STATEMENT OF
MARGARITA DEVLIN
PRINCIPAL DEPUTY UNDER SECRETARY FOR BENEFITS
PERFORMING THE DELEGABLE DUTIES OF
THE UNDER SECRETARY OF BENEFITS
VETERANS BENEFITS ADMINISTRATION (VBA)
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
ON
LEGISLATION
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Chairman Moran, Ranking Member Blumenthal, and other Members of the Committee: thank you for inviting us here today to discuss 25 bills that would affect VA programs and services. Joining me today are Dr. Mark Koeniger, Acting Assistant Under Secretary for Health for Patient Care Services, and Mr. David Barrans, Deputy Vice Chairman of the Board of Veterans' Appeals.

S. 749 Justice for ALS Veterans Act of 2025

Summary: This bill would amend 38 U.S.C. § 1311 to treat Veterans, whom the Secretary determines died from amyotrophic lateral sclerosis (ALS), as though they were, at the time of death, in receipt of or entitled to receive compensation for a service-connected (SC) disability that was rated totally disabling for a continuous period of at least 8 years prior to death, regardless of how long the Veteran had ALS. The amendment would apply to Veterans who died from ALS on or after October 1, 2022.

Position: **VA supports the intent of this bill, however, is unable to assess the impact to budgetary resources and therefore will follow-up with the Committee once this evaluation is complete or CBO has provided a score.**

Views: VA supports the intent of providing this benefit to ALS-affected families. This amendment would ensure that surviving spouses of Veterans who die from ALS receive increased Dependency and Indemnity Compensation under § 1311(a)(2), regardless of how long the Veteran had the disease, as long as the surviving spouse was married to the Veteran for a period of eight or more continuous years immediately preceding the death of the Veteran. Currently, this additional benefit applies only when the Veteran was totally disabled for 8 years prior to death and was married to the surviving spouse for that same period. The bill would remove that 8-year requirement specifically for the duration of time that the Veteran had ALS but keeps the length of marriage requirement.

VA recommends striking “the Secretary determines” within line 10 on page 2 of the bill. As provided in 38 U.S.C. § 5107(b), VA makes decisions based on consideration of evidence. The phrase “the Secretary determines” may raise unnecessary confusion as to whether there is a departure from the standard VA requirement that benefit determinations are based on evidence.

S. 1127 Dennis and Lois Krisfalusy Act

Summary: This bill would amend 38 U.S.C. § 2306(b)(2) to expand eligibility for memorial headstones and markers for certain spouses, surviving spouses, or eligible dependent children of Veterans and active-duty Service members. The bill would remove November 11, 1998, as the earliest date of death for these family members to be eligible. The limitation that the death must occur before September 30, 2032, would remain in the statute.

Position: **VA supports the intent of this bill and seeks amendment, however, is unable to assess the impact to budgetary resources and therefore will follow**

up with the Committee once this evaluation is complete or CBO has provided a score.

Views: VA supports this bill but seeks the removal of September 30, 2032, as the date by which an eligible family member's death must occur for VA to provide a memorial headstone or marker. VA recommends removing that date from 38 U.S.C. § 2402(a)(5), so that covered family members of active-duty Service members would remain eligible for burial in a VA national cemetery even if their deaths occur on or after September 30, 2032. VA supports entirely removing the date-of-death limitations in §§ 2306(b)(2) and 2402(a)(5). Eliminating the date-of-death requirement in each of these statutes would ensure that active-duty Service members who lose their loved ones while serving the Nation would retain the opportunity to obtain a government-furnished memorial headstone or marker or to choose to inter their loved ones in a VA national cemetery.

S. 3000 Fraud Reduction and Uncovering Deception in Department of Veterans Affairs Disability Exams Act of 2025 (FRAUD in VA Disability Exams Act of 2025)

Summary: This bill would require VA to establish a process for claims processors to identify and transmit to appropriate investigatory bodies instances of Disability Benefits Questionnaire (DBQ) fraud; establish a recurring audit of DBQs submitted to VA; inform individuals when their DBQ has raised a suspicion of fraud; and provide an annual report to Congress. The bill would authorize VA's Office of Inspector General (OIG) to use any authority applicable to an inspector general of the Federal Government that the OIG considers necessary to investigate the suspected activity. The bill would prohibit VA from reopening or changing any decision on a benefit claim due to an OIG DBQ investigation unless the claimant is convicted of fraud by a court of competent jurisdiction.

Position: **VA does not support this bill.**

Views: While VA appreciates the intent of this bill, it is redundant of current processes that review the authenticity of information reported on DBQs. VA provided mandated training—"Identifying Insufficient and Potentially Fraudulent [DBQs]"—to claims processors and quality reviewers in fiscal year (FY) 2025. The training focused on identifying examination insufficiencies when reviewing DBQs and reinforcing required actions when insufficiencies are identified. Prior to a decision, a DBQ is reviewed to ensure the information provided is consistent with the evidentiary record and free from improper alteration. If the review raises concerns, claims processors are instructed to take actions up to and including a fraud referral to the OIG, when appropriate.

VA has concerns with the bill's requirement to notify the claimant that VA suspects a DBQ may contain fraudulent information, particularly in cases involving DBQs completed by VA-employed or VA-contracted examiners. A suspicion of fraud does not necessarily mean that fraud has occurred, and alerting claimants could cause them additional anxiety regarding their claims. Furthermore, informing the claimant may inadvertently alert the suspected perpetrator to an ongoing criminal investigation. VA also has concerns with the bill's prohibition on reopening or changing a decision, as fraud can prejudice a claimant, warranting a change to the claimant's benefit. Under current practice, VA generally offers a new examination and, if warranted, revises the decision to ensure accuracy and fairness. The bill would eliminate VA's ability to take corrective action in such circumstances, potentially harming claimants who were not involved in the fraudulent activity.

S. 3098 Presumptive Clear Legal Assessment and Review of Illnesses from Toxic exposure Yields Act of 2025 (Presumptive CLARITY Act of 2025)

Summary: This bill would require VA to create and maintain a publicly accessible website listing all conditions and cohorts under consideration for establishing or

removing presumptions of service connection based on toxic exposure. The website would also describe VA's presumptive decision process, identify each condition's or cohort's status, and provide information on public notice and comment opportunities. Publication would be required within 180 days of enactment.

Position: **VA supports the intent of this bill however, is unable to assess the impact to budgetary resources and therefore will follow-up with the Committee once this evaluation is complete or CBO has provided a score but cites concerns.**

Views: VA supports the underlying goal of transparency in the presumptive decision process but has several concerns. Existing law already requires public transparency. Under 38 U.S.C. § 1172, enacted by the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act of 2022 (PACT Act), VA must annually publish in the Federal Register the conditions selected for review and invite public comment. VA policy—specifically Veterans Health Administration (VHA) Directive 1309—also mandates annual Federal Register publication of planned evaluations. PACT Act sections 509 and 808(b) already require display of toxic exposure research carried out or funded by the Executive Branch and Airborne Hazards and Open Burn Pit Registry participation numbers by State and Congressional district. The bill would add a parallel and substantially overlapping publication requirement without clarifying how it interacts with current statutory and regulatory mechanisms.

Additionally, the bill would require VA to publish all conditions and cohorts it is "considering," but it does not define when consideration begins. VA's presumptive process includes multiple phases—preparatory, scientific, administrative, and Secretary decision. Publishing conditions at the earliest stage, before evidence has been evaluated, could create premature expectations, public misunderstanding, and pressure on a process that depends on a careful scientific review.

The bill would also require VA to publish “steps and goals for time of completion for each step” and status updates. While VA appreciates the intention, scientific evidence reviews vary significantly in complexity and duration. Establishing fixed timelines could create unrealistic expectations; interfere with the need for rigorous, evidence-based analysis; and affect VA credibility when research is stalled or delayed for reasons beyond VA’s control.

VA welcomes continued engagement on ways to improve public understanding of the presumptive process while ensuring the integrity and scientific rigor that the process requires.

S. 3170 Stuck On Hold Act

Summary: This bill would require VA to implement an automated system for each of its customer service telephone lines that informs callers about the anticipated wait time and automatically offers a callback to any caller with an anticipated wait time of more than ten minutes. The bill would require VA to issue guidance as necessary to reduce the average wait time of callers to a covered line to not more than 10 minutes. The bill would not apply to the toll-free hotline provided under 38 U.S.C. 1720F(h) and the emergency department lines of VA’s health care facilities.

Position: **VA does not support this bill.**

Views: VA appreciates and shares the intent of this bill and Veterans-first goal of providing world class customer service for Veterans and other stakeholders but does not support this bill due to ambiguities in the text as written. Section 2(a) would require VA to implement a wait time notice and callback feature on each covered line. Covered lines are defined in section 2(c) as customer service telephone lines of the Department, with two exceptions explicitly listed. As written, this may include individual offices not encompassed in a contact center setting, such as Veteran Readiness & Employment (VR&E) offices or local VA medical center (VAMC) scheduling offices. Such telephone

lines would not have the technical capability to implement these requirements at this time. Further, the use of the term “callback” is unclear in its intent. A “virtual queue” would allow a caller to hang up, maintain their place in the queue, and receive a return call to connect them with an agent when their place in the queue arrives. A “callback” may also be interpreted as a customer-requested, scheduled callback at a future date and time. This latter interpretation would require VA to increase staffing levels to ensure that return calls are completed promptly and reliably. Success of this type of callback feature is dependent on balancing contact center agent staffing for such callbacks alongside agent staffing for new incoming call volume.

VA further notes that callback systems in the form of virtual queuing are already in place in certain contact centers. For example, VA callback systems are triggered for wait times that exceed 5 minutes in the VBA National Contact Center, VA Solid Start, Education Call Center, and Fiduciary Call Center. These contact centers also notify callers when the anticipated wait time is 5 minutes or longer. The VBA Insurance Call Center notifies callers of any anticipated wait times that exceed 30 seconds

VA does not support the requirement for VA to issue guidance necessary to reduce the average wait time of callers to not more than 10 minutes. For any contact centers with wait times above 10 minutes, any reduction in wait times would be managed by allocating additional resources to allow for increased call handling capacity. In these situations, VA would require funding to hire more contact center representatives or for enhanced technology to support implementation and maintenance of this section of the bill. In the absence of increased capacity, guidelines alone cannot reduce wait times without a degradation of services provided.

Additionally, VA is migrating enterprise-level contact centers to a modern, cloud-based contact center platform that offers robust, reliable callback functionality. These efforts would help to ensure a consistent, modernized, and reliable experience across all enterprise-level VA contact centers. Currently, VA lacks the necessary technology infrastructure to provide the defined level of support for VA lines that could be

considered "covered lines" but are outside of the enterprise-level VA contact centers, such as VAMCs and VR&E offices.

VA is committed to maintaining a high level of customer service with consistency and quality and supports the intent of this bill.

S. 3286 Veterans Appeals Improvement and Modernization Act 2.0

Summary: This bill would modify appeals processing at the Board of Veterans' Appeals (Board), to include expanding the current evidentiary windows at the Board; requiring additional content in Board decisions; and allowing Veterans Law Judges (VLJ) to issue a decision during a Board hearing.

Position: **VA does not support some sections of the bill.**

Views: This bill would restore several of the procedural mechanisms that existed under the older Legacy appeals system and would eventually lead to the inefficiencies in that system where Veteran wait times averaged 7-10 years for full resolution of their cases. Appeals that are processed under the Appeals Modernization Act (AMA) are fully resolved (that is, no remaining remands) over 7 years faster than those processed under the older Legacy appeals system. Operating together, many of the bill's provisions could add significant delays to appeals processing timelines and lead to exponential growth in appeals backlogs at a time when the Board is reducing the number of pending appeals in its inventory after the AMA went into effect in 2019. Over the last 18 months, the promises of AMA are being realized. Nearly 90% of the Board's output is now dedicated to AMA appeals and AMA wait times have drastically decreased during the past year - with average wait times down to just over 7 months on the Direct Docket and under 1 year for the Evidence Docket. The Board is closer to resolving Veterans' AMA Hearing Docket cases down to an average of 2 years. In sum, making procedural changes and expanding evidence windows at this time would reverse progress. VA's views on each section are as follows:

Summary: Section 2 of the bill would expand the time for submitting evidence that could be considered by the Board. It would also allow appellants to move from one Board docket to another, or to withdraw an appeal by filing a supplemental claim with the agency of original jurisdiction at any time before a Board decision (without losing continuous pursuit).

Position: **VA does not support this section.**

Views: Expanding the current evidentiary windows will make the AMA like the old Legacy system and drive increased ineffectiveness and longer wait times for Veterans. VA has an alternative proposal that will accompany the FY 2027 President's Budget. Moreover, while VA agrees with the intent of allowing claimant movement within the system, VA is concerned that, as drafted, the bill would defeat a key goal of the AMA system: ensuring Veterans have up to 1 year to challenge VA decisions, while not allowing unnecessary deferrals of those choices, which can adversely impact the timely resolution of appeals. Also, implementation would require coordination between the Board and VBA systems to ensure a clear transfer of jurisdiction and proper tracking of issues. Again, VA has developed a different proposal on this issue to help improve efficiency of the AMA dockets and it accompanies the FY 2027 President's Budget.

