STATEMENT OF
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PERFORMING THE DELEGABLE DUTIES OF THE
UNDER SECRETARY FOR BENEFITS,
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DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

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Chairman Moran, Ranking Member Blumenthal, and other Members of the Committee: thank you for inviting us here today to discuss 24 bills that would affect VA programs and services. Joining me today is Dr. Thomas O'Toole, Deputy Assistant Under Secretary for Health for Clinical Services from the Veterans Health Administration (VHA).

S. 342 Purple Heart Veterans Education Act of 2025

Summary: This bill would add a new 38 U.S.C. § 3319A that would authorize Veterans entitled to Post-9/11 GI Bill educational assistance who are awarded the Purple Heart for service in the Armed Forces occurring on or after September 11, 2001, to transfer a portion of their entitlement up to 36 months to one or more of their dependents. The monthly rate of payment to a dependent would be the same as the rate of payment that would otherwise be payable to the individual making the transfer, and the recipient of the transferred entitlement would generally be entitled to educational assistance in the same manner as the transferor. The transferor would be charged entitlement at the rate of one month for each month of transferred entitlement used. The dependent would be treated as the eligible individual for purposes of any administrative provisions. In the event of an overpayment relating to the dependent, both the dependent and the individual transferring the entitlement would be jointly and severally liable to the United States for the overpayment. If a veteran who has designated one or more transferees for transfer of entitlement dies before transferring all such entitlement, the remaining months of entitlement must be evenly distributed among the surviving designated transferees who are eligible to use them.

In addition, a child to whom entitlement is transferred would not be able to use such entitlement until completion of secondary school or until the child turns 18, and may use any transferred entitlement without regard to the 15-year delimiting date but only until the child turns 26, unless the child is a Veteran's or Service member's primary provider of personal care services. Also, if a transferee has been prevented from pursuing a program of education before turning 26 because an educational institution or

training establishment closed based on an executive order or due to an emergency situation, VA will extend the period for using entitlement.

Position: VA supports the intent of this bill, but cites concerns with the bill language and the need for additional funding.

Views: Currently, under 38 U.S.C. § 3319(a), transfers of educational assistance must first be approved by the Department of War (DoW), which may authorize the transfer "in the national security interests of the United States." This bill would not require DoW approval for transfers of educational assistance by individuals awarded the Purple Heart. Instead, new § 3319A(a) would allow any Purple Heart recipient entitled to Post-9/11 educational assistance to transfer entitlement to an eligible dependent based on authorization by the Secretary of Veterans Affairs.

In addition, new § 3319A(f) would allow an individual transferring entitlement to modify or revoke the unused portion of any transferred entitlement at any time by submitting written notice to the Secretary of Veterans Affairs. If an eligible Purple Heart recipient qualifies to transfer benefits under 38 U.S.C. § 3319, a transfer would have to be coordinated with DoW, even though VA approves the transfer requests. All transferred benefits are currently administered through DoW systems. VA believes implementation of this section would be most efficient if management of transferred benefits continues to use the current system, which would require notification of any revocation or modification to both DoW and VA. Thus, VA recommends including a requirement to also notify the Secretary of War in this section for an individual transferring entitlement to modify or revoke transferred entitlement.

Post-9/11 GI Bill transfer-of-entitlement modifications and revocations are dictated to VA by DoW Instructions dated September 27, 2018, which state that milConnect (https://milconnect.dmdc.osd.mil/milconnect/) must be used for all transfer modifications and revocations. Once DoW receives and approves these requests, it enters the information into VA's system (Veteran Information System (VIS)) for VA to view and manage transferees' benefits. Maintaining the current process, even if the Secretary of War does not have to approve transfers, would best serve the management of transferred entitlement. Even though the bill would direct VA and DoW to coordinate with each other to facilitate entitlement transfers in 38 U.S.C. § 3319A(l), for purposes of consistency, VA recommends that Congress clarify that the current process would apply to initial transfer requests as well.

Furthermore, the bill would specify in 38 U.S.C. § 3319A(h)(4)(A) that the death of the transferor would not affect the transferee's use of entitlement. The bill would also specify in 38 U.S.C. § 3319A(h)(4)(B) that if an individual entitled to educational assistance had designated a transferee or transferees but had not transferred all entitlement at the time of death, VA would evenly distribute entitlement between all transferees who are not otherwise precluded from using the benefits. This language precludes surviving dependents of a Veteran who receives the Purple Heart posthumously because a Veteran can only designate dependent transferees once

approved to transfer benefits. In the case of posthumous Purple Heart recipients, this could only occur after the Veteran's death when under current law a legal transfer cannot occur to these undesignated transferees. Also, the benefits would not automatically transfer to the surviving dependents even if the Purple Heart recipient's dependents were listed as dependents in a DoW or VA system since the Purple Heart recipient would have had to specifically designate the dependents for the transfer of entitlement. In addition, this bill would authorize a dependent in receipt of transferred benefits to transfer entitlement to another eligible dependent if the individual transferring entitlement dies before the dependent has used all of the transferred entitlement.

Cost Estimate: VA does not have a cost estimate for this bill.

