would evaluate compliance with the ADA, which is not generally applicable to Executive Branch agencies. It also would evaluate compliance with sections 504 and 508 of the Rehabilitation Act of 1973, which are applicable to Executive Branch agencies, but this could create greater obligation on the Department in terms of compliance and could be redundant. The Department would welcome the opportunity to work with the committee on technical amendments to the bill.

Regarding section 3, VA is already required to evaluate all existing discretionary committees to determine an existing need for continuation and engages in this process biennially. Discretionary committees are terminated when no longer valid. The nine active discretionary committees have all been determined to provide necessary insight and advice to VA operations. There are no discretionary committees that would currently meet the requirements for abolishment. The VA is concerned that section 3 may be duplicative to other requirements that the Department already has in place. As stated above, VA thanks the Committee for the opportunity to provide views on this proposed bill and would be happy to work with the Committee on technical assistance.

The estimated cost of establishing the committee is approximately $750,000 per year and $7.5 million over the initial proposed 10-year period of existence, unless extended by Congress.

S. 1441 Service Dogs Assisting Veterans Act of 2025 (SAVES Act of 2025)

Section 2(a) of this bill would require VA, not later than 24 months after the date of enactment, to establish a 5-year pilot program under which VA would award grants, on a competitive basis, to nonprofit entities to provide service dogs to eligible Veterans. Section 2(b) would provide that, to be eligible to receive a grant, nonprofit entities would have to submit to VA an application at such time, in such a manner, and containing such commitments and information as VA may require. Applications would have to include a proposal for the provision of service dogs to eligible Veterans, including how the entity would communicate with VA to ensure an increasing number of service dogs are provided to Veterans; applicants would also have to include a description of training and services provided by the entity, as well as the qualifications of the entity (including demonstrated experience in training service dogs in compliance with the requirements of the ADA).

Under section 2(c), VA would have to award a grant to each non-profit entity for which VA has approved an application. VA and the entity would have to enter into an agreement containing such terms, conditions, and limitations as VA determines appropriate. The maximum grant amount VA could award to a non-profit entity under this section would be $2 million. VA would have to establish intervals of payment for the administration of each grant awarded under this section.

Under section 2(d), grantees would have to use the grant amounts to plan, develop, implement, or manage (or any combination thereof) one or more programs that provide service dogs to eligible Veterans and ensures only eligible Veterans are allowed to participate in the program. VA could establish a maximum amount for each grant awarded under this section to cover administrative expenses. VA also could establish other conditions or limitations on the use of grant amounts.

Under section 2(e), grantees would have to notify each Veteran that receives a service dog through the grant that the dog is being paid for, in whole or in part, by VA, and they would have to inform such Veterans of the benefits and services available from VA for the Veteran and service dog. Grantees could not charge a fee to a Veteran receiving a service dog through the grant.

Under section 2(f), VA would have to provide to each Veteran who receives a service dog through a grant a commercially available veterinary insurance policy for the service dog, and, if VA provides such a veterinary insurance policy to a Veteran, VA would have to continue to provide the policy without regard to the continuation or termination of the pilot program.

Under section 2(g), VA could provide training and technical assistance to recipients of grants under this section.

Under section 2(h), VA would have to establish oversight and monitoring requirements as appropriate to ensure grants are used appropriately, and VA could take actions as necessary to address any issues identified through the enforcement of such requirements. VA could require each grantee to provide reports or written answers to specific questions, surveys, or questionnaires as VA determines necessary.

Section 2(i) would define terms for purposes of this Act. The term “eligible veteran” would be defined to mean Veterans under 38 U.S.C. § 101 who, as determined by a physician, have one more of the following disabilities, conditions, or diagnoses: blindness or visual impairment; loss of use of a limb, paralysis, or other significant mobility issue, including mental health mobility; loss of hearing; posttraumatic stress disorder (PTSD); traumatic brain injury (TBI); or any other disability, condition, or diagnosis VA determines, based on medical judgment, that it is optimal for the Veteran to manage the disability, condition, or diagnosis and live independently through the assistance of a service dog. The term “service dog” would mean any dog that is individually trained to do work or perform tasks that are for the benefit of a Veteran with a disability, condition, or diagnosis described above and directly related to the disability, condition, or diagnosis of the Veteran.