Summary: Section 3 would allow notice of Board decisions to be provided electronically unless a claimant (or the claimant's representative) elects to receive such notice in a manner other than electronically.

Position: **VA supports this section.**

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Summary: Section 4 would require the Board to add additional mandatory elements to each Board decision.

Position: **VA does not support this section.**

Views: Most of these elements are already included in Board decisions, including the identification of issues, summary of the evidence considered, summary of laws and regulations, explanation of elements not satisfied, and identification of elements that must be satisfied to grant service connection or the next higher rating. Those items are integrated into the body of the Board's decisions. We do not interpret this section as requiring a separate section of each Board decision to specifically identify the items listed, but—if it did so require—it would make the decisions longer, less understandable, and more time-consuming to prepare. Either way, the inefficiency here would lead to fewer decisions being adjudicated and fewer Veterans receiving resolution in a timelier manner. Most notably, requiring a summary of the evidence as a separate section would likely lead to more challenges to Board decisions solely for the failure to specifically mention every piece of evidence. This would lead to appeals and remands on mere technicalities, causing work without benefit to the Veteran. If the bill were amended to say Board decisions will "generally" include these elements, it would have less negative impact on efficiency because, as noted above, Board decisions generally include these elements. With regard to the requirement that the Board provide an explanation to the Appellant about how to obtain or review evidence used in the decision, that notice is provided by the agency of original jurisdiction (AOJ) at the initial stage of adjudication, when it has the most benefit to the claimant, as opposed to at the end of the appeal process. Overall, the proposed change is not mindful of the primary audience being addressed in these decisions: the Veteran, family member, caregiver, or survivor. More hyper-technical legal requirements mean more boilerplate legal language in Board decisions, which means lengthier and more confusing decisions for that primary audience. Even minor mistakes in trying to meet those requirements would

result in enterprising lawyers filing more court appeals resulting in technical remands back to the Board where the lawyers collect fees and the Veterans receive nothing. This would be a dream scenario for some lawyers. Board decisions are already frequently longer than many U.S. Supreme Court decisions based on the current statutory and case law requirements.

Summary: Section 5 would require VA to conduct a review of the electronic systems used to process Board appeals. Within 1 year, VA would have to submit a plan that ensures seamless integration between systems used by the AOJ and the Board, and lifecycle tracking of appeals.

Position: **VA supports the intent of this section, but cites concerns.**

Views: Integration of VBA and Board systems is generally consistent with ongoing modernization efforts and may improve coordination and visibility across the appeals process. However, caregiver assistance programs are administered by VHA and incorporating VHA program data into VBA and Board integration efforts may present technical, operational, and inter-administration coordination challenges. Also, the inclusion of VHA-managed programs in these requirements could have broader implementation implications. Furthermore, VA expresses concern as the current technological capabilities of the agency do not allow for lifecycle tracking of appeals of decisions. Technical capability requires extensive development to improve the visibility and management of the lifecycle of claims and issues.

Summary: Section 6 would add a process in which claimants could obtain review of a Board decision by a different VLJ than who signed the decision.

Position: **VA does not support this section.**

Views: There are already a number of mechanisms to seek review of a Board decision, including appeal to the U.S. Court of Appeals for Veterans Claims (CAVC), filing a supplemental claim with new and relevant evidence, or filing a motion for reconsideration. In fact, last year, the Board ruled on 794 Motions for Reconsideration under the AMA. This bill has the potential to increase that by tens of thousands of appeals. Providing an additional mechanism to request re-review of Board decisions would result in VLJ shopping and would decrease the Board's ability to adjudicate appeals in a timely manner, as it could be forced to expend significant resources re-adjudicating claims that have already undergone review and received a decision. Moreover, unlike the AOJ, the Board has neither "higher level reviewers" nor VLJs who are different decision levels. Under current regulations, an appellant's Motion for Reconsideration must identify the specific issue(s) that are being challenged with the initial Board decision. This bill would remove that crucial limitation—it would effectively require the Board to issue a new, independent appellate decision every time an appellant asks for one. In practical terms, the Board would likely have to issue tens of thousands of these independent decisions each year, leaving tens of thousands of other Veterans still waiting in line to receive their first decision. This situation would likely add significant delay and increase wait time for all Veterans.

Summary: Section 7 would allow the VLJ to conduct a hearing to issue the decision, at their discretion, in whole or in part during the hearing.

Position: **VA does not support this section.**

Views: At the hearing stage, the VLJ may not have done a detailed review of all the evidence in the file and the applicable provisions of law to determine the fullest relief available. It is not uncommon for VLJs to have an initial impression during a hearing that

subsequently changes upon a deeper review of the facts and law while writing the decision. Moreover, the bill does not address how a decision during a hearing would be able to comply with the statutory requirement that Board decisions contain a written statement of findings and conclusions, and the reasons or bases for these findings and conclusions. 38 U.S.C. § 7104(d). For example, an oral grant of a 60% disability rating at a hearing could be subject to CAVC remand because it constitutes a denial of a higher rating, was not written, and was not adequately explained. Almost all oral denials and partial grants could be subject to a remand returning the case to the Board.

Summary: Section 8 would require the Secretary to submit to Congress and publish on a VA website a report on the outcome of appeals, including with respect to supplemental review, higher-level review, and options for appeals to the Board.

Position: **VA does not support this section.**

Views: Implementing this requirement may present operational considerations, particularly with respect to standardizing data definitions and reporting methodologies across systems that were not originally designed for unified, cross-lane analysis. Variations in how outcomes, issue types, and remand reasons are currently recorded, and the absence of sufficiently granular data to support the required level of reporting, may necessitate the development of new data standards, classification frameworks, and system enhancements to enable consistent and comprehensive reporting. In addition, compiling the required level of detail—such as disaggregation by diagnostic code, agency of original jurisdiction, and specific outcome categories—would likely require substantial data integration efforts between VBA and Board systems, which are not yet fully interoperable. Ensuring data accuracy, consistency, and completeness across these systems may require the creation of new data exchange mechanisms, validation processes, and governance structures. These efforts could impose additional resource and workforce demands, including increased reliance on data analytics and information

technology support. The requirement to publish deidentified data also introduces privacy and disclosure considerations, particularly where highly granular data could increase the risk of re-identification in smaller cohorts. VA may need to implement data suppression or aggregation protocols to mitigate these risks, which could in turn affect the level of detail available in the report. Moreover, without appropriate contextualization, publicly reported outcomes data may be subject to misinterpretation, particularly with respect to remand rates or other indicators that may reflect process improvements rather than deficiencies. Finally, as a technical matter, the Committee may wish to replace the term “insure” with “ensure” in proposed 38 U.S.C. § 5109(c).

Summary: Section 9 would require VA to enter into an agreement with a non-Department entity who has knowledge of the VA appeals process and the Federal rules of appellate procedures to carry out a review of such process. Section 10 would direct the Comptroller General of the United States to review VA implementation of precedential decisions issued by the CAVC or the VA Office of General Counsel.

Position: **VA supports the intent of this section but cites concerns.**

Views: To the extent these reviews could yield insights, VA supports the intent of this section but cites concerns about the budgetary impacts of these reviews as well as any delays and costs associated with potentially implementing the recommendations of the reviewers.

S. 3311 Veterans Affairs Peer Review Neutrality Act of 2025

Summary: Section 2 would add a new 38 U.S.C. § 7311B; the proposed subsection (a) would require peer review committee members to withdraw from participation if the individual has direct involvement with the care under review, or the individual is unable to conduct an objective, impartial, accurate, and informed review. In

addition, under the proposed subsection (b), VA would have to conduct an additional review by a neutral peer review committee at another VA facility for quality management reviews conducted with respect to care provided by a peer review committee member.

Position: **VA supports the intent of this bill but does not believe the legislation is necessary, as the requirements outlined in the bill are already consistent with current VA guidelines.**

Views: VA supports the underlying premises in the bill, such as maintaining the integrity of peer reviews, protecting confidential quality assurance information, and ensuring such reviews are free of bias and potential conflicts of interest that would compromise the integrity of the review. These objectives align with existing VA guidance and procedures, which already require removal of reviewers with conflicts and provide for neutral evaluation mechanisms when needed. As such, VA does not view additional statutory authority as necessary to achieve the outcomes envisioned by the bill.

S. 3395 Mammography Access for Veterans Act of 2025

Summary: Section 2(a) would amend section 102 of the Making Advances in Mammography and Medical Options for Veterans Act (the MAMMO for Veterans Act; P.L. 117-135; 38 U.S.C. § 7322 note), which requires VA to conduct a 3-year pilot program to provide telescreening mammography services for certain Veterans. These amendments would change the pilot program into a permanent program and would amend the reporting requirement to require a report not later than May 1, 2027, instead of the date that is 1 year after the conclusion of the pilot program.

Section 2(b) would require VA, not later than 2 years after enactment, to ensure VA offers at least one of the following programs in each State and Puerto Rico: the program under section 102 of the MAMMO for Veterans Act, a full-service mammography program in a VA facility, or a VA mobile mammography program.

Section 2(c) would require VA ensure that each of the programs under subsection (b) is accessible for Veterans with paralysis, a spinal cord injury or disorder (SCI/D), or another disability, consistent with applicable accessibility requirements.

Section 2(d) would provide a rule of construction that nothing in this section or its amendments could prevent VA from expanding telescreening mammography services to VA facilities that: (1) were not participating in the pilot program under section 102 of the MAMMO for Veterans Act as of the day before the date of enactment of this Act; or (2) located in States where VA does not offer breast imaging services at its facilities.

Position: **VA does not support this bill as written.**

Views: VA is concerned about whether this bill would limit or prohibit Veterans from accessing mammography and breast imaging services through the Veterans Community Care Program (VCCP) under 38 U.S.C. § 1703. Section 102(b) of the MAMMO for Veterans Act, as amended, would authorize VA to use VA community-based outpatient clinics, mobile mammography, federally qualified health centers (FQHC), rural health clinics, critical access hospitals, clinics of the Indian Health Service (IHS), and other sites as VA determines feasible to provide mammograms under the program. While section 102(b) does include non-VA facilities—specifically FQHCs, critical access hospitals, and IHS clinics, as well as potentially "other sites"—section 102 is already unclear as to whether this authority is intended to alter, expand, limit, or otherwise affect Veterans' eligibility for or use of VCCP for mammography services. We recommend the bill be clarified to ensure there is no ambiguity regarding how section 102 and the requirements of section 2(b) relate to the VCCP authority in 38 U.S.C. § 1703. VA further recommends clarifying that services provided by this authority may be provided through VCCP.

We also note that there are practical considerations that are necessary in determining whether a mammography program is viable in a facility. In particular, it is

critical that a sufficient number of patients use the services to ensure that providers maintain their credentials and qualifications. The current reality, where some facilities simply have an insufficient patient population to support a comprehensive screening and diagnostic mammography program, would continue to pose challenges with the proposed expansion under section 2(b) of the bill. Due to the rigorous technical demands for mammography examinations, sustained technical proficiency for technologists generally requires that they complete a minimum number of mammography exams every 2 years. To meet this requirement and sustain technical proficiency, the VA national Radiology Program generally recommends that a facility have at least 3,500 women Veteran users who meet screening guideline eligibility within a 1-hour average driving time of the proposed point of care to ensure there is enough volume to support an on-site mammography program. In addition, this quality threshold creates a significant constraint on the establishment of standalone mobile mammography programs, which are likely to have lower numbers of screening eligible women. This volume standard is unlikely to be met by a VA facility initiated mobile programs and, therefore, mobile mammography programs should only be considered in markets where this model of care delivery is logistically feasible.

VA has other technical concerns with the bill. Initially, because the bill would make permanent the program required by section 102 of the MAMMO for Veterans Act, this should be codified in title 38, U.S.C., for ease of reference and identification. Further, the bill does not define the term “State”; in the absence of further definition, VA generally interprets this term consistent with 38 U.S.C. § 101(20), which includes each of the 50 States or commonwealths, the territories, and possessions of the United States, including the District of Columbia and Puerto Rico. By referring to “each State and Puerto Rico” in section 2(b), the bill appears to suggest that § 101(20) does not define “State” for purposes of this bill, but that would also seemingly exclude the District of Columbia. We note also that the second part of the rule of construction in subsection (d)(2) does not include a reference to Puerto Rico, which seems to suggest that it is not covered by that part of the rule.

S. 3591 Thomas M. Conway Veterans Access to Resources in the Workplace Act

Summary: This bill would require the Department of Labor (DOL), in coordination with VA, to develop a notice detailing benefits available to Veterans, and to require employers to display such notice. The bill would also require an information campaign to inform employers of the notices and the requirement to display such notices.

Position: VA defers to Department of Labor on this bill.