S. 668 Supporting Access to Falls Education and Prevention and Strengthening Training Efforts and Promoting Safety Initiatives for Veterans Act of 2025 (SAFE STEPS for Veterans Act of 2025)

Summary: Section 2(a) would establish a new 38 U.S.C. § 7310B regarding an Office of Falls Prevention. Proposed § 7310(B(a) would require the Under Secretary for Health (USH) to establish and operate in the Veterans Health Administration (VHA) an Office of Falls Prevention (the Office), which would be located in VA Central Office and would be headed by the Chief Officer of Falls Prevention, who would report to the USH. The USH would have to provide the Office with such staff and other support as may be necessary to effectively carry out its functions. The USH could reorganize existing offices within VHA as of the date of the enactment of this section to avoid duplication with the functions of the Office.

Proposed § 7310B(b) would define the functions of the Office as: (1) providing a central office for monitoring and encouraging VHA's activities with respect to the provision, evaluation, and improvement of health care services relating to falls prevention provided to Veterans by VA; (2) developing and implementing standards of care for the provision by VA of health care services relating to falls prevention; (3) monitoring and identifying deficiencies in standards of care for the provision of health care services relating to falls prevention, providing technical assistance to VA medical facilities and VA programs that support Veterans in their own homes, addressing and remedying deficiencies of such facilities and programs, and performing oversight of implementation of such standards of care; (4) monitoring and identifying deficiencies in standards of care for the provision of health care services relating to falls prevention through the community and providing recommendations to the appropriate office to address and remedy any deficiencies; (5) overseeing distribution of resources and information related to falls prevention for Veterans; (6) promoting the expansion and improvement of VHA clinical, research, and educational activities with respect to health care services relating to falls prevention, including research activities on falls prevention conducted between VA's Office of Research and Development (ORD) and the National Institute on Aging; (7) promoting the development or expansion of rigorous quality assessment or improvement processes designed to prevent falls; (8) coordinating home modification and adaptation programs administered by the Under Secretary for Benefits

(USB) under 38 U.S.C. chapter 21 and 38 U.S.C. § 1717(a)(2); and (9) carrying out such other duties as the USH may require.

Proposed § 7310B(c) would require the Chief Officer to oversee and support a national education campaign directed principally to Veterans determined to be at risk for falls, their families, and their health care providers. The campaign would have to focus on reducing falls, falls with major injury, and repeat falls for Veterans receiving VA care and increasing awareness of available benefits, grants, devices, or services provided by VA that would aid Veterans in reducing falls and preventing repeat falls. The Chief Officer would also be responsible for awarding grants or contracts to qualified organizations for the purpose of supporting local education campaigns focusing on reducing falls, falls with major injury, and repeat falls for Veterans receiving VA care.

Proposed § 7310B(d) would require the Chief Officer work with ORD and the National Institute on Aging to develop research for evidence-based falls prevention programs that would benefit Veterans, including programs that overlap with VA priorities, programs that may focus on or be of particular benefit to Veterans, and programs that may include participants with multiple comorbidities. The bill would further set forth additional requirements associated with these efforts. VA and the National Institute on Aging would have to establish a joint subject matter expert panel to develop recommendations for falls prevention interventions for Veterans with service-connected disabilities, including home modification interventions. VA and the National Institute on Aging would have to establish this panel within 180 days of the date of enactment, with responsibility for selecting its 8 members equally divided between the 2 agencies.

Section 2(b) of the bill would amend section 203(c) of the Older Americans Act of 1965 (42 U.S.C. § 3013(c)), which generally establishes requirements regarding Federal agency consultation, to include VA among the agencies that could be included in an Interagency Coordinating Committee on Healthy Aging and Age-Friendly Communities. It would also include the Veterans' Affairs Committees of the House of Representatives and the Senate among those receiving regular reports to Congress.

Section 2(c) would require VA, not later than 180 days after the date of enactment, to issue or update VHA Directives for facilities and providers relating to safe patient handling and mobility policies at the national, Veterans Integrated Service Network (VISN), and health-care system levels. These directives would have to require biennial training for providers, ensure that any medical facility where patients may need assistance with transfer or mobility have access to safe patient handling and mobility technology appropriate for the setting to enable safe transfer and mobilization for access to care and activities of daily living for Veterans who are paralyzed or who need assistance with mobility, and requiring all emergency settings have immediate access to safe patient handling and mobility technology to enable safe transfer, fall recovery, and repositioning.

Section 2(d) would require VA to determine the feasibility and advisability of carrying out a pilot program to provide home improvements and structural alterations to

prevent falls for all Veterans eligible for those services from VA. Not later than 1 year after the date of enactment, VA would have to submit to Congress a report indicating its plans to carry out a pilot program to provide home improvements and structural alterations to prevent falls for all Veterans eligible for those services from VA and specifying why VA determined that it was not feasible or advisable to carry out such a pilot program. If VA carries out the pilot program, not later than 180 days after termination of the pilot program, VA would have to submit to Congress a report on lessons learned from the pilot program and any recommendations on extending or expanding the pilot program.

Section 2(e) would require VA, not later than 2 years after the date of enactment, to submit to Congress a report on falls prevention initiatives within VA. This report would have to evaluate, for the 3-year period preceding the date of enactment, 10 different elements regarding VA programs and services.