Section 2(j) would authorize to be appropriated $10 million for each of the five consecutive fiscal years following the fiscal year in which the pilot program is established.

VA supports this bill, subject to amendments and the availability of appropriations.

VA provides benefits for service dogs for eligible Veterans who have been diagnosed with a visual, hearing, or substantial mobility impairment (including mental health mobility) when the VA clinical team treating the Veteran for such impairment determines, based upon medical judgment, that it is optimal for the Veteran to manage the impairment and live independently through the assistance of a trained service dog. *See* 38 C.F.R. § 17.148(b). VA provides a commercially available veterinary insurance policy for service dogs, as well as payments for travel expenses associated with obtaining a dog if the Veteran is eligible for beneficiary travel under 38 U.S.C. § 111 and 38 C.F.R. part 70 and if pre-approved for such benefits.

While not involving the provision of service dogs, since February 2022, VA has been implementing the Puppies Assisting Wounded Servicemembers for Veterans Therapy Act (P.L. 117-37), which requires VA to conduct a pilot program to provide canine training to eligible Veterans diagnosed with PTSD as an element of a complementary and integrative health program for such Veterans. Service dogs provide essential support for many Veterans.

We appreciate that the bill generally focuses on creating a more direct connection in the legislation between grant funds and the provision of service dogs to eligible Veterans, but we believe this could be clearer. Specifically, in section 2(d), the bill would require grantees to use funds "to plan, develop, implement, or manage (or any combination thereof) one or more" programs that provide service dogs to eligible Veterans. Allowing the use of funds to plan a program that provides service dogs, but which ultimately does not provide service dogs, is not an ideal use of funds. We recommend the bill simply state that grantees would use funds to provide service dogs to eligible Veterans. In VA's experience, Veterans can wait between 1 and 3 years between when a dog has been recommended by VA and when a Veteran has been fully paired with a service dog that has graduated training. VA believes the grants provided under this authority could help increase the supply of service dogs to reduce this delay. In any grant program, but particularly in the case of service dog training, it is essential to ensure that funds are properly used.

Several provisions in the bill raise concerns. First, VA recommends clearly aligning the definition of service dog under this section with VA's existing definition in regulations. Second, VA is concerned about the list of disabilities that was presented in the bill. Specifically, the inclusion of TBI, for which a Veteran may already otherwise qualify based on having a significant mobility issue, and PTSD, as there is no substantial evidence to date that service dogs provide improvements in functioning and quality of life for Veterans with PTSD as compared to emotional support dogs. VA recommends striking these provisions. We note, similar to the discussion above regarding Veterans with TBI qualifying for a service dog when they have a significant mobility issue, Veterans with PTSD can receive a service dog on the same basis. Further, VA recommends including additional language that would ensure clear authority for the administration of a grant program. Finally, we note that the current bill expands eligibility to all Veterans who meet the requirements of 38 U.S.C. § 101, not just Veterans enrolled in VA health care. This would complicate administration of this program.

We also note that this proposal would likely require dedicated staff in a new office to administer this program.

VA does not have a cost estimate for this bill.

S. 1591 Acquisition Reform and Cost Assessment Act of 2025 (ARCA Act of 2025)

This bill includes nine total sections, with section 1 providing a short title and table of contents.

Section 2(a) would add new subchapter VII, "Acquisition Organization, Cost Assessment, and Program Evaluation," to chapter 81 of title 38, U.S.C. The new subchapter would include section 8181, "Definitions," which would add definitions for the terms "major acquisition program" and "non-major acquisition program" that would apply

throughout the subchapter. Section 2(b) would amend 38 U.S.C. § 308 to increase the number of Assistant Secretaries from seven to eight, including the addition of an Assistant Secretary for “Acquisition and innovation”.