S. 3647 Disabled Veterans Dignity Act of 2026

Summary: Section 2(a) would state four findings of Congress, including: (1) bowel and bladder care are supportive and necessary medical services for Veterans with SCI/D when they are unable to manage these functions independently; (2) inadequate care will lead to complications and problems such as autonomic dysreflexia that can be potentially life-threatening and result in illness and hospitalization; (3) bowel and bladder care are essential to support Veterans with SCI/D in non-institutional settings, improve quality of life, optimize health, and prevent complications from neurogenic bowel and bladder; and (4) family caregivers and individually employed caregivers provide life-sustaining care for the bowel and bladder care needs of Veterans that allow them to live in their communities. Section 2(b) would provide the sense of Congress that family caregivers and individual employed caregivers should not be subject to self-employment taxes and treated as vendors or contractors for the Veterans to whom they provide care, Veterans should not be forced to finish their bowel and bladder care needs in a set period of time that does not consider their individual needs, and Veterans should not be subjected to ongoing clinical determinations regarding their bowel and bladder care needs absent a decision by their medical care provider that such care is no longer needed.

Position: **VA has no objection to this section.**

Views: VA has no objection to this section and defers to Congress in terms of its findings and in expressing its sense.

Summary: Section 3(a) would require VA to establish a program to address the bowel and bladder care needs of covered Veterans.

Section 3(b) would require VA to provide bowel and bladder care under this program to covered Veterans based on clinical need, which could include covered Veterans receiving aid and attendance benefits from VA. A covered Veteran could receive bowel and bladder care under the program through a qualified family member, an individually employed caregiver, or a contracted home health agency. VA would have to conduct an individualized assessment with respect to a covered Veteran to determine the number of hours of bowel and bladder care needed by such Veteran under the program. Before denying bowel and bladder care for any covered Veteran under the program, VA would first have to obtain review of and concurrence with respect to such denial from a designated VA SCI/D Center.

Section 3(c) would require VA ensure the bowel and bladder care program is coordinated with other VA programs and benefits for which the covered Veteran is eligible to ensure that covered Veterans and caregivers receive appropriate support without duplicating benefits or services.

Section 3(d) would require VA provide to each family member or individually employed caregiver providing care to a covered Veteran under this program necessary supportive medical training to participate in and receive payment by VA for the provision of such care. VA would have to establish such requirements, conditions, and qualifications for providers of care under the program as necessary to provide clinically

appropriate bowel and bladder care to covered Veterans and to ensure the financial and administrative integrity of the program.

Section 3(e) would require VA to provide a monthly stipend to family members and individually employed caregivers and payment to contracted home health agencies for care provided to covered Veterans under the program. The stipend for a family member or individually-employed caregiver for care provided to a covered Veteran under the program would be determined by VA, based on the amount and degree of assistance and provided, and could not exceed the fifth step of the applicable grade of the General Schedule hourly rate paid to nursing assistants who provide such care at the VA medical facility that is nearest to the residence of the Veteran. Payment to a home health agency for care provided to a covered Veteran could not exceed the payment rates of VA under 38 C.F.R. § 17.4035 (relating to payment rates and methodologies under VCCP), or successor regulations.

Section 3(f) would require family members and individually employed caregivers providing care to covered Veterans to provide such documentation and information in such format and under such terms as VA may require as a condition of receiving payment under the program.

Section 3(g) would state that if a covered Veteran had been medically determined to require care under the program for a continuous period of 3 years or more, the Veteran would be deemed to require such care for life or until such time as the medical provider for such Veteran determined the service was no longer needed.

Section 3(h) would state that family members and individually employed caregivers providing care to covered Veterans under the program would not be considered vendors or contractors for purposes of the program.

Section 3(I) would prohibit the provision of care under the program to Veterans who can perform their bowel and bladder functions without assistance.

Section 3(j) would define the term “covered Veteran” to mean an enrolled Veteran with an SCI/D who is dependent upon others for bowel and bladder care while residing in a non-institutional setting.

Position: **VA supports this section, subject to amendments, and the availability of appropriations.**

Views: While VA has already been operating this program for approximately 35 years, specific Congressional authorization, along with further definition and parameters, would help VA ensure that Veterans in need of these services can access the support they need to live independently. We do recommend ensuring VA has flexibility to continue to adapt this program to the needs of Veterans and their caregivers, and we would be happy to work with the Committee to ensure the bill reflects this goal.

We do have some concerns with some of the language. For example, the bill would define “covered Veteran” as an enrolled Veteran who has an SCI/D; however, there may be Veterans who do not have an SCI/D but who otherwise require neurogenic bowel and bladder care (such as those who have a neurological condition, those with limited hand function, severe trauma, or multiple comorbidities). Further, we understand the sense of Congress that family caregivers and individually employed caregivers should not be subject to self-employment taxes, but we recommend Congress clearly state in the operative bill text the tax liabilities, if any, associated with VA payments under this authority.

VA has technical edits to the bill and would welcome the opportunity to discuss these further with the Committee. For example, we recommend this authority be codified in chapter 17 of title 38; amending 38 U.S.C. § 1720L, regarding home- and community-based programs and which was just codified as part of the Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act, would

seem an ideal place to locate this. We also recommend clarifying requirements related to employed caregivers, specifically who is employing them and what obligations VA has to caregivers employed directly by Veterans.

Cost Estimate: This section would result in no additional cost to VA.

S. 3653 Veterans' Bill of Rights Act of 2026

Summary: Section 3(a) would require VA to carry out efforts to inform Veterans of their rights with regard to the receipt of health care, benefits, and services furnished by VA. Section 3(b) would require VA, in carrying out subsection (a), to ensure that Veterans are aware of the following rights: (1) the right to receive health care from VA or, when eligible, community providers authorized by VA; (2) the right to be treated with courtesy, respect, and dignity in all interactions with VA personnel; (3) the right to receive clear, complete information about treatment options and to provide informed consent for care furnished by VA; (4) the right to receive comprehensive, understandable information about VA benefits, programs, and services for which Veterans may be eligible or entitled; (5) the right to apply for benefits furnished by VA at any time and to receive clear explanations from VA regarding eligibility determinations concerning such benefits; (6) the right to seek care or raise concerns without fear of stigma, retaliation, or adverse action by VA; (7) the right to the protection of personal information and medical records consistent with provisions of Federal law relating to privacy, protection of personal information, and medical records; (8) the right to file complaints concerning services furnished by VA and to receive timely, thorough investigation and resolution of those complaints; (9) the right to clear written notification from VA regarding the status of claims, benefits, and appeals filed with VA; and (10) the right to appeal adverse decisions from VA and to receive fair hearings from VA within a reasonable time.

Section 3(c) would require VA to: (1) integrate the rights described in subsection (b) into all VA policies, directives, patient-facing materials, and employee-

training programs; (2) ensure every VA employee receives annual training on such rights; (3) prominently display such rights at all VA facilities and on VA's website; (4) in consultation with the Departments of War (DoW) and DOL, include a dedicated instruction module on these rights as part of the curriculum for the Transition Assistance Program (TAP) under 10 U.S.C. § 1144; (5) within 180 days of enactment, ensure these rights are accessible through a prominent, dedicated feature within VA's official mobile app and the eBenefits portal (or successor personal benefits portal); (6) require each VA medical facility to designate a patient advocate or ombudsman to conduct an annual internal audit to assess facility compliance with these rights, including a review of Veteran satisfaction surveys and the timeliness of grievance resolutions; and (7) ensure that any written or electronic acknowledgement of a claim for benefits or an application for health care services includes a summary statement of these rights, emphasizing the Veteran's right to transparent communication and grievance redress.

Section 3(d) would set forth two rules of construction. First, no provisions in this section could be construed to create a cause of action for damages or judicially enforceable rights beyond those already established under Federal law. Second, no provisions in this section could be construed to alter statutory eligibility requirements for VA care or benefits.

Position: **VA supports the intent of this bill but cites concerns.**

Views: VA supports the intent of ensuring that Veterans know their rights with regard to the receipt of health care, benefits, and services furnished by VA. However, VA has significant concerns that, as currently drafted, the rights listed (though not judicially enforceable) are phrased more broadly than existing statutory rights and obligations, which could create confusion for Veterans regarding their actual statutory rights and obligations. In other words, this bill would create a dichotomy, where VA is advertising and disseminating a list of broad, general rights, but continuing to adjudicate entitlement under existing statutes and implementing regulations.

In terms of health care, VA has already established patient rights in regulation at 38 C.F.R. § 17.33. However, VA's regulations clearly stipulate when those rights may be restricted (such as when a health care professional reasonably believes that the full exercise of the specific right would adversely affect the patient's physical or mental health or would significantly infringe upon the rights of or jeopardize the health or safety of others). The bill contains no similar exceptions, which could create confusion. This is particularly a concern with section 3(b)(6), which would require that Veterans have, "The right to seek care or raise concerns without fear of stigma, retaliation, or adverse action from the Department." While VA fully agrees with the intent of this provision, there are times when a Veteran could seek care that would adversely affect the Veteran's physical or mental health or that could infringe upon the rights of or jeopardize the health or safety of others, and VA needs flexibility to address these unique and rare situations. Similarly, section 3(b)(1) provides that Veterans have the "right to receive health care from the Department of Veterans Affairs." While VA aspires to provide health care to as many Veterans as possible, Congress has passed laws to define who is and is not a Veteran, 38 U.S.C. § 101, as well as the terms of military service that meet statutory eligibility standards to receive VA health care. *See, e.g.,* 38 U.S.C. § 1710. Congress has also limited where Veterans may receive care. *See,* 38 U.S.C. § 1724.

The rights listed also are generally duplicative with current laws and policies. For example, VA has already defined core values, core characteristics, and customer experience principles, for how employees interact with Veterans and other beneficiaries, which have been implemented through regulations in 38 C.F.R. part 0, subpart A. Moreover, the right to informed consent for treatments and procedures is duplicative of existing VA law and regulation. VA maintains an unwavering commitment to the health and safety of Veterans. A critical component of this commitment is ensuring that informed consent practices are consistently and rigorously applied across all VA health care facilities in accordance with VA statutory and regulatory authority and policy requirements. VA already implements the requirement of 38 U.S.C. § 7331 to "ensure … to the maximum extent practicable [that] all patient care" be provided "only with the

full and informed consent of the patient" or a representative through 38 C.F.R. § 17.32 and its implementing policy VHA Directive 1004.01(3), Informed Consent for Clinical Treatments and Procedures. VA practitioners are already required to conduct and document an informed consent discussion with every Veteran, or the Veteran's surrogate when the Veteran lacks decision-making capacity, for any medical treatment or procedure recommended to them. This process includes a thorough explanation of the clinical indications, risks, benefits, and alternatives, enabling Veterans or their surrogates to make voluntary and informed decisions about their care.

With respect to disability compensation, existing regulations, including 38 C.F.R. § 3.103, already address Veterans' rights. And with respect to privacy, all Veterans and their family members are guaranteed the right to privacy through laws and regulations (e.g., 38 C.F.R. § 1.576 and 5 U.S.C. § 552a). VA protects Veteran and claimant privacy by limiting the collection and use of personal information to what is necessary to adjudicate and administer benefits, and by operating under Federal statutes such as the Privacy Act and the Health Insurance Portability and Accountability Act through VA-wide privacy policies.

Section 3(b)(5) would include a right to a "clear explanation[]" regarding eligibility determinations, but this would also create tension with existing program efficiencies across many VA programs. For example, due to operational efficiencies within VA's home loan guaranty program, the program renders eligibility determinations (a Certificate of Eligibility) almost instantaneously in nearly 80% of cases upon receiving electronic applications from Veterans or lenders on their behalf, demonstrating an efficient system that quickly renders decisions. VA is concerned that fully implementing section 3(b)(5), as drafted, could disrupt the tailored and effective operations currently in place within the VA home loan program and result in delays to a Veteran's loan closing. Additionally, the VA home loan program is administered by various financial companies, each operating under its own guidelines and in many cases, VA interfaces with the lender more often than the Veteran.

Similarly, regarding educational benefits, as of March 25, 2026, approximately 47.5% of Veterans and beneficiaries applying for Post-9/11 GI Bill (Chapter 33) benefits in FY 2026 received an eligibility determination automatically. As of the same date, over 60% of all Education claims are processed automatically, with an average completion time of 1.1 days. Section 3(b)(5) would create tension with this efficient processing.

VA does not support the requirement to include a dedicated instruction module in TAP under section 3(c)(4) as it could facilitate the removal of other critical information from the 1-day VA Benefits and Services course (for TAP): and/or could require separating Service members to participate in a longer TAP session. Additionally, a separate instruction module related to Veterans' rights would deviate from the intent of the statutorily mandated VA Benefits and Services course, which is to provide instruction on benefits administered by the Secretary under the law. Alternatively, if this bill were enacted, VA could publish the Veterans' Bill of Rights, as part of the supplemental TAP materials, such as the Benefits and Services Participant Guide. This would provide Service members with a written reference to the Veterans' Bill of Rights, versus creating a longer VA TAP course, or removing existing content from the course.