Section 3(a) would amend 38 U.S.C. § 1710A, which generally establishes conditions under which VA must provide nursing home care to service-connected Veterans, to require VA to ensure that a licensed physical therapist or licensed occupational therapist conducts a falls risk assessment for individuals determined by a physician to have fallen or to be at risk of falling during the previous 1-year period during the stay of the individual in the nursing home. Section 3(b) would amend 38 U.S.C. § 1710B, which generally requires VA to provide extended care services to eligible Veterans, to include among those services the conduct of an annual falls risk assessment and the provision of fall prevention services by a licensed physical therapist or licensed occupational therapist.

Position: VA does not support the bill.

Views: VA remains committed to the journey to high reliability and maintaining a culture of zero harm, Veteran safety, and whole health, and fall prevention and management is one component of safe mobility for Veterans as falls and resulting injuries are one of the most common adverse patient events in VA. Falls and their consequences can be devastating, especially for elderly Veterans, and represent a major public health problem around the world. However, VA does not support this bill because current efforts and authority are sufficient to achieve the intended results of this bill and because technical issues with the bill would create unnecessary legal uncertainty.

In terms of current efforts, VA's National Center for Patient Safety established the Fall Prevention and Management program in FY 2025; this program advocates for coordinated, interdisciplinary fall risk screening, prevention, and management strategies. This program is targeted at reducing fall-related injuries, aligning procedures, and providing comprehensive standardized guidance for fall event reporting. Significant foundational work for this effort has already been accomplished, including initial work to draft a national directive, establishing a national steering committee, implementing a pilot project to expand fall event reporting, and creating a resource center for VA

professionals. VA is concerned that enacting this legislation could disrupt these current efforts, which could actually delay efforts to reduce falls among Veterans.

VA has technical concerns with the bill as well that create unnecessary legal uncertainty. For example, in proposed § 7310B(b)(4), the bill refers to monitoring and identifying deficiencies in standards of care for the provision of health care services relating to falls prevention "through the community pursuant to this title." It is unclear if this is intended to refer to the Veterans Community Care Program (VCCP) operated under 38 U.S.C. § 1703; if the VCCP was not the intended reference, we recommend the bill be revised for clarity. Additionally, proposed § 7310B(c)(2) would seemingly authorize the Chief Officer to award grants, but the legislation contains no further specific authority that would be needed to execute a grant program. In the absence of such authority, VA would rely on the contracting authority provided under this paragraph instead. Further, the proposed pilot program authority under subsection (d) is unclear, both as to whether VA is required to execute the program at all (it appears to be permissive in this respect) and how this pilot program would differ from VA's existing authority to furnish home improvements and structural alterations.

Cost Estimate: VA does not have a cost estimate for this bill.

S. 926 Saving Our Veterans Lives Act of 2025

Summary: Section 2(a)(1) would create a new 38 U.S.C. § 1720M, subsection (a) of which would require VA to carry out a program to provide to eligible individuals, upon their request, covered items (or a redeemable voucher to aid in the distribution of a covered item) and information relating to the benefits of, and options for, secure firearm storage. The term "covered item" would be defined in proposed § 1720M(e) to mean a lock box that: is used for the secure storage of a firearm and ammunition; is designed, intended, and marketed to prevent unauthorized access to a firearm or ammunition; may be unlocked only by means of a key, combination, or other similar means; is in compliance with the applicable standard of the American Society for Testing and Materials F2456-20, or any successor standard; is manufactured in the United States; and is not eligible or intended for commercial or individual resale. The term "eligible Veteran" would be defined in the same proposed subsection to mean a Veteran or an individual described in 38 U.S.C. § 1720I(b), which generally refers to former Service members with other-than-honorable discharges and who have other qualifying service.

Proposed § 1720M(b) would authorize VA, in carrying out the program required by subsection (a), to work with organizations that have experience, expertise, and business knowledge regarding secure firearm storage and secure firearm storage devices.

Proposed § 1720M(c) would require VA to design and carry out a public education campaign to inform eligible individuals of the availability of covered items under subsection (a). In carrying out the public education campaign, VA could partner with organizations that have experience with respect to secure firearm storage devices.

VA would have to include in the public education campaign material that assures eligible individuals that their participation in the program would not impact lawful ownership of firearms.

Proposed § 1720M(d) would require VA, not later than October 1, 2025, and annually thereafter, to submit to Congress a report that includes a description of the program under subsection (a), the number of covered items distributed by VA and the number of covered items redeemed outside of VA under the program during the period covered by the report, an assessment of efforts made to increase outreach and distribution of covered items under the program to eligible individuals who are not enrolled in VA health care, an assessment of any obstacles to increasing outreach to eligible individuals who are enrolled in VA health care and to such individuals who are not, and an identification of additional steps that will be taken in the following year to improve the processes through which eligible individuals receive a covered item under the program.

Section 2(a)(2) would make a clerical amendment to reflect the amendment made by paragraph (1).

Section 2(b) would require VA, in consultation with representatives of organizations and agencies that are subject to a memorandum of understanding with VA on preventing Veteran suicide and other such entities as VA determines appropriate, to develop an informational video on secure storage of firearms as a suicide prevention strategy and publish such informational video on a VA website. VA would also have to publish information to inform individuals who participate in the program under the proposed § 1720M that any lockbox furnished pursuant to such program is not eligible or intended for commercial or individual resale.