Section 2(c) would add a new section 8182, “Acquisition organization,” to title 38, U.S.C., which would direct the Secretary to designate an Assistant Secretary for Acquisition and Innovation, who would also be the Chief Acquisition Officer (CAO). The Assistant Secretary would be the head of the Office of Acquisition and Innovation, and major program offices would align under the Office. The budget for the Office would be established in VA’s budget justification materials submitted to Congress. The Secretary would appoint three Deputy Assistant Secretaries (DAS), who would report to the Assistant Secretary for Acquisition and Innovation—a DAS for Logistics, a DAS for Innovation, and a DAS for Procurement. The DAS for Logistics would be responsible for the administration of logistics and supply chain operations. The DAS for Innovation would be responsible for all research development, testing, and innovation development organizations, including the VHA Innovation Ecosystem. The DAS for Procurement would be responsible for all VA procurement and contracting organizations.

VA supports the intent of this section, subject to amendments and the availability of appropriations.

VA supports the intent of this section, subject to amendments, because it enhances the focus on and coordination of acquisition and innovation activities, ensuring they align with Presidential priorities to streamline processes, improve efficiency, and foster a more innovative approach to acquiring and developing capabilities. This new role and organization better support and reflect the CAO's responsibilities and the increasing complexity of VA's acquisition needs. The CAO serves as the primary advisor to the Secretary for all major acquisitions, manages 17,000 acquisition professionals, and is responsible for providing oversight of approximately $100 billion in VA's major acquisition programs. VA believes additional amendments are needed to give effect to the intent of this section, particularly with revising the dollar value for major/non-major acquisition programs to align with the definition of “Major Information Technology Project” in 38 U.S.C. § 8171(5) (as added by the Department of Veterans Affairs Information Technology Reform Act of 2022 (section 403 of the Joseph Maxwell Cleland and Robert Joseph Dole Memorial Veterans Benefits and Health Care Improvement Act of 2022; P.L. 117-328, Div. U)). VA also recommends adding a DAS for Acquisition, Program Management, and Performance, who would report to the Assistant Secretary for Acquisition and Innovation. This additional DAS role would focus on the critical aspects of VA's "Big A" acquisitions. This role would transcend mere procurement, placing a strong emphasis on lifecycle management that is intricately structured around vital elements: requirements planning, programming and budgeting, policy innovation, performance standards, governance, and enhancing the capabilities of the acquisition workforce. This comprehensive approach would ensure that our major acquisitions are both effective and forward-thinking, paving the way for successful outcomes.

VA does not have a cost estimate for this section.

Section 3 would add a new section 8183, “Major acquisition program managers.” The new section would direct the Deputy Secretary to appoint a manager to administer a major acquisition program not later than 30 days after the Secretary approves commencement of the program. Each appointed manager would report to the Assistant Secretary for Acquisition and Innovation and be responsible for developing a “program baseline.” The program baseline would include a description of each acquisition phase; requirements for advancing the program; and estimates for cost, schedule, and performance for the lifecycle of the program. The manager would be responsible for ensuring that the program is in compliance with such requirements, securing funding, adopting standardized processes, and ensuring personnel responsible for estimating the budget for the program are able to raise concerns prior to the establishment of the program baseline. The manager would be responsible for ensuring that: the program complies with cost accounting standards as applicable; the program has a qualified workforce; and the program has adequate technology and production capacity prior to commencing if the program is related to manufacturing.

The manager would be required to submit a certification, within 90 days of establishing the program baseline, stating that alternative requirements were considered prior to establishing the program baseline. The certification would be submitted to the program decision authority (the Assistant Secretary for Acquisition and Innovation). The Secretary would ensure that the program management offices for the major acquisition programs are independent of VBA, VHA, and the National Cemetery Administration (NCA), and other staff offices by reporting directly to the Assistant Secretary for Acquisition and Innovation. The manager would be required to notify the program decision authority within 30 days of the conclusion of an acquisition phase of a major acquisition program. The manager would not be allowed to proceed to a subsequent acquisition phase without the authorization of the program decision authority.