Section 3(c)(6) would require VA to designate a patient advocate or ombudsman to "conduct an annual internal audit to assess compliance." However, VA notes that patient advocates or ombudsmen are neither selected nor trained in conducting compliance audits and are not organizationally aligned to conduct such an audit independently due to the nature of their work. As a result, the patient advocate would be essentially auditing their own performance and compliance with VA's existing Core Values, Core Characteristics, and Customer Experience Principles.

VA appreciates and shares the goal of transparency and awareness for all Veterans but does not support section 3(c)(7) as it would complicate and lengthen critical claim and application related communications from VA. Veterans and stakeholders have consistently provided feedback asking VA to streamline and simplify claims-related communications to ensure Veterans have access to the necessary

information to properly manage their role in the claims process. Adding the proposed content to these communications would add additional complexity that may distract from the critical claims and application related information.

Again, because the rights listed would have no legal effect under section 3(d), the bill would create false expectations for Veterans and would require more administrative work on VA's part without an obvious improvement in services or benefits. The additional training requirements, for example, would consume VA resources in developing and administering this training. The requirement to "integrate the rights…into all [VA] policies, directives, patient-facing materials, and employee training programs" (emphasis added) would impose significant, unfunded implementation requirements on VA that would not materially alter the delivery of benefits and services to Veterans.

VA has additional technical edits on this bill as well.

S. 3706 Produce Prescriptions for Veterans Act

Summary: Section 2(a) would amend 38 U.S.C. § 1701(6), which defines the term "medical services" for purposes of chapter 17, to include the provision of produce prescriptions among medical services VA could or would have to furnish to eligible Veterans. Section 2(b) would further amend 38 U.S.C. § 1701 by including a new paragraph (11) that would define the term "produce prescription" to mean a service in which VA provides a benefit to a Veteran who has a diet-related chronic condition and is food-insecure or refers such a Veteran to receive a benefit, including a voucher or debit card, for the purchase of fruits and vegetables to improve a diet-related chronic condition.

Position: **VA does not support this bill.**

Views: While VA is supportive of the bill's intent, to improve nutrition access and support Veterans with diet-related chronic conditions, VA does not support the bill in its current form due to several structural, legal, and operational concerns that would need to be addressed before implementation.

VA has significant concerns with the proposed structure of produce prescription benefits as proposed in this bill. First, the definition of the term produce prescription in proposed section 1701(11) refers both to VA providing a benefit and to VA referring a Veteran to receive a benefit. VA generally cannot provide cash, or the equivalent of cash, in lieu of providing a service. If Congress wants VA to provide financial assistance, under certain conditions, to Veterans who face food insecurity, we recommend Congress clearly authorize such services with appropriate safeguards to prevent fraud, waste, and abuse; we do not recommend including such operative language in a definition. However, it is unclear how VA could provide any such assistance exclusively "for the purchase of fruits and vegetables to improve a diet-related chronic condition," as such funds would be fungible and auditing those purchases would likely prove extremely complicated. The referral language in proposed section 1701(11) also needs clarification, as it is unclear to whom VA would be referring Veterans to receive the benefit and if the referral would specifically include "a voucher or debit card.

In addition, the bill is potentially too narrow in its current form. While certain Veterans exhibit both diet-related chronic conditions and food insecurity, other issues including, but not limited to, housing instability can impede access to resources, such as adequate refrigeration, food storage capacity, or functional cooking facilities, and constrain Veterans' ability to effectively utilize the prescribed produce. Under these conditions, a produce prescription intervention is unlikely to achieve the intended clinical or food security outcomes.

Further, the bill does not indicate who is eligible for produce prescriptions or whether by adding the definition to medical services Congress intends for eligibility

requirements otherwise applicable to medical services to control, 38 U.S.C. § 1710. Nor is it clear what constitutes a “diet-related chronic condition,” or how VA would apply the requirement that a Veteran be “food insecure,” as this status could change over time (and could change as a result of the produce prescription itself). The bill also refers to this as a “prescription,” but it is unclear if the expectation is that a clinical provider would “write” the Veteran a prescription for produce to receive this benefit or how the prescription would be processed.

Also, including “produce prescription” in the definition of medical services under section 1701(6) would subject the receipt of produce prescriptions to copayment requirements for certain Veterans under 38 U.S.C. §1710(g); however, it is unclear if Veterans who are food-insecure could afford the copayments required by section 1710(g). Further, eligible Veterans can elect to receive medical services through VCCP under 38 U.S.C. § 1703, but it is not clear how VA could operationalize this benefit through the VCCP. This could involve significant additional contractual and administrative work.

S. 3726 National Veterans Strategy Act of 2026

Summary: The bill would add a new 38 U.S.C. § 120 to the U.S.C. Proposed section 120(a) would require the President, in collaboration with key stakeholders, to establish metrics to determine the well-being of the Veteran population. The metrics would have to apply to areas of physical health, mental health, spiritual health, economic security and opportunity, education, family and social engagement, and civic engagement.

Proposed section 120(b) would require the President to formulate and submit to Congress at least once every 4 years a national strategy to align the resources and efforts of various government, non-profit, and private sector organizations to help Veterans achieve success in the metrics required by subsection (a)(1). In formulating the strategy, the President would have to consult with key stakeholders and the general

public. The strategy would have to include consideration of the various needs of Veterans across demographics (including age, geography, sex, race, period of military service, disability, health conditions, education level, and marital and family status). The strategy would have to provide for methods to evaluate overall well-being of Veterans using the metrics required by subsection (a)(1). The strategy would have to provide direction for what benefits and services should be applied to assist Veterans who do not meet the metrics required by subsection (a)(1) in certain areas of health and well-being; it also would have to prescribe how and by whom such services and benefits should be applied to maximize effectiveness and efficiency across Federal, State, local, non-profit, and private sector resources. The strategy would have to include standard metrics to evaluate the outcomes achieved from delivering services and benefits to Veterans. Each Federal agency and recipient of a Federal grant, as a condition on the continued receipt of that grant, would have to apply these standard metrics consistently and uniformly across programs.

Proposed section 120(c) would state, notwithstanding any other provision in this section, that the President could not take any action with regard to a national strategy developed under subsection (b) if, within 60 days after Congress received a national strategy, Congress enacted a joint resolution disapproving the national strategy. This subsection would set forth requirements for the form and process of a joint resolution of disapproval, including timelines for committee and floor consideration.

Proposed section 120(d) would require the President, except as provided for in subsection (c) and not before the date that is 60 days after the date on which the President submits to Congress the strategy, to direct the heads of Federal agencies to coordinate with State and local governments, non-profit organizations, and the private sector to implement the strategy. Each head of a Federal agency would have to ensure that the agency aligned its resources, services, and initiatives with the objectives outlined in the strategy. Each head of a Federal agency would also have to, as applicable, incorporate the metrics required by subsection (a)(1) and the strategy into the agency’s strategic plan required following the start of a new Presidential term as

required by 5 U.S.C. § 306. The President would have to submit to Congress an annual report detailing implementation of the strategy, including progress toward achieving the goals of the strategy in the areas specified in subsection (a)(2). Each report would have to include a review of the performance metrics required by subsection (a)(1), among other required assessments and identifications.

Proposed section 120(e) would require the President quadrennially to review the national strategy and the metrics required by subsection (a) and update the strategy and metrics as the President considers necessary. Each review would have to assess the effectiveness of initiatives carried out pursuant to the strategy, identify challenges encountered by the Federal Government in carrying out the strategy, and recommend legislative or administrative action to address those challenges. The President would have to ensure that each review included public input through public hearings, surveys, or other appropriate methods.

Proposed section 120(f) would provide a rule of construction that nothing in this section could be construed to authorize an officer or employee of the Federal Government to carry out any program or policy that is inconsistent with any other provision of Federal law, including the elimination or rescission of any program, benefit, or service required by Federal law.

The bill would require the President, not later than 2 years after enactment, to establish the metrics required by subsection (a)(1). It would also require the President to submit to Congress, not later than 4 years after enactment, the first strategy required by subsection (b)(1).

Position: **VA does not support this bill.**

Views: VA notes that portions of the bill may overlap with existing statutory requirements, including 38 U.S.C. §§ 523 and 527. VA also notes that defining Veteran "success" and "well-being" may differ for each individual and may not be generally

quantifiable. Further concerns exist around creating a definition that is objective, measurable, and replicable in an area that can be construed as highly subjective. It is possible that evaluating well-being by focusing on Veteran prosperity may provide a better assessment than measuring "success." In any event, developing a standardized metric would require substantial time and coordinated effort.

VA would need substantial funding to coordinate the resources needed to formulate and implement the strategy. Additionally, because VA does not always have access to all data related to Veterans' interactions with non-VA Federal services, developing and maintaining this metric would also necessitate cross-agency collaboration to establish data-sharing rules and refresh cycles.

Many programs within VA cater to a unique demographic of Veterans. The bill may result in transitioning these programs from program-centric frameworks to outcome-centric approaches. However, this outcome-centric model may overlook critical contextual elements, such as staffing dynamics and the complexities of individual Veterans' situations, which are essential for effectively addressing the diverse needs of these populations.

S. 3988 Veterans Spinal Trauma Access to New Devices (STAND) Act

Summary: Section 2 of the bill would amend 38 U.S.C. § 1706 by adding a new subsection (d). The proposed subsection (d)(1) would require VA, in managing the provision of hospital care and medical services, to furnish (through direct provision of service, referral, or a VA telehealth program) a preventative health evaluation annually to any Veteran with an SCI/D who elects to undergo the evaluation. The proposed paragraph (2) would require that the evaluation include an assessment: (A) of any circumstance or condition the Veteran is experiencing that indicates a risk for any health complication related to the SCI/D; (B) regarding chronic pain and its management; (C) regarding dietary management and weight management; (D) regarding prosthetic equipment; and (E) with respect to the provision of any assistive technology, including

spinal cord neuromodulation technology (such as non-invasive transcutaneous spinal stimulation) that could help maximize the voluntary motor or autonomic function, independence, or mobility of the Veteran, including suitability of such technology for home use and need for training, programming, and remote follow-up.

Proposed paragraph (3) would require VA, in maintaining, prescribing, or amending any guidance, rules, or regulations issued by VA regarding the requirements in the new subsection (d), to consult with VA's SCI/D program managers, VA clinicians employed as specialists in SCI/D, and representatives of organizations recognized under 38 U.S.C. § 5902 (generally, organizations that prepare, present, and prosecute claims for VA benefits). Before issuing any guidance, rules, or regulations regarding the requirements set forth in this new subsection, VA would have to consult with manufacturers of assistive technologies and other entities relevant to the provision of assistive technologies if the guidance, rules, or regulations would directly affect such manufacturers or entities. VA would have to ensure, to the extent possible, that any Veteran known by VA to have an SCI/D receive information annually about the annual evaluation and the benefits to undergoing this evaluation.

Proposed paragraph (4) would authorize VA, as clinically appropriate, to provide training, programming, and remote monitoring, and follow-up for assistive technologies through telehealth.

Proposed paragraph (5) would require VA, within 1 year of the enactment of this Act and every 2 years thereafter, to submit to Congress a report on the number of Veterans who received medical care or hospital services from VA and used an assistive technology, received VA care or services and were assessed for the provision of an assistive technology, and received VA care or services and were prescribed an assistive technology. VA would also need to, for any assistive technology prescribed, identify the category of such technology (including spinal cord neuromodulation) and summarize the functional outcomes associated with the prescription of such technology

if available. Further, VA would have to report the year-to-year change in the percentage of Veterans with an SCI/D who received an evaluation described above.

Proposed paragraph (6) would require VA, in evaluating the performance metrics of a Veterans Integrated Service Network (VISN) for any year beginning after the date that is 1 year after the date of the enactment of this Act, to consider the provision of the preventative health evaluations described above.

Proposed paragraph (7) would define the term “assistive technology” to mean a powered medical device or electronic tool used to treat or alleviate symptoms or conditions caused by an SCI/D, including a personal mobility device (including a powered exoskeleton device), a speech-generating device, a spinal cord neuromodulation technology (including non-invasive transcutaneous spinal stimulation using sensory/afferent pathways intended to improve voluntary motor function, autonomic function, independence, or quality of life), and an implantable spinal cord stimulation system approved by the Food and Drug Administration (FDA), as clinically appropriate and consistent with VA prosthetic and sensory aids policy.

Position: **VA does not support this bill.**

Views: VA is committed to providing comprehensive, lifelong, innovative, and specialized care that is safe and evidence-based for Veterans with SCI/D. VA does not support this bill because it would reduce VA’s ability to ensure the safety of Veterans and would compromise the integrity of the clinical decision-making process. It would also increase administrative costs to VA, burden clinicians’ time, and ultimately result in reduced access to clinically appropriate care.