Section 2(c) would establish a rule of construction that nothing in this Act could be construed: to collect personally identifiable information of an individual who participates in the program under the proposed § 1720M for the purpose of tracking firearm ownership; to require any such individual to register a firearm with VA or any other Federal, state, tribal, or local unit of government; to require mandatory firearm storage for any such individual; to prohibit any such individual from purchasing, owning, or possessing a firearm under 18 U.S.C. § 922; to discourage the lawful ownership of firearms; or to create or maintain a list of individuals participating in the program.

Section 2(d) would authorize to be appropriated to VA $5 million for each of FY 2026 through 2036 to carry out this section and the amendments made by this section.

Position: VA does not support this bill as drafted.

Views: VA strongly agrees with efforts to reduce Veteran suicide, which may include providing lock boxes to Veterans. However, the bill as drafted is too broad, and the resources needed to implement would significantly exceed the authorized

appropriation of $5 million per year. We welcome the opportunity to meet with the Committee to pursue amendments that would address the concerns described below and align with VA's current program.

Late last year, VA established a lock box distribution program, where VA providers can place orders for lock boxes for enrolled Veterans. VA's program also includes education materials for Veterans and clinicians. VA clinical practice guidelines recommend the distribution of lock boxes as a risk mitigation strategy for Veterans at risk of suicide. Our current efforts are focused on Veterans with a risk of suicide, documented within the last 12 months, placing them at medium- to high-risk of suicide who have access to firearms; this access includes peripheral access, where a Veteran may not own a firearm, but may live in a home where someone else does. Through VA's current initiative, providers can place orders for lock boxes, track these orders, and ensure distribution.

The bill would require VA to develop education and training content, as well as a public education campaign, but VA is already working to increase awareness of firearm safety programs like the one described above. The bill is fairly prescriptive in terms of what material must be developed (an informational video), and how this would be developed. VA currently provides materials developed in collaboration with organizations like the National Shooting Sports Foundation (NSSF) and others, which we believe to be sufficient for our current needs. VA has not engaged in a broader public awareness campaign because VA cannot furnish lock boxes to persons other than enrolled Veterans with a documented clinical need. To avoid confusion, our communications are focused on enrolled Veterans and providers to ensure they can access available resources. Additionally, VA's mandatory suicide prevention training course, VA S.A.V.E. (Spot, Ask, Validate, Encourage), includes information on accessing lock boxes through VA, and VA's collaboration with PsychArmor has supported updating this content and distributing it more widely.

VA has concerns about the scope of this bill, which would require VA to carry out the program to provide lock boxes to all Veterans, not just those enrolled in VA care, and not just those at risk of suicide. It would also include former Service members whose service does not qualify them as Veterans for purposes of title 38, United States Code. VA estimates that the lock boxes it distributes cost, on average, $150 each, so making these available to all 18 million Veterans in the United States, with no limitation on the number of lock boxes that could be obtained, could result in a significant drain on VA resources. Further, given the specific parameters that lock boxes must meet, this may increase the average cost per box even more. For example, VA does not currently provide fingerprint-enabled boxes, as the purpose of the lock boxes is to create time and space between suicidal ideation and action and a digitally accessible device would frustrate that purpose. However, if VA were required to make these available under the program, the costs could also increase.

Given these concerns, we anticipate that the $5 million authorization limit would be reached well before the demand had been met, which would likely lead to frustration

on the part of Veterans who may have greater need, including Veterans with a risk of suicide, documented within the last 12 months, placing them at medium- to high-risk of suicide who have access to firearms, but who are unable to be among the first to receive a lock box under this program. We further note that the $5 million in authorization would also be applicable to the outreach and education efforts, which by themselves could easily eclipse the authorized limit.

Beyond these substantive concerns, VA has several technical comments on the bill that we can share with the Committee upon request.

Cost Estimate: VA does not have a cost estimate for this bill at this time.

S. 1116 Ensuring Veterans' Final Resting Place Act of 2025

Summary: This bill would amend 38 U.S.C. § 2306(h), which currently authorizes VA to provide, in lieu of burial in a national cemetery and other memorialization benefits, a plaque or urn to commemorate the memory of a Veteran whose remains are cremated and not interred. This bill would allow, in addition to a plaque or urn, burial in a national cemetery or other memorialization benefits for the Veteran.

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

Views: VA shares Congress' apparent view that this authority should be amended.

Congress is aware of the negative comments VA received when it published a notice of proposed rulemaking implementing the plaque-and-urn benefit. VA took specific steps in its regulatory documents to ensure members of the public would be aware that acceptance of the plaque or urn benefit would be in lieu of other memorialization or burial benefits. Most of the comments received on the rulemaking raised concerns regarding the waiver of future eligibility for burial or memorialization benefits through acceptance of a commemorative plaque or urn. We appreciate Congress' effort to introduce this bill to address the concerns but note that the bill raises other concerns.

This bill would remove the current language in 38 U.S.C. § 2306(h) that prohibits VA from providing a headstone or marker under section 2306 or any burial benefit under 38 U.S.C. § 2402 for any individual who has received a commemorative plaque or urn. In doing so, families that choose cremation as the manner of disposition would be able to first receive a plaque or urn and then apply for and receive a headstone or marker or burial benefits in a national cemetery. This arrangement would create an inequity for families that choose to inter their loved ones in a casket, as the urn or plaque benefit is only available to individuals whose remains are cremated. Additionally, there are increased costs associated with this bill, as headstones or markers and burial benefits

would now be available in addition to the plaque or urn benefit, and many more families would choose to receive the additional benefits.