VA supports the intent of this section, subject to amendments.

VA supports the intent of this section, subject to minor amendments, as VA has taken action to establish a policy that major acquisition programs require certified program managers and teams appointed by the Deputy Secretary to ensure efficient planning, execution, and oversight of VA’s most complex and high-stakes programs. VA also seeks to ensure that Assistant Secretary for Acquisition and Innovation would align and seek input from other senior functional areas regarding statutory requirements for program oversight.

VA does not have a cost estimate for this section.

Section 4 would transfer all contracting officers and acquisition centers to the Office of Acquisition and Innovation. All activities related to the administration of logistics and supply chain operation would be consolidated under the DAS for Logistics.

VA supports the intent of this section.

VA does not have a cost estimate for this section.

Section 5 would require the Secretary to enter into one or more contracts for the independent verification and validation (IV&V) of a major acquisition program or major information technology project. To be awarded a contract, the CAO would have to determine that the entity performs or has performed, within a 3-year period as prime contractor, IV&V or systems engineering and technical advisory support of major acquisition programs or defense systems. The entity, including its subsidiaries, subcontractors, and investments, would be precluded from receiving an award if it was performing or had performed within a 3-year period a covered contract for the project or system involved or for VA. If requested by Congress, contracting officers would be required to submit an organizational conflict of interest mitigation plan submitted by the entity within 30 days from the request. VA would send a copy of the IV&V to Congress not later than 30 days after it was performed. The Chief Financial Officer would need to ensure, to the extent practicable, that each organizational subdivision that enters into a contract for IV&V proportionally contributes to the funding of each contract.

VA supports the intent of this section, subject to amendments.

VA supports the intent of this section, subject to amendments. With the exclusive mandate for IV&V by external contractors, the Department would need to carefully review existing IV&V and testing-related contracts for compliance while ensuring continuity. This shift may unintentionally exclude experienced VA contractors who lack the required DoD-related contract experience; therefore, VA believes refining the proposed legislative language for clarity and proactively addressing these exclusions would be crucial to mitigating operational disruptions. To preserve operational integrity and effectiveness, leveraging both governmental expertise and external contractor support in IV&V processes is vital, and adhering to industry standards such as IEEE Std. 1012 while maintaining flexibility in IV&V implementation will ensure comprehensive oversight without compromising quality.

VA does not have a cost estimate for this section.

Section 6 would add a new section 8184, “Cost assessment and program evaluation.” This new section would establish a Director of Cost Assessment and Program Evaluation (CAPE) who would report directly to the Secretary. The CAPE Director would provide independent analysis and advice to the Secretary and other senior VA officials on matters assigned to the Director pursuant to this section and to 38 U.S.C. § 303. Proposed section 8184(c) would establish two Deputy Directors within the CAPE Office, one for Cost Assessment and one for Program Evaluation. Proposed section 8184(d) would define the responsibilities of the CAPE Director. The Secretary would have to ensure that the Director promptly received the results of all cost estimates and cost analyses conducted by VBA, VHA, NCA, or staff offices and all studies conducted by the Administration, in connection with such cost estimates and cost analyses for major acquisition programs and major automated information system programs of the Administrations. The Director also would have to have timely access to any records and data in the Department. Proposed section 8184(h) and section 6(b) of the bill would define VA’s annual reporting requirements. Finally, section 6(b) would define reporting requirements on the monitoring of operating and support costs for major acquisition programs.

VA does not support this section

While VA agrees with the intent behind establishing a CAPE Director function to enhance oversight, VA does not support this section. VA does not believe that establishing the function and roles in law is necessary. VA seeks the flexibility to develop and expand existing capabilities within the Office of Management without the additional constraints prescribed in this section.

VA does not have a cost estimate for this section.