In particular, VA is opposed to proposed subsection (d)(3), which would require VA to consult with the manufacturers of assistive technologies “and other entities relevant to the provision of assistive technologies” if VA’s guidance, rules, or regulations “would directly affect such manufacturers or entities.” Mandatory consultation with such

entities in the development of clinical guidance would introduce a conflict of interest that could easily compromise patient safety. This would not only set a concerning precedent, but it would contradict best practice for the development of clinical protocols in health care settings. Research indicates that increased stakeholder involvement in the development of clinical protocols or clinical practice guidelines (CPG) can result in poor quality protocols that fail to ensure safety and do not meet the needs of clinicians in guiding best care for patients. The recommended course of action for the development of high-quality clinical protocols is to utilize research and subject matter experts from a range of settings and expertise. VA's assessment and procurement of assistive technologies is consistent with the standard practice of care for Veterans with SCI/D.

Additionally, the provisions in proposed subsection (d)(5), which would require detailed reports from VA, would consume clinicians' and administrators' time without apparent value; this additional burden would reduce the ability to see more Veterans in clinical appointments and to process requests for assistive technology and other devices, ultimately reducing Veterans' access to timely and appropriate care. VA's current data systems capture when assistive technology is procured, but the other data elements in the bill are not available. VA's systems are not able to capture instances where Veterans are evaluated, but not found suitable, for assistive technology, or Veterans who decline assistive technology.

While VA already has the authority to prescribe and purchase the devices and technology required by the bill, VA is concerned about the breadth of the definition of the term "assistive technology" in the bill. The term would mean a powered medical device or electrical tool used to treat or alleviate symptoms or conditions caused by an SCI/D, including a personal mobility device (including a powered exoskeleton device), a speech generating device, a spinal cord neuromodulation technology, and an implantable spinal cord stimulation system approved by the FDA. Given the breadth of this term, the associated procedural requirements would apply in multiple instances; this would make practical implementation very difficult, if not impossible.

Provisions of this bill related to the preventative health evaluation and assistive technology assessment are unnecessary because VA is already meeting those requirements. VHA Directive 1176(2), Spinal Cord Injuries and Disorders System of Care, dated September 30, 2019, (amended February 7, 2020), already requires Annual Comprehensive Preventive Evaluations be offered to all Veterans with SCI/D, and these requirements meet or exceed all elements of the bill in this regard. Furthermore, explicitly prioritizing powered assistive technology during annual evaluations diminishes the value of all other aspects of the comprehensive medical and functional evaluation that is performed. While assistive technology is seen as a critical component of the evaluation, it is not weighted above other interventions or considerations in providing Veteran-centered care.

To the extent the bill is concerned that Veterans do not have an opportunity to determine which assistive technologies would be best for them, VA providers work closely with Veterans to identify their needs and recommend the best solutions for them. When devices like exoskeletons are identified as a potential option to improve independence and mobility of a Veteran, VA allows the Veteran to try the device for up to 90 days to determine whether it is the appropriate solution for them. However, as of February 2025, data indicate that nearly one third of Veterans who use an exoskeleton during this trial period decide against using it beyond the trial period. VA is pursuing a similar approach with the emerging technology of transcutaneous spinal stimulation after FDA approval for this device for home use. This method ensures Veterans receive the device or technology that best meets their functional needs while avoiding waste that could otherwise result if these technologies were furnished without the Veteran's personal experience. This reflects VA's commitment to both clinically appropriate care as well as accountable fiscal stewardship.

Additionally, it is critical to ensure that Veterans can safely use any devices they are prescribed. VA was an early adopter of exoskeleton technology, and powered exoskeletons have been provided to Veterans with SCI/D since 2015, shortly after the FDA first approved powered exoskeletons for home use. To provide guidance and

ensure consistency in screening, evaluation, and training, VA developed a rigorous clinical protocol, which was shared with VA facilities in December 2015. This clinical protocol was updated in 2026, reflecting current updated literature and additional exoskeleton products that have received FDA clearance for personal use in the community since the prior publication. VA is developing a similar protocol for transcutaneous spinal stimulation.

Further demonstrating VA's commitment to supporting exoskeletons and innovative technology, VA performed one of the largest national randomized, controlled multi-center exoskeleton research studies, investigating home/community use, efficacy, and safety of powered exoskeletons in Veterans with SCI/D. Powered exoskeletons can lead to assisted ambulation in individuals with SCI/D, yet they require careful evaluation of potential users, extensive training, inclusion of a companion for safe use, extensive clinician experience, and specific manufacturer training and expertise by staff for safe and effective use by individuals with SCI/D. Notably, the criteria for each device are largely based on FDA specifications. VA has taken an individualized approach to Veterans' exoskeleton training to minimize the burden on Veterans who are interested in and are evaluated for clinical appropriateness to utilize this technology.

Exoskeletons are complicated medical devices, and exoskeleton-trained clinicians must consider a number of factors when issuing this equipment. Factors include but are not limited to: level of spinal cord injury, height, weight, hip and leg length measures, joint range of motion (flexibility), skin integrity, spasticity, arm/hand strength, bone density, history of fractures, blood pressure, autonomic dysreflexia, cardiovascular health, cognition, environments of intended use, Veteran's goals for use of the device, vision, and the ability to develop the skill needed to operate this equipment. Due to the complexity of the devices, a large number of Veterans who are interested in exoskeletons are not appropriate for the use of these devices. Additionally, for safety reasons, the devices currently available in the United States require a companion to be present when an individual is utilizing this technology. Many individuals lack access to an appropriate companion to help with management of the

device, which can weigh up to 51 lbs. Requiring the presence of a companion while utilizing the device can result in the perception of decreased independence to users who are fully independent when using a wheelchair. The involvement of a companion also prolongs the training period and requires significant commitment from both the Veteran and companion.

Exoskeletons have been studied in a number of settings, and there are many potential benefits, such as standing, walking, cardiovascular response, spasticity management, weight loss, bowel function, and bone density. Evidence of adverse events, including fractures, falls, skin breakdown, autonomic dysreflexia, and soft tissue injuries have been reported across subjects, studies, and devices. Currently, there are no established CPGs regarding the use of exoskeletons. For each individual, it is still largely unknown if the benefits outweigh the risks and how to identify candidates who will most likely benefit from the technology. Therefore, VA has developed a clinical protocol that emphasizes patient preference and safety. Importantly, through safe, evidence-based services and devices, VA will continue its ongoing efforts to support Veterans with SCI/D in their goals of optimizing their health, functional mobility, and independence. Those efforts include careful evaluation and when appropriate, provision of assistive technology devices including powered exoskeletons.

Clinical application of transcutaneous and epidural spinal stimulation requires close safety monitoring as we implement this novel technology within VA. VA is focused on ensuring Veterans have access to and can use specialized technology to address their needs. VA is continually reviewing current clinical protocols to ensure Veterans receive timely, high-quality, and evidence-based care and technology.

S. 3992 Joint Medical Facilities Fund Act of 2026

Summary: Section 2(a) would establish a new section 1110c in title 10, U.S.C., regarding the Joint Medical Facility Fund. Proposed section 1110c(a) would establish on the books of the Treasury under VA a fund known as the Joint Medical Facility Fund

(the Fund). Proposed section 1110c(b) would state that the purpose of this Fund would be to facilitate the joint funding of designated combined Federal medical facilities of DoW and VA. Proposed section 1110c(c) would authorize amounts to be transferred to the Fund by DoW from amounts authorized and appropriated for DoW and from amounts authorized and appropriated by VA, as determined by a methodology jointly established by DoW and VA that reflects the mission-specific activities, workload, and costs of provision of health care at DoW and VA facilities. Amounts could be transferred to the Fund from medical care collections under 10 U.S.C. § 1095, 38 U.S.C. § 1729, and the Federal Medical Care Recovery Act (P.L. 87693; 42 U.S.C. § 2651 et seq.). Proposed section 1110c(d) would provide that amounts transferred to the Fund would be available to fund operations of designated combined Federal medical facilities of DoW and VA, including capital equipment, real property maintenance, and minor construction projects that are not required to be specifically authorized by law under 10 U.S.C. § 2805 or 38 U.S.C. § 8104. Amounts transferred to the Fund by DoW could be used for facility operations of the Captain James A. Lovell Federal Health Care Center (FHCC), consisting of the North Chicago VAMC the Navy Ambulatory Care Center, and supporting facilities designated as a combined Federal medical facility under an operational agreement covered by section 706 of the Duncan Hunter National Defense Authorization Act for FY 2026 (the NDAA for FY 2026; P.L. 110417; 122 Stat. 4500). The availability of amounts transferred to the Fund would be subject to the provisions of 38 U.S.C. § 1729A. In general, amounts transferred to the Fund would remain available until the end of the first fiscal year beginning after the date of the transfer; however, of the amounts transferred in a fiscal year, an amount not to exceed two percent of such amount would remain available until the end of the second fiscal year beginning after the date of the transfer. Proposed section 1110c(e) would require the Fund be administered in accordance with an executive agreement between VA and DoW. The agreement would have to be consistent with section 706 of the NDAA for FY 2026 and provide for an independent review of the methodology established under subsection (c). The executive agreement would also have to provide for the development and implementation of an integrated financial reconciliation process that meets the fiscal reconciliation requirements of DoW and VA. This process would have to identify the

fiscal contributions of DoW and VA to the Fund, taking into consideration accounting, workload, and financial management differences.

Section 2(b) would repeal section 1704 of the NDAA for FY 2010 (P.L. 111-84; 123 Stat. 2571), which provides joint funding authority similar to what this bill would establish in proposed 10 U.S.C. § 1110c.

Section 2(c) would require DoW and VA to jointly submit a report to Congress, not later than 180 days after enactment, indicating DoW and VA medical facilities that either Secretary, or both, consider appropriate to be designated as combined Federal medical facilities of DoW and VA.

Position: **VA strongly supports this bill.**

Views: VA strongly supports this bill, which is based on a legislative proposal VA included in the FY 2026 President's Budget request. This bill would make permanent the funding authorities for the Joint DoW-VA Medical Facility Demonstration Fund (the Fund), originally established by section 1704 of the NDAA for FY 2010 (P.L. 111–84; 123 Stat. 2571). Codification would eliminate the annual uncertainty and potential delays associated with seeking renewal through the NDAA. The FHCC provides essential health care services to Veterans and military personnel. Codifying these safeguards would ensure uninterrupted funding, preventing disruptions that could negatively impact patient care. Codifying the authority also would signify a lasting commitment to the joint DoW/VA health care model, fostering stability and encouraging further collaboration and innovation in integrated care. Permanent authority would allow for more effective long-term planning and resource allocation, promoting efficient and responsible use of taxpayer dollars. Finally, providing permanent authority would reduce administrative costs and streamline processes, as annual legislative efforts consume valuable time and resources. Codification would streamline the process, freeing up personnel to focus on other high priority matters.

Cost Estimate: In the FY 2026 President's Budget request, VA estimated that enactment of this authority would result in no costs to VA.

S. 3993 Reducing Arbitrary Barriers to Apprenticeship Act of 2026

Summary: This bill would amend 38 U.S.C. §§ 3313(g)(3)(B) and 3032(c) and 10 U.S.C. § 16131(d) to increase the monthly rate VA would pay for apprenticeships or on-job training (OJT) programs under the Post-9/11 GI Bill (Chapter 33), the Montgomery GI Bill-Active Duty (Chapter 30), and the Montgomery GI Bill-Selected Reserves (Chapter 1606). Currently, VA pays a monthly housing stipend under Chapter 33 for pursuit of a full-time apprenticeship or OJT program that is based on the housing stipend payable under title 37, reduced by 20% of the full stipend after 6 months, and reduced by an additional 20% of the full stipend after every subsequent 6-month period for the first 2 years of training. This bill would require VA to pay the full monthly amount of the basic allowance for housing payable under 37 U.S.C. § 403 for a member with dependents in pay grade E-5 residing in a particular area, without a reduction based on the training time period.

In addition, this bill would require VA to pay the full monthly educational assistance allowance under Chapter 30 and Chapter 1606 for the duration of participation in an apprenticeship or OJT program, instead of a reduced amount that is further reduced after 6 and 12 months. This bill would also require VA to adjust the entitlement charges under Chapters 30 and 1606 for each month VA pays an educational assistance allowance to reflect the increased monthly educational assistance payments for participation in an apprenticeship or OJT program. VA would not reduce entitlement proportionately because there would be no reduction in payments.

Furthermore, this bill would protect all beneficiaries (Chapters 33, 30, and 1606) from a reduction in their monthly housing stipend if they fail to complete 120 hours of training while pursuing an apprenticeship or OJT program in an occupation that

performs work classified in Sector 23 of the most recent publication of the North American Industry Classification System, which is the designation for the construction sector.

Position: **VA supports this bill but cites concerns.**

Views: VA recognizes the essential role apprenticeship programs play in addressing the Nation's skilled-worker shortage and the importance of strongly supporting increased participation in apprenticeship programs. Because these programs are central to closing the workforce gap, VA supports legislative efforts that enhance and expand apprenticeship participation. However, VA is concerned that this proposal appears to rely on an unsupported assumption that Veterans are not participating in apprenticeship programs because GI Bill benefits are not sufficiently competitive, and that increasing benefit rates across programs would therefore drive greater participation in apprenticeship programs. VA has no evidence indicating that benefit levels are the reason Veterans do not pursue or complete apprenticeships. Moreover, the proposed approach risks depleting Veterans' entitlement (and taxpayer dollars), making it harder for Veterans to complete their apprenticeship programs and therefore unintentionally disadvantaging them, without achieving the intended increase in skilled Veteran workers.