VA has faithfully taken steps to implement the law as enacted. VA understands the desire of some survivors to retain the cremated remains of a loved one, as well as their desire to feel that VA has provided appropriate recognition of their loved one's service. VA notes that two benefits are currently available to such families—burial flags and Presidential Memorial Certificates—neither of which require families to forfeit other benefits. We support Congress' efforts to provide a meaningful benefit to these survivors. VA would like to work with the Committee to discuss more equitable or cost-effective solutions.

Cost Estimate: VA estimates this bill would have significant costs to the Discretionary account of $3.3 million in 2026, $67.3 million over 5 years, and $210.3 million over 10 years.

S. 1657 Review Every Veteran's Claim Act of 2025

Summary: Section 2 of this bill would amend the heading of 38 U.S.C. § 5103A(d) to read "Medical Examination for Claims for Benefits." Section 2 would also amend section 5103A(d)(2) by striking ''treat an examination or opinion as being necessary to make a decision on a claim for purposes of'' and inserting "provide for a medical examination or obtain a medical opinion under." Finally, this bill would add a new section 5103A(d)(3) specifying: "If a veteran fails to appear for a medical examination provided by the Secretary in conjunction with a claim for a benefit under a law administered by the Secretary, the Secretary may not deny such claim on the sole basis that such veteran failed to appear for such medical examination."

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

Views: Generally, VA must review and consider all the evidence gathered in support of the claim. Currently, however, 38 CFR § 3.655(b) requires VA to deny a claim if a Veteran fails to report for an examination as part of a supplemental claim, a claim for increase, or an original claim other than an original compensation claim. This bill would prohibit denying such claims on the sole basis of failure to report for an examination. Revision to 38 CFR § 3.655(b) would be required.

Currently, VA has a statutory duty under 38 U.S.C. § 5103A to provide a medical examination or obtain a medical opinion when such examination or opinion is necessary to decide a compensation claim. A medical examination or opinion is necessary to decide a claim where the evidence of record contains competent evidence that the claimant has a current disability associated with their active military, naval, air, or space service, but the medical evidence of record is insufficient for VA to decide the claim.

VA notes that, while this bill would prohibit denial of a claim solely on the basis that a Veteran failed to appear for a VA medical examination, cases may remain where, without the examination, there is insufficient evidence to support entitlement. Hence, even if this bill were enacted, claims may still be denied in those circumstances. The only difference would be that the denial would be due to lack of sufficient evidence rather than for failure to appear for the examination alone.

VA seeks to augment the language of the bill to address the situation where a Veteran does not report for a scheduled VA medical examination and there is not sufficient evidence of record to determine impairment level. Not closing a claim unless and until a Veteran reports for a scheduled VA medical examination may lead to a significant negative impact on VA claims timeliness. VA suggests that the bill include the following sentence at the end of new paragraph (d)(3): "In such circumstance, the claim will be determined based on the evidence of record."

Additionally, this bill would eliminate the current regulatory difference under 38 CFR § 3.655(b) between how failure to report for an examination is treated in conjunction with an original compensation claim (i.e., the first initial claim for one or more benefits administered by VA) and in conjunction with a claim for increase or a supplemental claim.

VA supports this bill because it would reinforce VA's general practice of reviewing and considering the full body of evidence before deciding a claim, which includes when the Veteran fails to report to VA medical examination. VA notes that the risks and costs associated with implementing this bill could be substantially mitigated if 38 CFR § 3.655(b) was not eliminated by specifying that failure to report results in a rating determination based on the evidence of record.

However, VA notes its concern that this bill may have the effect of continuing and worsening the practices of those involved in the for-profit industry that prepares and submits Disability Benefits Questionnaires (DBQs) who often provide inconsistent and questionable disability impairment descriptions in exchange for large fees and a portion of any future VA compensation benefits awarded. These bad actors intentionally and specifically instruct Veterans not to report for their scheduled VA disability examinations. Despite this concern, VA claims processors will continue to evaluate all evidence, including privately completed DBQs. If a DBQ shows indicators of potential inauthenticity or fraud, claims processors can assign it low or no probative value. Should authenticity or alteration concerns arise, further development may be necessary, such as validating results with the provider, obtaining medical records, arranging a VA examination, or referring to the Office of Inspector General.

Cost Estimate: VA does not have a cost estimate for this bill.

S. 1665 Obligations to Aberdeen's Trusted Heroes Act of 2025 (OATH Act of 2025

Summary: Section 2 of the bill would amend 38 U.S.C. § 5100 to add a definition of the term "secrecy oath program," which would apply for purposes of chapter 51. This term would mean a United States Government program in which participants are required to sign a non-disclosure agreement (NDA) preventing the disclosure of any information regarding the program under penalty of court-martial or criminal punishment.

Position: VA cites concerns with this section.

Views: VA cites concerns that this definition appears to be overly broad, as it is not limited to NDAs related to military operations that could form the basis for a compensation claim. If a Service member were required to sign an NDA for a reason unrelated to military preparation or operations, that would technically meet the requirements of participation in a "secrecy oath program." If the reason for the NDA, however, were organizational or in such a context as to present no risk of harm to the Service member, it is unclear why that would necessarily establish a different effective date for compensation for a disability completely unrelated to participation in the secrecy oath program.