Section 7 would add two new sections, 8185 and 8186, titled “Other transaction authority” and “Advance market commitments for technologies or services for provision of health care,” respectively. Proposed section 8185 would establish another transaction authority (OTA) that would permit VA to enter into transactions with non-traditional contractors to perform certain types of research or innovation development activities. The authority could also be exercised by the Deputy Assistant Secretary for Innovation for activities that align with the mission of the VHA Innovation Ecosystem, provided certain requirements are met. The criteria include research that is not duplicative, a determination by the senior procurement executive that the research is appropriate, that the transaction will not exceed $5 million to include all options (unless a determination is made to exceed such limits), and other details and limitations. It also would specify notice and reporting requirements to Congress, require VA prescribe regulations to carry out the section, and limit authority under this section to a term of 3 years after the date of enactment. Finally, it would define various terms.

Proposed section 8186 would grant VA authority to enter into advance market commitments by guaranteeing VA purchase, at a predetermined price, a technology or service provided by an entity that addresses an unmet need in the provision of health care to Veterans. It further would specify criteria that must be met prior to entering into an advanced market commitment, to include clearly defined and transparent rules, clear definitions, defined dispute settlement mechanisms, and the ability to modify under certain conditions. The section also would outline a reporting requirement to notify Congress within 120 days of execution of an advanced market commitment.

VA supports the intent of this section.

VA supports the intent of this section because it would provide VA with the tools to drive rapid innovation. OTA would minimize barriers, facilitate more streamlined bidirectional collaborations with industry, and help VA attract new, private sector entities that do not traditionally engage with VA. Having OTA, including for research, prototyping, and follow-on production, as a flexible acquisition tool would enable VA to address its immediate challenges today and prepare us to tackle future challenges to modernize VA rapidly in the years to come.

VA does not have a cost estimate for this section.

Section 8 would require VA to monitor the training and experience gap of professionals and establish or expand any existing internship or development pipelines for 1102 contracting officers at VA.

VA supports the intent of this section.

VA supports the intent of this section because it underscores VA's need to expand internship and development pipelines for 1102 contracting officers to address training and experience gaps. VA has initiatives underway and will continue to prioritize improving the skills and competencies of its acquisition workforce, thereby enhancing the Department's long-term operational efficiency and effectiveness in managing acquisitions.

VA does not have a cost estimate for this section.

Section 9 is a clerical amendment to amend the table of sections to add subchapter VII and sections 8181-8186 to 38 U.S.C.

VA supports the intent of this section.

VA welcomes the opportunity to work with the Committee on technical assistance, including necessary conforming amendments.

There is no cost associated with this section.

S. 1543 Veterans Opportunity Act of 2025

This bill includes four total sections, with section 1 including a short title.

Section 2(a) of this bill would create a new chapter 80 in title 38, U.S.C. This new chapter 80 would include three new sections: 8001, 8002, and 8003. The new section 8001 would establish and outline the functions of the Veterans Economic Opportunity and Transition Administration (VEOTA) and make clear that it is headed by an Under Secretary for Economic Opportunity and Transition.

Under new Section 8002, VEOTA would be responsible for administering the following:

(1) Vocational rehabilitation and employment programs.
(2) Educational assistance programs.
(3) Veterans' housing loan and related programs.
(4) The Secretary's responsibilities with respect to the Transition Assistance Program under 10 U.S.C. § 1144.
(5) Any other VA program that the Secretary determines appropriate.

New Section 8003 would require an annual report to Congress regarding program-related data from the fiscal year covered by the report.

Section 2(b) specifies that the effective date for the establishment of chapter 80 would be October 1 of the first fiscal year commencing after the enactment of the Act. Section 2(c) addresses labor rights, and specifies that any labor rights, inclusion in bargaining units, and collective bargaining agreements affecting VA employees transferred to VEOTA would remain the same post-transfer.

Section 3 would establish the position of Under Secretary for Veterans Economic Opportunity and Transition, outline the Under Secretary's responsibilities, and establish the procedures under which the position would be filled. These procedures would be codified in a new section 306A of title 38, U.S.C.