Research does not indicate that Veterans are underrepresented in apprenticeship and OJT programs. According to a report created for DOL at the request of the Chief Evaluation Office by Project for Middle Class Renewal at the University of Illinois at Urbana-Champaign and the Illinois Economic Policy Institute, Veterans comprise 8% of apprenticeships[1]. This is comparable to the percentage of Veteran enrollment in postsecondary education. According to Department of Education data,

[1] Bruno, R., & Manzo, F. (2025, January 20). White Paper. *Living Wages in Registered Apprenticeship Programs: An Assessment by Industry, Demographics, State, and Labor Policy*. https://illinoisepi.wordpress.com/wp-content/uploads/2024/12/pmcr-ilepi-living-wages-in-registered-…

Veterans make up 3.7% of undergraduate students[2]. In the 2019-2022 period covered by the report, Veterans outperform non-Veterans in apprenticeship completion rates at 67.8% for Veterans compared to 57.6% for non-Veterans. In the construction industry, Veterans were 13% more likely to complete their apprenticeship, and Veterans realized an earnings growth from an average of $18 per hour on “day one” to more than $32 per hour, a 77% growth[3]. Therefore, it appears that Veterans are participating in apprenticeship programs but not using their GI Bill benefits. One explanation is that they want to conserve their GI Bill benefits to obtain degrees to augment their apprenticeship training, to be able to transfer benefits to dependents, or to save benefits for future training. Moreover, there is no data to support the conclusion that increased program expenditures will increase GI Bill utilization.

Additionally, VA has concerns that removing the reduction in benefits payments will have the unintended consequence of exhausting Veterans benefits. Currently, entitlement charges are prorated based on payment tiers. VA charges a percentage of entitlement for months of payments that are less than the full monthly housing allowance (MHA) rate. However, under the bill, VA would have to charge full entitlement when it pays the full MHA, resulting in exhaustion of benefits more quickly. Also, the special provisions concerning Sector 23 jobs would require VA to pay the full-time rate for apprenticeships or OJT programs for Sector 23 jobs regardless of the hours of training completed. If a Veteran fails to complete 120 hours of training, VA would pay the full amount of benefits, resulting in a loss of a full month of entitlement even though the Veteran did not train for a full month. For example, if a Veteran only worked 5 hours in a month instead of 120 hours, the Veteran would be far off pace to achieve journeyman status and full employability but would have lost a full month of entitlement. In other words, the Veteran could be without economic support from the GI Bill to continue training to achieve employability.

[2] Postsecondary National Institute, *Veteran Students in Higher Education*, p. 2 (Updated February 2025) https://pnpi.org/wp-content/uploads/2025/02/Veterans_FactSheet_Feb25.pdf
[3] Ibid.

To increase participation in apprenticeship programs, VA partners with DOL and is taking actions to improve marketing and awareness of apprenticeships and OJT programs. According to VA data covering FY 2025, about 15,000 Veterans are using their GI Bill benefits to participate in apprenticeship and OJT programs. While VA lacks data to identify the cause of the low level of benefits use (approximately 15,000) compared to total Veterans in apprenticeships (approximately 231,000), there is no indication that current payment rates contribute to the cause.

Additionally, the bill does not amend Chapter 31 to increase the monthly subsistence allowance rate VA pays Veterans participating in apprenticeship or OJT programs as part of the VR&E program. Pursuant to 38 U.S.C. § 3108(c)(1), VA can reduce the subsistence allowance payment for pursuing apprenticeships or OJT programs to an amount considered equitable. If the intent of this bill is to ensure equity for all Veterans pursuing OJT and apprenticeships, we recommend amending Chapter 31 to require VA to increase the subsistence allowance for VR&E program participants pursuing apprenticeships, subject to the availability of appropriations.

Finally, VA is concerned about difficulties implementing this bill, which would require significant changes to VA Information Technology (IT) systems. Therefore, VA requests that Congress include additional IT development funding and a 2-year future effective date to provide VA time to implement these IT changes. VA would also require additional appropriations to cover the increased costs of the monthly payments.

VA welcomes the opportunity to work with Congress to more effectively address these challenges and develop solutions that genuinely improve outcomes for Veterans pursuing apprenticeship and OJT opportunities.

S. 3999 Women Veterans Specialty Care Access Act

Summary: Section 2(a) would require VA to ensure that any covered Veteran could directly schedule an appointment for women's specialty care, including through

the VCCP under 38 U.S.C. § 1703, without requiring a referral from a VA primary care provider. Section 2(b) would require VA to ensure that direct scheduling was available through each VAMC or clinic that offers women's specialty care and via telephone, online scheduling tools, and any other modality used by VA for scheduling specialty care. Section 2(c) would prohibit VA from requiring any additional approval, referral, or screening step as a condition of a covered Veteran's accessing women's specialty care. Section 2(d) would state a rule of construction that nothing in this section could be construed to alter or waive eligibility or access standards for the receipt of care or services under 38 U.S.C. § 1703. Section 2(e) would define two terms for purposes of this section. First, the term "covered Veteran" would mean a woman Veteran enrolled in VA care who is eligible for the receipt of women's specialty care under the laws administered by VA. Second, the term "women's specialty care" would mean gynecology care, obstetrics care, maternity care, and postpartum care.

Position: **VA supports the intent of this bill but cites concerns.**

Views: As of December 4, 2025, women Veterans can now schedule appointments directly with gynecology specialists without a referral from a VA primary care provider. However, a determination of clinical necessity is still made prior to scheduling the appointment. Furthermore, VA already allows Veterans access to gynecology in the community without a referral when the care is determined to be clinically necessary and the Veteran meets the statutory and regulatory eligibility criteria. Therefore, it appears section 2(a) of the bill may be unnecessary.

VA is concerned with inconsistencies in the language in this bill and how this authority would fit into VA's existing statutory authorities. VA generally furnishes care to enrolled Veterans under 38 U.S.C. § 1710, and care under § 1710 is care that VA has determined is necessary. Care that Veterans access through the VCCP is still care under § 1710 and still subject to the requirement that VA determine such care is necessary; care under § 1703 is further subject to the limitation that VA authorizes that care. The bill, however, would allow Veterans to schedule care, including through the

VCCP, without VA first determining that care is necessary. Further, section 2(c) would prohibit VA from requiring "any additional approval, referral, or screening step as a condition of a covered Veteran accessing women's specialty care." We recommend revising the bill to clarify that VA must still determine that care is necessary before it can be furnished; absent such a change, VA would still have to interpret the language to include such a requirement. If VA were not required to determine that the care is necessary in the first place, this could be a violation of Office of Management and Budget (OMB) Circular A76, which requires that inherently Governmental functions (including the obligation of Federal resources, which would result from a Veteran seeking care without VA determining it to be necessary or without authorizing that care in the first place) must be performed by Government employees. Veterans who self-scheduled appointments that VA determined were not necessary could be solely liable to the provider for such care.

Additionally, VA has concern about the scope of services covered by this bill. The definition of women's specialty care includes obstetrics, maternity and postpartum care. Including these services within the scope of this bill would circumvent our maternity care coordination program, which is designed to ensure the appropriate care coordination for the safety of our Veterans. VA is required by the Protecting Moms Who Served Act of 2021 (P.L. 117-69) to carry out a maternity care coordination program, so if this bill were enacted, VA could be put in the position where it would have to violate one of these two laws.

VA would appreciate the opportunity to discuss the concerns underlying this bill further with the Committee to determine whether legislation is needed, and if so, how this bill could be amended to address the concerns identified here and to achieve the intended goal of the bill.

S. 4043 Health Care for Homeless Veterans Act

Summary: Section 2 would amend 38 U.S.C. § 2031, which authorizes VA to provide care and services under 38 U.S.C. § 1710 to Veterans suffering from serious mental illness and to Veterans who are homeless, by removing the sunset provision in section 2031(b), which is currently set to expire on September 30, 2026.

Position: **VA strongly supports this bill.**

Views: VA strongly supports this bill, which is based on a legislative proposal that VA submitted in the FY 2026 President's Budget request. VA has implemented the Health Care for Homeless Veterans (HCHV) program pursuant to the authority in section 2031. HCHV programs often serve as the first gateway for eligible Veterans who are homeless to access VA health care, mental health and substance use treatment, and linkage to other community care and resources. Since 2011, Congress has extended the expiration date in section 2031(b), most often in 1- or 2-year intervals. While VA appreciates Congress's continued support of HCHV though these extensions, passing this bill would eliminate the threat of interruption in VA's authority, thereby allowing for longer term planning and helping ensure the long-term success of the HCHV program.

Cost Estimate: VA estimates that enactment of this authority would result in 1-year, 5-year, and 10-year discretionary costs of $189 million, $1.02 billion, and $2.3 billion, respectively. VA estimated that enactment of this authority would result in 1-year, 5-year, and 10-year mandatory costs of $120.5 million, $651 million, and $1.4 billion, respectively.

S. 4140 Carlton H. Ingram Veterans' Benefits Improvement Act

Summary: This bill would amend 38 U.S.C § 1155 to impose requirements on how VA may adopt and apply the schedule of ratings for compensating disability. Specifically, section 2 of the bill would require VA to construct the schedule of ratings in a manner that discounts the beneficial effects of medication or treatment when evidence

can be used to establish a so-called “baseline” level of disability without those beneficial effects. Section 2 of the bill would also instruct that VA cannot construe the requirement to discount beneficial effects in a way that would prevent Veterans from seeking compensation for additional disabilities that result from medication or treatment of an SC condition.

Position: **VA does not support this bill.**

Views: Preliminarily, VA observes that this legislation is unnecessary to achieve Congress’s stated goal. On February 27, 2026, the Secretary of Veterans Affairs rescinded Interim Final Rule AS49, *Evaluative Rating: Impact of Medication*, with the stated intent not to reintroduce it in the future. On March 30, 2026, the U.S. Court of Appeals for the Federal Circuit granted the Secretary’s motion to voluntarily dismiss the appeal of *Ingram v. Collins*. VA has already begun implementing, and will continue to implement, the ruling of the United States Court of Appeals for Veterans Claims in *Ingram*.

The portion of § 1155 that the bill would retain and redesignate as subsection (a) mandates that “the ratings shall be based, as far as practicable, upon the average impairments of earning capacity resulting from such injuries in civil occupations,” subject to periodic readjustment by VA “in accordance with experience.” This instructs VA, in light of evolving medical and scientific knowledge, to align its criteria for evaluating disability with functional loss that directly results in occupationally significant impairment. Consistent with *Ingram*, VA already determines whether the impact of medication or treatment on a Veteran’s level of functional impairment should be used as an explicit rating consideration when VA periodically reassesses the evaluative criteria of individual body systems and diagnostic codes.

The changes to § 1155 proposed by the bill, however, would likely create substantial confusion over the statutory standards governing VA’s adoption and application of the schedule of ratings. Section 2 of the bill, by requiring under proposed

§ 1155(b)(1) that VA discount the beneficial effects of medication or treatment in *all* disability rating contexts, would be in tension with the guiding mandate being retained under proposed § 1155(a). Taking medication or undergoing treatment does not automatically affect disability level. Medication or treatment might have no impact on functional loss for some individuals, minimal impact for others, and greater impact for still others. Taking medication or undergoing treatment are not always good indicators of occupationally significant disability that impairs earning capacity, which would remain the foundational standard under section 1155 for constructing the schedule of ratings.

Furthermore, because proposed § 1155(b)(1) would mandate that beneficial effects be discounted "when evidence can be used to establish a baseline without those beneficial effects," this bill would likely lead to inequitable and inconsistent ratings for Veterans who do not have sufficiently documented evidence available. As a corollary to these concerns, proposed § 1155(b)(1) might also encourage Veterans to discontinue taking medication to obtain higher ratings or determine a previously unknown "baseline," which could undermine VA's efforts to provide effective health care. Most importantly, this mandate is unnecessary as VA has already undertaken implementation of *Ingram* in accordance with governing judicial precedent.

Finally, VA does not consider proposed subsection (b)(2) to be necessary. VA already provides compensation for any disability that is "due to or the result of a service-connected disease or injury" and specifies that such secondary conditions "shall be considered a part of the original condition" in accordance with 38 C.F.R. § 3.310. This includes conditions resulting from treatment or medication for an SC condition, as is well reflected in VA practice and governing judicial precedent.