Summary: Section 3(a) of the bill would amend 38 U.S.C. § 6303, which generally deals with outreach services by VA. Specifically, not later than 90 days after the date on which participants in a secrecy oath program (as defined in 38 U.S.C. § 5100, as amended) are released from the oath taken under such program, VA would have to identify the Veterans who participated in the program, notify them of all VA benefits and services for which they may be eligible, and distribute information about such benefits and services (and other governmental programs VA determines would be beneficial to Veterans). If VA identified Veterans who should have been notified under the previous provision but who did not receive such notice, VA would have to provide this notice to these Veterans.

Section 3(b) would require VA, not later than 90 days after enactment, to identify the Veterans who participated in the secrecy oath program at Edgewood Arsenal at Aberdeen Proving Ground, Maryland, at any time between January 1, 1948, and December 31, 1975, notify such Veterans of all VA benefits and services for which they may be eligible, and distribute the information described above.

Position: VA does not support this section, unless amended, and subject to the availability of appropriations.

Views: VA cites concerns with section 3(a) of this bill. The identification of participants in secrecy oath programs will require collaboration between VA and DoW, which results in delays for the Veteran. The timely notification of participants may be hindered by incomplete or outdated contact data, particularly in cases where individuals have not previously sought VA benefits or where records are fragmented across various

systems and databases. Additionally, updates to VA correspondence and VA systems would likely be required to tailor notifications to Veterans who were participants in secrecy oath programs. As such, VA respectfully suggests a period of at least 180 days to ensure sufficient time for information sharing between agencies, participant identification and location, and potential system and correspondence updates.

VA further notes that it may be extremely difficult to identify when Veterans are released from an oath under a secrecy oath program. Beyond such information being defined in the NDA (to which VA would not be a party), NDAs may not establish a single, common date applicable to all persons subject to them. For example, an NDA may state that information may not be disclosed until 5 years after the signing of the NDA, or 5 years after the completion of the activities associated with the NDA. Such unknowable and variable timelines would likely mean that VA would have to rely on the provision allowing VA to provide notice whenever VA identified Veterans who should have been notified; in other words, it seems unlikely that in many cases, VA could provide notice within the 90-day period contemplated by the bill.

VA does not support section 3(b) of this bill, unless amended. Section 3(b) would establish as the relevant period for participation in the Edgewood Arsenal testing program at Aberdeen Proving Ground as beginning on January 1, 1948, and ending on December 31, 1975. However, according to a DoW Deployment Health Support Directorate Fact Sheet (Version 07-01-2006), Edgewood Arsenal Chemical Agent Exposure Studies occurred from 1955 to 1975. VA has concerns that the date range provided in section 3(b) may include Veterans who participated in testing at Aberdeen Proving Ground but who were not participants in the Edgewood Arsenal testing program and, therefore, were not subject to the Edgewood Arsenal secrecy oath. VA currently has an established Integrated Project Team (IPT) that is working towards identifying Edgewood Arsenal testing program participants. The IPT is establishing claim tracking mechanisms, notification processes, and claims processing guidance.

Summary: Section 4 of the bill would amend 38 U.S.C. § 5110, which generally sets forth the effective dates of awards, to state that the effective date of an award of disability compensation to Veterans who participated in a secrecy oath program (including at Edgewood Arsenal at Aberdeen Proving Ground, Maryland, at any time between January 1, 1948, and December 31, 1975) would be the day following the date of the Veteran's discharge or release.

Position: VA does not support this section, unless amended, and subject to the availability of appropriations.

Views: VA does not support section 4 of this bill, unless amended. VA is concerned that section 4, as written, could afford a Veteran an effective date prior to the date a disability arose, i.e., the date entitlement is shown.

Veterans often seek service connection for later-developing conditions that did not manifest while in service or shortly after discharge or release. In those instances, section 4 would potentially entitle a Veteran to years, even decades, of backpay regardless of when the disability first began. Consistent with concerns expressed regarding section 2, VA likewise is concerned that section 4, as written, would entitle a Veteran to such an effective date regardless of whether the particular disability was related to his or her participation in the secrecy oath program. Such outcomes are contrary to the principle uniformly reflected throughout title 38, U.S.C., that compensation should not be paid for a period during which a Veteran is not suffering from a disability resulting from service.

Moreover, the effective date that section 4 of this bill would establish is not required by the remedial holding of the United States Court of Appeals for the Federal Circuit in *Taylor v. McDonough*, 71 F.4th 909 (2023) (*en banc*). There, the court held that, when a Veteran has been determined to be entitled to benefits for one or more disabilities stemming from participation in the Edgewood Arsenal testing program, the required effective date of such benefits is the date that the Veteran would have had in the absence of the challenged government conduct (i.e., imposition of the secrecy oath). *Id.* At 946. While this date *may* correspond to the day following discharge or release when facts show that a disability arose during service, *Taylor* does not compel such a date when a disability did not manifest until years later.