Section 4 of the bill would require VA to report to Congress, within 180 days of the date of enactment, on the progress toward establishing VEOTA and would prevent the transfer of functions to VEOTA until VA certifies to Congress that the transition of services to VEOTA will not negatively affect the provision of services to veterans and that services are ready to be transferred. This certification must be submitted no earlier than April 1 and no later than September 1 of the first fiscal year commencing after the

enactment date. If the certification is not made by the specified date, the Secretary must provide Congress with a report explaining the delay and estimating when certification will be made.

VA does not support this bill.

While VA appreciates the Committee's focus on improving services and resources offered, the Education, Loan Guaranty, Veteran Readiness and Employment (VR&E), and Outreach, Transition, and Economic Development (OTED) programs are part of an integrated suite of interdependent services and benefits that also includes compensation, pension, and insurance programs. Together, they form a suite of benefit-related resources that Veterans can rely on.

In FY 2024, VA processed over 4.3 million education claims in an average of 5.7 days. Over 2.1 million claims were automated, delivering real-time benefit decisions to Veterans and their dependents. VA paid over $12 billion in education benefits for 901,463 Veterans and their beneficiaries. VA guaranteed 416,376 loans worth $155.4 billion in FY 2024. Loan Guaranty also assisted 158,290 borrowers retain homeownership and/or avoid foreclosure, resulting in a $3.33 billion savings in estimated foreclosure costs to the Government. VR&E helps Service members and Veterans with service-connected disabilities and a barrier to employment prepare for, find, and maintain suitable jobs through counseling and case management. There were over 140,000 VR&E participants in FY 2024, with more than 44,000 new plans developed to assist Veterans, and over 12,000 Veteran Rehabilitations. Since the launch in December 2019 through April 2025, VA Solid Start has successfully connected with 586,029 recently separated Service members, representing a 74.7% successful contact rate. This includes a total of 140,123 successful contacts in FY 2025 through April 2025.

To support such robust and complex operations, numerous enabling staff offices are necessary, such as finance, human resources, facilities, production optimization, outreach and engagement, field operations, business process integration, strategic program management, performance analyses, communications, and executive review. These enabling organizations would have to be recreated within the new administration in order to effectively operate, requiring additional executive leadership and replicated structures. The addition of another administration would increase the leadership oversight for programs that are currently in place, contrary to the modernization efforts that are underway.

Additionally, if the VEOTA was enacted, VA would require ample time to plan for this considerable transition to ensure services are not negatively affected. Therefore, while VA remains committed to communicating closely with the Committees, it does not support a specified timeframe for reporting or certification.

VA does not have a cost estimate for this bill. We note that General Operating Expense costs would result from the enactment of this bill for Management Direction

and Support for enabling staff offices, which would include payroll and non-payroll costs (travel, contract support, centralized payments, etc.). No mandatory costs would be associated with the proposed legislation. We also note that the creation of a new administration could require additional information technology resources to support an increase in staff and any new information technology solutions that may be needed.

S. 1533 Making Permanent and Codifying Pilot Program for use of Contract Physicians for Disability Examinations

Subsection (a) of the bill would add a new section 5103B to title 38, U.S.C., regarding the use of contract physicians for disability examinations.

Subsection (a)(1) of proposed § 5103B would allow disability examinations carried out through the Under Secretary for Benefits be made by qualified persons other than VA employees.

Subsection (a)(2) of proposed § 5103B would allow disability examinations conducted by a qualified person under paragraph (1) be performed under a contract entered into by the Under Secretary for Benefits.

Subsection (b)(1) of proposed § 5103B pertains to the licensure of contracted health care professionals and would allow contracted disability examiners to conduct examinations at any location in any State as long as the examination is within the scope of their authorized duties under the contract.