S. 4220 Veterans Health Administration Novel Therapeutics Preparedness Act

Summary: Section 2 would express five findings of Congress: (1) emerging therapeutic interventions, including certain psychedelic-assisted therapies under

evaluation by the FDA as of the date of enactment, may significantly alter the treatment landscape for posttraumatic stress disorder, depression, and other mental health conditions affecting Veterans; (2) the administration of certain emerging therapies may require intensive clinical engagement, interdisciplinary teams, dedicated clinical space, structured preparation, and post-treatment integration that differ substantially from traditional outpatient mental health services; (3) VA is uniquely positioned to deliver integrated, Veteran-centered care that combines medical, mental health, and peer support services within a single system of care; (4) absent centralized governance and implementation planning, VA may face delays, safety risks, or inconsistent access following regulatory approval of such therapies; and (5) establishing a dedicated Office of Novel Therapeutics will ensure that VA is prepared to responsibly evaluate, research, and implement emerging treatment modalities consistent with patient safety and evidence-based practice.

Position: **VA has no objection to this section.**

Views: VA has no objection to this section and defers to Congress in expressing its findings.

Summary: Section 3 would add a new subchapter VI to chapter 73 of title 38, U.S.C., regarding novel therapeutics. This subchapter would consist of new sections 7391-7397.

Proposed section 7391 would define two new terms for this new subchapter. The term “Center of Excellence” would mean a VAMC designated under proposed section 7394 as a Center of Excellence for novel therapeutics to advance research, training, and implementation of emerging therapeutic interventions. The term “emerging therapeutic intervention” would mean a pharmacological, biological, or other therapeutic modality under evaluation or review by the FDA.

Proposed section 7392(a) would establish in VHA, under the Office of the Under Secretary for Health (USH), an Office of Novel Therapeutics (the Office). Proposed section 7392(b) would state the head of the Office would be the Director of the Office of Novel Therapeutics, who would be appointed by the USH; the Director would have to possess demonstrated expertise in clinical research and implementation science and report directly to the USH. Proposed section 7392(c) would require the Office to serve as the primary coordinating authority within VHA for matters relating to emerging and novel therapeutic interventions. Proposed section 7392(d) would establish 12 duties of the Office: (1) developing and overseeing national policy, guidance, and clinical standards for the evaluation, research, and potential implementation by VHA of emerging and novel therapeutic interventions for mental health conditions affecting Veterans; (2) developing a national clinical model for the administration of intensive therapeutic interventions, including structured preparation, monitored administration, and post-administration integration; (3) developing guidance regarding patient eligibility and candidacy for emerging therapeutic interventions, ensuring that utilization management or step therapy requirements do not unduly restrict access where clinically appropriate; (4) developing implementation-readiness plans for therapies that may receive approval from the FDA; (5) conducting a workforce-readiness assessment to identify clinicians and peer support specialists with prior training or certification relevant to emerging therapeutic interventions and gaps in training, supervision, and clinical capacity necessary to support safe and effective implementation of such interventions; (6) establishing national training and credentialing standards for clinicians administering novel therapeutics; (7) developing a standardized, competency-based training framework for clinicians and peer support specialists participating in emerging therapeutic interventions, including preparation, monitored administration, integration, safety monitoring, interdisciplinary collaboration, and culturally competent care; (8) distinguishing between research protocols and clinical implementation standards to ensure that patient care models are not constrained solely by sponsor-driven research design; (9) coordinating with the Office of Research and Development; (10) developing guidance to ensure continuity of care; (11) identifying no fewer than one VAMC in each VISN to develop infrastructure and workforce-readiness for emerging therapeutic

models; and (12) establishing criteria for the designation of Centers of Excellence and overseeing compliance with national standards.

Proposed section 7393(a) would require the Office to establish a Clinical Implementation Program for Emerging Therapeutics (the Program) to evaluate the effectiveness, feasibility, safety, and scalability of emerging therapeutic interventions within VA. Proposed section 7393(b) would require the Program to utilize effectiveness-implementation hybrid models to evaluate both clinical outcomes and real-world implementation factors with respect to emerging therapeutic interventions; test and refine care delivery models; generate real-world evidence to inform potential systemwide adoption; and assess workforce, infrastructure, cost, and operational requirements necessary for broader implementation. Proposed section 7393(c) would authorize VA to prioritize one or more brain or mental health conditions affecting Veterans when carrying out the Program. Proposed section 7393(d) would authorize VA to conduct the Program at one or more Centers of Excellence and at such other VAMCs as appropriate.

Proposed section 7394(a) would authorize VA to designate one or more VAMCs as Centers of Excellence for novel therapeutics. Proposed section 7394(b) would require the Centers of Excellence to serve as a national leaders in research, clinical training, and implementation of emerging therapeutic interventions, develop and disseminate best practices and clinical standards across VHA, provide technical assistance and training to other VAMCs, integrate interdisciplinary care models, incorporate Veteran advisory input into program development, and coordinate with academic affiliates and external research partners. Proposed section 7394(c) would require the Centers of Excellence to operate in coordination with, and under standards established by, the Office.

Proposed section 7395(a) would establish a Veterans Advisory Committee on Novel Therapeutics (the Committee). Proposed section 7395(b) would require VA to select members of the Committee, including: (1) Veterans with lived experience of

mental health treatment furnished by VA; (2) Veterans who have participated in clinical research involving emerging therapeutic interventions; (3) family members or caregivers of Veterans described in (1) or (2); (4) representatives from academic institutions affiliated with VA with expertise in clinical research, behavioral health, or emerging therapeutic interventions; and (5) subject matter experts as appropriate. Proposed section 7395(c) would require the Committee to provide input on patient safety considerations, informed consent practices, implementation and access barriers, and patient-centered care design.

Proposed section 7396 would require VA, in carrying out this subchapter, to coordinate with the Secretary of the Department of Health and Human Services, the FDA Commissioner, the Administrator of the Centers for Medicare & Medicaid Services, DoW, and the Administrator of the Drug Enforcement Administration to support regulatory readiness, development of reimbursement and billing pathways, scheduling and rescheduling considerations, and shared data infrastructure for monitoring safety, quality, and outcomes.

Proposed section 7397 would require VA to submit to Congress an annual report describing VA research activities relating to emerging therapeutic interventions, clinical outcomes and patient-reported outcomes under the Program under proposed section 7393, safety events and adverse outcomes, workforce readiness and training capacity, implementation barriers (including staffing, procurement, and infrastructure needs), and recommendations for legislative or administrative action relating to novel therapeutics.

Section 3(b) of the bill would require VA, within 180 days of enactment, to submit to Congress a national preparedness and implementation strategy for emerging mental health therapeutics, including workforce capacity assessments, facility modification needs, projected timelines for phased implementation, and barriers to implementation.

Position: **VA does not support this bill.**

Views: VA supports the intent of the bill to advance preparedness and implement novel and emerging mental health treatments for Veterans. However, VA already has existing procedures in place that meet the intent of the bill and will not benefit from the additional authorities it would provide.

VA does not believe a new office is needed to carry out the duties and requirements outlined in this bill. Under its current authorities, VA has established an Integrated Project Team (IPT) for psychedelics, which has been proactively addressing the majority of the functions that would be assigned to the proposed office. The IPT was established to inform VHA senior leaders on key issues associated with psychedelic treatments for mental health conditions, develop guidance for research and clinical implementation of psychedelic treatments at VHA, develop a program evaluation infrastructure to ensure VA has information to make data-driven decisions about psychedelic treatments, develop guidance describing resource requirements to support implementation, develop resources to support psychedelic treatment through community care, and develop communications for VHA to support the dissemination of accurate information on the use of psychedelics for mental health treatment to Veterans, clinicians, and other key stakeholders. As such, the bill's requirements would largely duplicate the efforts of the existing IPT.

VA has a number of technical concerns on this bill, some of which are summarized below. We would be pleased to discuss these and additional comments with you in more detail.

We caution against establishing prescriptive duties for a new Office for multiple reasons. The specificity included in this bill would limit the proposed Office's ability to adapt to new conditions without seeking a change in its statutory authority. The breadth of duties this bill assigns would result in duplication of functions or tasks that are currently performed by other VA offices at the national, VISN, and VAMC levels, as well as by current VA Centers of Excellence. Moreover, the bill would require significant staffing focused on novel therapeutics rather than current areas of responsibility.

Without additional funding or hiring authority, this bill would severely restrict VHA's ability to provide adequate services to Veterans because many of its current staff would be redirected to prepare for psychedelic treatment implementation. The structure and the size of the proposed Office would limit VHA's ability to adapt to new conditions and would be inconsistent with VHA's current reorganization efforts.

Limiting the scope of such an Office to modalities that are "under evaluation or review by the FDA" could unintentionally undermine the intent of the bill to ensure that novel treatments are made available to Veterans. Once a compound is approved by the FDA for clinical use, it would no longer meet the definition of emerging therapeutic intervention and would no longer be within the scope of the Office of Novel Therapeutics. It does not appear that the intent of the drafters of the bill was to end the involvement of the Office once FDA approval occurs, as it appears that the Office could still be helpful in supporting access to such treatments after FDA approval.

With regard to the expertise that would be required for the Director of the Office of Novel Therapeutics, the focus on research and implementation of science expertise is not consistent with the duties, requirements and functions of such an Office and would undermine the success of the Office, if established, in carrying out its role.

With regard to developing a national clinical model for administration of intensive treatments, it is very unlikely that a single national clinical model would be appropriate and applicable for the administration of these types of interventions. Different treatments will require different models and, even for the same treatment, different therapeutic models may be appropriate and would need to be evaluated. In addition, once the FDA has approved such substances for clinical use, they may be subject to FDA oversight and Risk Evaluation and Mitigation Strategies, which are outside of VHA's control.

The bill text is also inconsistent in referring to VAMCs; sometimes these are specifically referred to in the context of VAMCs, but in other places, the language is not restricted in this way. It is unclear if all of the references to "medical centers" should be

VAMCs or if this was intended to include non-VAMCs as well. In the absence of further changes, VA would interpret the term “medical centers” to be limited to VAMCs, but we encourage the bill to be clear in this regard.

We note that the Committee would expressly be an advisory committee and subject to the Federal Advisory Committee Act (5 U.S.C. § 1001 et seq.). The requirement for the Committee to recruit and review members with specific mental health care experiences is problematic because VA would have to ask potential nominees to reveal personally identifiable information (and potentially sensitive health information) as part of the review process; this information then would have to be safeguarded in VA’s systems to ensure no improper disclosure. Proposed section 7395 does not provide the specific authority most other VA advisory committees have in terms of establishing subcommittees, appointment terms, pay, meetings, reports, and other administrative authorities. The absence of such language could limit the efficacy of the Committee or produce operational challenges. Authority to establish subcommittees, for example, is an important asset for the Committee to have and a standard provision in Federal Advisory Committee Act charters.

180 days is an insufficient amount of time to submit to Congress a national preparedness and implementation strategy, as would be required by section 3(b) of the bill.

S. XXXX Veteran Acquired Brain Injury Caregiving Act

Summary: Section 2(a) would require VA, not later than 180 days after enactment, to carry out a 5-year pilot program under which an “eligible Veteran mission-driven nonprofit” organization could receive funds under the Veteran-Directed Care (VDC) program for providing services to eligible Veterans. Section 2(b) would require VA to select not fewer than five VAMCs at which to carry out the pilot program. Section 2(c) would require VA, not later than 1 year after enactment and annually thereafter until the termination of the pilot program, to submit a report to Congress on the number of

eligible Veterans receiving assistance under the pilot program, the number of "eligible Veteran mission-driven nonprofits" participating in the pilot program, and an evaluation of the clinical outcomes of Veterans participating in the pilot program, Veteran satisfaction with the pilot program, and other relevant data the Secretary determines appropriate. Section 2(d) would define the term "eligible Veteran" to mean a Veteran who is clinically assessed to have an acquired brain injury. The term "eligible Veteran mission-driven nonprofit" would mean an organization: (1) described in section 501(c)(3) of the Internal Revenue Code of 1986 that is exempt from taxation under section 501(a) of such Code; (2) that provides services provided under the VDC program for a Veteran; and (3) the individuals to which the organization provides assistance, including under authorities other than in this section, consist of not less than 70% Veterans. Section 2(d) defines the term "Veteran-Directed Care program" to mean the program under 38 U.S.C. § 1720L(b).

Position: **VA does not support this bill.**

Views: VDC is a national VA program that gives eligible Veterans a flexible budget and lets them direct their own in-home support, enabling them to stay in their homes and communities rather than be institutionalized. This consumer-directed model allows Veterans—or their family caregivers—to select providers and manage services, helping Veterans remain in their homes and communities. Importantly, the VDC program is not limited by diagnosis and already supports a broad range of needs.

Under 38 U.S.C. § 1720L(h), VA has broad authority to approve qualified VDC providers beyond those specifically listed in § 1720L(b)(2). This flexibility allows VA to work with a wide array of organizations capable of supporting Veterans' care needs. The bill's approach—directly funding a provider organization—could shift decision-making away from the Veteran and undermine the Veteran-centered structure of the program.