VA presumes that the intent of this bill is to effectuate the holding of *Taylor* consistently with the effective date principles established throughout the rest of the statutory scheme. One way to achieve this would be to amend proposed 38 U.S.C. § 5110(b)(5)(A) to read as follows: “The effective date of an award of disability compensation to a veteran described in subparagraph (B) of this paragraph shall be the day following the date of the veteran’s discharge or release, or the date fixed in accordance with the facts found, whichever is later.”

Furthermore, VA does not support section 4, unless amended, to the extent that this provision purports to define participation in the Edgewood Arsenal testing program. As previously explained, VA is concerned that the date range specified in section 4 may include Veterans who participated in testing at Aberdeen Proving Ground but who were not participants in the Edgewood Arsenal testing program conducted from 1955 to 1975 and thus were not subject to the Edgewood Arsenal secrecy oath.

Cost Estimate: VA does not have a cost estimate for this bill.

S. 1868 Critical Access for Veterans Care Act

Summary: Section 2(a) would amend 38 U.S.C. § 1703(d))(1), which generally establishes eligibility criteria for the VCCP, to include a new basis of eligibility for community care. Under proposed § 1703(d)(1)(F), a covered Veteran would be eligible to elect to receive care through the VCCP for care or services sought at a critical access hospital or provider-based rural health clinic affiliated with such hospital (including care

or services sought from an eligible VCCP provider located in the surrounding community due to a referral from a CAH/RHC provider of such hospital or clinic due to a referral from such hospital or clinic), if the Veteran resided within 35 miles of such hospital or clinic.

Section 2(b) would amend 38 U.S.C. § 1703(a)(3), which generally limits the receipt of care or services under the VCCP to care or services authorized by VA, to create an exception as set forth in a new proposed § 1703(d)(5). The proposed § 1703(d)(5) would state that VA could not require a covered Veteran to receive authorization or a referral prior to the receipt of care under the new § 1703(d)(1)(F).

Section 2(c) would amend 38 U.S.C. § 1703(i), which generally establishes rules for payment rates for care and services under the VCCP, to provide in a new paragraph (7) specific payment rates for providers under the VCCP. Specifically, at a critical access hospital, VA would have to pay the critical access hospital rate established under the Medicare program instead of a service-based rate. For care or services furnished at a provider-based rural health clinic affiliated with such hospital, VA would have to pay the rate specified under section 1833 of the Social Security Act (42 U.S.C. 1395l). Additionally, claims for covered Veterans receiving care under proposed § 1703(d)(1)(F) would have to include an identifier denoting the care or services provided under that authority; such claims would have to be reimbursed at the cost-based level under the Medicare program. VA, in consultation with the Centers for Medicare & Medicaid Services, could furnish additional guidance regarding this claims process in accordance with the best practices of Medicare Administrative Contractors (MAC) in processing cost-based reimbursement for services furnished at critical access hospitals or provider-based rural health clinics affiliated with such hospitals. Finally, claims for covered Veterans receiving care under the proposed § 1703(d)(1)(F) would have to be reviewed, and payment would have to be issued, in accordance with the findings of such review not later than 60 days after submission of the claim.

Section 2(d) would amend 38 U.S.C. § 1703(o) (which we believe should be a reference to subsection (q)) to include a definition of the term “critical access hospital,” which would have the meaning given that term in section 1861(mm) of the Social Security Act (42 U.S.C. § 1395x(mm)).

Section 2(e) would require VA, not later than 1 year after the date of enactment, to submit to Congress a report on third party administrators (TPA) and community care providers concerning the implementation of these amendments, including timely approval and payment of claims under the proposed § 1703(d)(1)(F), and overall user experience associated with care or services provided pursuant to these amendments.

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

Views: VA strongly agrees with the intent to improve the quality and availability of care to Veterans in highly rural areas, like Montana and North Dakota. We support the

goal of improving access for rural Veterans and want to work with the Committee to clarify how this new authority would integrate with existing VA care processes.

The bill would create a new eligibility pathway under38 U.S.C. § 1703(d)(1)(F). We recommend further clarification on how this authority would interact with the VA's existing requirement to determine clinical-necessity under § 1710 while ensuring the bill's removal of prior authorization is implemented as intended by Congress. , Congress has created other authorities in §§ 1720J, 1725, 1725A, and 1728 – where pre-authorization is not required. If Congress were to create a specific exception to prior authorization, VA would implement that direction, but VArecommends ensuring the language clearly aligns with operational requirements. We note that the bill does not alter VA's responsibility to determine whether care is clinically necessary; it only would remove the requirement for priority authorization for eligible Veterans under this provisions.

We believe further discussion can help ensure the bill's implementation aligns with the Committee's intent, while providing the best access to care for rural Veterans and supporting consistent operations across VA and community care providers.

Cost Estimate: VA does not have a cost estimate for this bill.

S. 1992 Veterans Appeals Efficiency Act of 2025

Summary: Section 2(a) would amend 38 U.S.C. § 5109B to require VA to provide Congress with annual reports on the average length of time that a claim, or issue within a claim, is pending with the Secretary following a remand from the Board; the number of cases advanced on the Board's docket; and the number of appeals dismissed by the Board.

Position: VA supports the intent of the bill, subject to the availability of appropriations, but cites concerns with the current bill as drafted. The Department shares its positions on each subpart for clarity. VA cites concerns with section 2(a).