Subsection (b)(2) of proposed § 5103B would define a health care professional as "a person who is eligible for appointment to a position in the Veterans Health Administration [(VHA)] covered by [38 U.S.C. § 7402(b)] who—(A) has a current unrestricted license to practice the health care profession of the health care professional; (B) is not barred from practicing such health care profession in any State; and (C) is performing authorized duties for the Department pursuant to a contract entered into under subsection (a)."

Subsection (c) of proposed § 5103B would direct that the expenses associated with contracted disability examinations, including payments for examination travel and incidental expenses, "be reimbursed to the accounts available for VBA general operating expenses of the Veterans Benefits Administration and information technology systems from amounts available to the Secretary for payment of compensation and pensions."

Subsection (d) of proposed § 5103B would require establishment of a mechanism whereby medical evidence introduced by applicants for benefits during examinations "that the health care professional considers new and material to the application" can be transmitted to the Secretary.

Subsection (b) of the bill would provide a clerical amendment to the table of

sections based on the proposed § 5103B.

Subsection (c) of the bill would require VA, no later than 3 years after enactment, to report to Congress on the effect of the contract examination authority on the cost, timeliness, and thoroughness of medical disability examinations.

VA supports this bill, subject to amendments and the availability of appropriations.

VA appreciates the Committee's intent to make permanent and codify the pilot program for use of contract physicians for disability examinations and strongly supports that goal. However, VA provides the following comments.

In the proposed title, *§ 5103B. Use of contract physicians for disability examinations*, VA recommends replacing "physicians" with "health care providers," as VA utilizes a wide range of qualified medical professionals to conduct disability examinations. Additionally, this would ensure consistency with the language used in proposed § 5103B.

VA recommends adding the terms "registration, or certification" after the phrase "…has a current unrestricted license," in subsection (b)(2) of proposed § 5103B since not all providers require a license (see, for instance, 38 U.S.C. § 7402(b)(3), (b)(8), (b)(11)). Of note, the requirement set forth in subsection (b)(2)(B) may be redundant to the requirements set forth in 38 U.S.C. § 7402(f) which requires that health care providers not have had a state license, registration, or certification terminated for cause or have voluntarily relinquished such license, registration, or certification after being notified of potential termination for cause.

VA also recommends that proposed § 5103B(d) be removed. This provision has the potential to create problems with custody of official government records, which may impact date of claim and timely receipt of evidence. VA does not have contractual privity with the contract examiners. Instead, the examiners are subcontracted with VA's contract vendors. Proposed § 5103B(d) would allow a non-VA employee or non-VA-contracted party to establish constructive custody of records on behalf of VA. While VA may create policies regarding the timing of delivery of such records with contract vendors, VA cannot enforce those policies directly with the subcontracted examiners. Any delay on the part of a subcontracted examiner in submitting evidence to VA on behalf of a Veteran might result in a later date of claim than if the Veteran submitted the evidence directly to VA and raises the risk of litigation over the matter.

Additionally, the proposed § 5103B(d) would create an evidentiary burden on contract examiners that is not applied to VHA examiners. If an applicant for benefits provides evidence during an examination, the VHA examiner is directed to review the evidence, document it in the examination report, and then return it to the applicant with the instruction that the applicant immediately submit it to VBA.

Of particular concern, the proposed § 5103B(d) would condition the transmission of evidence to the Secretary on the health care professional's determination that the evidence is "new and material." Initially, VA notes that the phrase "new and material" is no longer in use and has been replaced with the phrase "new and relevant" evidence (*see* 38 U.S.C. §§ 5103A, 5108, 5110). More problematically, health care professionals are responsible for providing examinations to aid in the adjudication of claims for VA benefits; they are not qualified or authorized to determine what constitutes evidence that is new or relevant (or material) to those claims. These are adjudicative (rather than medical) standards that must be addressed by trained claims adjudicators.

VA thanks the Committee for the opportunity to provide views on this proposed bill and would be happy to work with the Committee on technical assistance.

VA does not have a cost estimate for this bill.

Conclusion

This concludes my statement. We would be happy to answer any questions you or other Members of the Committee may have.