We note that the specific requirements included in the definitions of “eligible Veteran” and “eligible Veteran mission-driven nonprofit” could inadvertently limit the scope of this program. In terms of eligible Veterans, the definition would exclude Veterans who may have a brain injury or illness that has a genetic or degenerative basis. The definition of “eligible Veteran mission-driven nonprofit” could exclude otherwise qualified providers from being eligible for payment under the VDC. We recommend revising the bill to expand eligibility so that Veterans can choose among a wide array of qualified providers and organizations.

VA also has concerns that the 180-day timeline for implementation is likely too short to allow VA to prepare and implement this program as intended.

S. XXXX Veterans Outdoor Rehabilitation Act

Summary: Section 2(a) would require VA to establish a program under which VA awarded grants to covered State entities to expand access to structured outdoor recreation programs for Veterans that enhance Veteran wellness. Section 2(b) would allow a covered State entity that received an award to use the grant to: directly develop and administer an outdoor recreation program for Veterans; contract with local outfitters, guides, non-profit organizations, or community-based outdoor recreation providers to conduct such program; develop partnership to deliver structured outdoor programming for Veterans; reduce financial barriers to participation in such program, including equipment, program fees, and reasonable transportation costs; conduct outreach to Veteran populations to raise awareness about the program; expand an existing outdoor recreation program for Veterans operated in the State; and coordinate with Federal agencies involved in land management with respect to the program, including the National Park Service, the Bureau of Land Management, the Forest Service, the U.S. Fish and Wildlife Service, and the Army Corps of Engineers.

Section 2(c) would authorize VA, to the extent practicable, to ensure grants awarded under this section support Veterans in a broad range of States representing

varying geographic regions and population densities. Section 2(d) would require VA to encourage collaboration between covered State entities participating in the grant program under this section and the Federal agencies named above to expand access by Veterans to outdoor spaces, reduce administrative barriers, and identify appropriate locations for organized activities. VA would also be required to encourage covered State entities participating in the grant program to coordinate with other covered State entities to maximize access by Veterans to outdoor recreation opportunities.

Section 2(e) would provide that, for a covered State entity to receive a grant under this section, it would have to submit to VA an application therefor that includes: (1) a plan for administering funds awarded under the grant, (2) criteria for selecting partners for the outdoor recreation program or programs carried out by the entity, (3) a certification that the outdoor recreation program or programs carried out by the entity meet qualification standards determined by the State, and (4) methods for collecting data for participation in the outdoor recreation program or programs carried out by the entity. Section 2(f) would provide that, subject to the availability of appropriations, each covered State entity that submitted an application meeting the requirements under subsection (e) for a grant would be approved to receive such grant in an amount of not less than $200,000 for the applicable fiscal year. If additional amounts were available for a fiscal year, those additional amounts would have to be distributed among the covered State entities for which an application subsection (e) was approved.

Section 2(g) would require each covered State entity in receipt of a grant to submit to VA, not less frequently than annually, a report that includes participation metrics regarding any outdoor recreation program carried out by the entity using grant funds and observations with respect to any outdoor recreation program carried out by the entity.

Section 2(h) would define terms for purposes of this section. The term “outdoor recreation program” would mean a nature-based activity designed to improve the mental and physical well-being of Veterans, including activities that promote physical

engagement, peer connection, skill-building, or therapeutic benefit, and may include adaptive or accessible activities designed to accommodate Veterans with disabilities. The term “covered State entity” would mean the primary agency of a State that is responsible for programs and services for Veterans.

Section 2(i) would authorize to be appropriated to VA $10 million for each fiscal year to carry out this section.

Position: **VA does not support this bill.**

Views: VA supports efforts to expand outdoor recreation opportunities for Veterans; however, we have significant concerns with the bill as written. Fundamentally, we do not believe VA should be the lead agency for a grant program for States to support outdoor recreation. We believe another agency that manages public lands, such as the Department of the Interior, would be better suited, consistent with the Federal Interagency Council on Outdoor Recreation recommendations under section 113 of the EXPLORE Act (P.L. 118-234) and the Interagency Task Force on Outdoor Recreation for Veterans under section 203 of the Veterans COMPACT Act of 2020 (P.L. 116-214).

If VA had to implement this authority, the bill would not provide sufficient authority to review and approve applications, establish oversight mechanisms, or ensure compliance with Federal grant standards. Additional provisions, and modifications to existing ones, would be needed to provide VA clear authority to administer, monitor, and enforce the program in accordance with applicable law.

VA is also concerned that the bill as drafted could unintentionally convey that State-run, grant-funded outdoor recreation programs constitute clinically supervised therapeutic interventions. However, VA would not have authority to ensure clinical oversight or therapeutic value.

For these reasons, VA cannot support the bill in its current form but stands ready to work with the Committee on technical revisions and alternatives that more appropriately align agency roles and authorities. Soliciting technical assistance from other Federal agencies and Departments may also improve the bill.

S. XXXX Maternal Health for Veterans Act of 2026

Summary: Section 2(a) would require VA, not later than 1 year after enactment, and annually thereafter through FY 2031, to submit to Congress (and make publicly available) a report summarizing VA's activities relating to maternity health care or coordination, data on maternal health outcomes of Veterans who receive care furnished by VA, data on patients who are dually eligible to receive assistance from VA and IHS and the maternity health care outcomes associated with receiving such care, and VA's recommendations to improve the maternal health outcomes of Veterans, with a particular focus on Veterans from demographic groups with elevated rates of maternal mortality, severe maternal morbidity, maternal health disparities, or other adverse perinatal or childbirth outcomes.

Section 2(b) would authorize to be appropriated to VA $15 million for each of FY 2027-2031 for VA's programs relating to maternity care coordination and related programs, including the maternity care coordination program described in VHA Handbook 1330.03, "Maternity Health Care and Coordination," dated October 5, 2012. The amounts authorized to be appropriated are in addition to any other amounts authorized for maternity health care and coordination for VA.

Position: **VA does not support this bill.**

Views: The reporting requirements under section 2(a) are not necessary, as VA can provide information to Congress upon request without a statutory requirement to do so. Further, the Government Accountability Office (GAO) recently completed a report (GAO-24-106209, "VA Should Improve Its Monitoring of Severe Maternal Complications

and Mental Health Screenings") very similar to this reporting requirement pursuant to section 4 of the Protecting Moms Who Served Act of 2021 (P.L. 117-69); VA agreed with GAO's recommendations to monitor (1) trends in severe maternal morbidity by Veteran characteristics and (2) maternity care coordinators' screening of Veterans for mental health conditions. It is also important to note VA does not have a mechanism to determine dual enrollment for IHS Veterans.

Additionally, the authorization of appropriations is not necessary, as the language in section 2(b)(2) effectively allows VA to use any funds it deems necessary for maternity care coordination and programs; the language in section 2(b)(1), by itself, would actually serve as a limitation on how much funding VA could dedicate to maternity care coordination, particularly 5 years in the future. We further note this is the same amount Congress authorized to be appropriated for FY 2022 in the Protecting Moms Who Served Act of 2021 (P.L. 117-69). Further, section 2(b) refers to a VHA Handbook that no longer exists; VHA rescinded this Handbook when it issued VHA Directive 1330.03, Maternity Health Care and Coordination, in November 2020, with subsequent amendments made in 2025.

S. XXXX Optimizing the Department of Veterans Affairs Workforce for Veterans Act of 2026 (Optimizing the VA Workforce for Veterans Act of 2026)

Summary: This bill would establish new requirements for human capital planning, reduction in force (RIF) notifications, and Congressional notice and reporting requirements on administrative reorganizations.

Section 2 of this bill would establish a new section, 38 U.S.C. § 729, which would require VA to establish and maintain a Department-wide 5-year workforce planning process designed to align staffing and operational capacity with projected demand for benefits and services, while also requiring recurring Congressional updates and GAO review.

Section 3 of the bill would establish a new section, 38 U.S.C. § 729A, that would require VA to provide a RIF notification to both Congress and affected VA employees at least 60 days prior to carrying out the action. The notices would have to include the following: details of the total number of employees affected; the offices affected including the location, the program, total number of employees before and after, and the services being abolished; justification for the RIF including the new staffing levels resulting from the RIF and how the RIF aligns with the human capital plan required under section 729; the budget effects of the RIF; and how the RIF will improve benefits and services.

Section 4 would amend 38 U.S.C. § 510 by updating the elements of the "detailed plan and justification" required under subsection (b). The bill would add a new subsection (e) which would require the Secretary to submit reports to Congress every 180 days for the two years following the completion of an administrative reorganization requiring submission of a detailed plan and justification. The report would have to include an assessment of the administrative reorganization using results-based performance metrics.

Position: **VA does not support this bill as written.**

Views: The agency is already engaged in efforts addressing aspects of the bill. The bill also adds administrative requirements that overlap with and may conflict with existing regulations promulgated by the Office of Personnel Management (OPM). Further, some of the requirements established in the bill are missing key factors tying those requirements to other benchmarks and requirements in Federal law and VA policy.

With regard to the strategic human capital plan, VA is initiating a Department-wide FY 2026-2029 Strategic Workforce and Succession Plan (SWSP), which includes the current and future demand, a workforce gap analysis, staffing and skill development

plans, and monitoring implementation for progress and outcomes, aligned to OPM's workforce planning model. The revised SWSP framework addresses VA's need to fully implement leading workforce planning practices also identified in the 2025 GAO assessment of VA's cybersecurity workforce.

VA continues to provide VA-wide workforce data, in accordance with section 505 of the VA MISSION Act of 2018 (P.L. 115-182), by Departmental component and medical facility for personnel encumbering positions, accessions and separation actions, vacancies by occupation, and the percentage of new hires for the Department who were hired within the time-to-hire target disaggregated by Administration.

Also, VA is following Executive Order 14356, "Ensuring Continued Accountability in Federal Hiring," requiring the annual VA Staffing Plan and quarterly updates integrating the Merit Hiring Plan requirements which monitor progress in VA's hiring goals for job offers and onboarding, as well as hiring Veterans and military spouses, early career talent and science, technology, engineering, and math (STEM). The VA Staffing Plan is inclusive of a staffing plan by office for full-time equivalent personnel, contractors, and total personnel spending in the previous and current fiscal years. To cut down on reporting burdens, OPM is pausing formal Human Capital Operating Plan submissions for the current year and integrating them into the quarterly updates for Annual Staffing Plans.

Proposed section 729A would identify a minimum 60-day notice period to the appropriate House and Senate Committees of any proposed RIFs within the Department. However, failure to comply with the notice period or other requirements in proposed section 729A(a) would be considered a prohibited personnel practice under 5 U.S.C. § 2302(b). The requirements in the bill would exclusively expose VA to challenges from impacted employees and corrective actions by the Office of Special Counsel to which no other agency would be subject. While VA understands the intent behind this provision, we would appreciate the opportunity to work with the Committee

on modifying the language to clarify who should be held accountable for the failure to meet the requirements and how they should be held accountable.

Employee notification requirements are also unclear as written. For example, one concern is whether the notification to Congress and VA employees under proposed section 729A would be required in advance or concurrently with the required notice period for employees (60 days) under the existing OPM regulations governing RIF procedures (Part 351 of title 5, C.F.R.). VA recommends coordination with OPM to ensure continued alignment of the bill's RIF and other requirements with OPM regulations and policy. Clarification and coordination are critical given OPM's authority to approve a shortened RIF notice period of 30 days. If enacted, the requirements in the bill would impact VA's ability to waive those timelines. Given the size of VA, it would also be administratively burdensome to provide an additional level of quantitative details to employees beyond what is already required under the OPM RIF regulations.

The new elements added to the detailed report and justification required under subsection (b) of 38 U.S.C. 510 lack a clear connection to existing requirements for the documentation and budget information related to reorganizations under Federal law, including 5 U.S.C. Chapter 29 and 31 U.S.C. Chapters 13, 15, and 31. VA notes the "results based performance metrics" referenced in the bill would be difficult to produce and assess, as most administrative reorganizations would represent a small subset of the organization and not necessarily entirety of the organization. Regardless, the amendments would also add to existing administrative burdens in relation to administrative reorganizations.

S. XXXX To Increase Burial and Funeral Expenses Paid by VA in the Case of Death from a Service-Connected Disability

Summary: This bill would amend 38 U.S.C. § 2307 to increase the current SC burial benefit from $2,000 to $3,000 and provide an automatic annual adjustment in this allowance which is tied to the consumer price index (CPI).

Position: **VA supports the intent of this legislation, however, is unable to assess the impact to budgetary resources and therefore will follow up with the committee once this evaluation is complete or CBO has provided a score.**

Views: This bill would remove the current disparity where the combined value of the non-service-connected (NSC) burial and plot allowance exceeds the SC burial allowance. This disparity began on October 1, 2025, as a result of the SC burial allowance being a fixed amount ($2,000) and NSC burial and plot allowances being tied to the CPI, resulting in annual increases (a combined $2,004 since October 1, 2025). This change would reinstate the SC burial allowance as the greater benefit, maintaining VA's intent to provide special recognition of Veterans whose deaths are directly related to their military service. It would also tie the SC burial benefit to the CPI, avoiding the need for periodic legislative intervention to keep pace with inflation.

Conclusion

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