Views: VA cites concerns with the portion of section 2(a) requiring a report on the average length of administrative adjudication following Board remands. As an initial matter, VA cites concerns with the phrase "or issue within a claim" as a criterion for reporting. The Appeals Modernization Act (AMA; P.L. 115-55) does not contain a definition of "issue," so that term should be clarified in the statute as having the meaning set forth by VA in 38 CFR § 3.151(c), which treats disability compensation for each individual disability as a separate issue. Assuming that is the definition envisioned, VA does not currently have the technical capacity to reliably track timeliness at the issue level. Particularly in the case of legacy appeals, multiple appealed issues may be aggregated into a single Board decision, which, if tracked under current capabilities as one claim, could unintentionally skew the average timelines required under this bill. Achieving the technical capability to implement the bill would require expenditure of

substantial program and information technology resources and, therefore, require appropriations. VA does not have a cost estimate.

VA proposes that, if this provision moves forward, the bill should disaggregate the reporting requirement into the average for legacy claim remands and for remands under AMA because once all legacy remands are completed, the need for reporting on the legacy system remands would cease.

VA also cites concern with the portion of section 2(a) that would require reporting on the number of cases advanced on the docket (AOD) to be disaggregated by the reason provided in the request. While VA can report the number of cases granted AOD after a decision is rendered, disaggregated by reason (i.e., age, financial distress, serious illness, other), current systems do not track motion denial reasons.

VA further cites concern with the portion of section 2(a) that would require reporting on the number of Board dismissals, disaggregated by dismissals due to the claimant's death, and whether the death was a suicide. First, while VA currently can report the number of dismissals due to death, Board systems do not track cause of death. Second, this raises substantial privacy concerns, including the risk of exposing personal information, compromising confidentiality laws, and retraumatizing surviving families.

The agency is currently notified by the Social Security Administration (SSA) once a claimant has passed away. A death certificate may not always be of record to determine that the appeal should be dismissed, and the record may contain incomplete evidence to establish that a Veteran passed away by suicide. Therefore, VA cautions that any reporting on this specific data point may not be accurate or beneficial given the limited nature of available information and the privacy concerns noted above. Moreover, VA cautions that this requested data point may create an unintended perceived correlation between a pending appeal and Veteran suicide.

Summary: Section 2(b) would require the Secretary to prescribe guidelines for advancement of a case on the Board's dockets.

Position: VA does not support this provision.

Views: VA does not support this provision, which would require the Board to prescribe guidelines for AOD, including the type of evidence required to support the motion. VA views this provision as a duplicative and unnecessary requirement. The criteria for advancement on the docket—e.g., advanced age (defined as 75 years or older), serious illness, and severe financial hardship -- are already contained in statue and regulations. The Board applies the relevant statutes and regulations to guide its determinations on motions for AOD to ensure that those appellants most in need of an

expedited decision receive priority processing. Decisions with an AOD status comprised approximately 24% of the Board's fiscal year (FY) 2025 caseload.

Summary: Section 2(c) would add new section 38 U.S.C. § 5109C to require the Secretary to track data, and submit to Congress an annual report, regarding whether each claim for a particular benefit is: continuously pursued, filed in the national Work Queue but not assigned for adjudication, afforded expeditious treatment by VBA, remanded by the Board, or pending a Board hearing. The Secretary would also be required to track instances where a VBA adjudicator does not comply with remand instructions of the Board, supplemental claims filed within continuous pursuit after a finally adjudicated decision, and "first notices" submitted to the Secretary of death of individuals in receipt of VA benefits.

Position: VA cites concerns with portions of this provision and opposes other portions of it.

Views: This section would require VA to substantially modify its systems to track and report numerous aspects of claims processing. As expressed below, some proposed tracking requirements would impose a heavy and, in our view, unnecessary burden on the Board.

VA cites concern with the portion of section (2)(c)(1) that would require VA to track claims, and issues within claims, that are continuously pursued. As an initial matter, we incorporate our suggestion above (in our views on section 2(a)) regarding the definition of "issue." Additionally, the Board has no ability to track this information within its current case management systems, partly due to a lack of consistency in how claims are identified, and efforts to do so would require significant information technology development and testing resources to achieve changes in business processes and necessary system integration across VA. This would create a heavy and unnecessary resource burden on the Board.

VA opposes the portion of section 2(c)(1) that would require VA tracking and reporting on instances in which a VBA adjudicator does not comply with instructions in a Board remand decision. Complying with this requirement for AMA appeals would involve an entirely new structure and review program covering all post-remand Agency of Original Jurisdiction (AOJ) decisions, which would require considerable additional personnel resources and information technology development costs. This increased resource burden would divert valuable personnel and financial resources away from the Board's focus on deciding pending appeals as swiftly and fairly as possible. Tracking compliance with Board remands also would require increased system integration to track remands and would require significant VA technological development and testing to successfully accomplish.

Even with system modification, tracking noncompliance with Board remands presents practical problems with obtaining accurate data. First, compliance with a Board remand is a subjective measure that might not be consistently captured by individual Veterans Law Judges for several reasons, and this would lead to inconsistent data of questionable reliability for potential intervention strategies. Second, if the AOJ grants the claim in full without conducting the development directed by the Board, it is unclear if this would trigger reporting requirements under a failure to comply even though the claim has been resolved in the Veteran's favor. Third, for AMA claims, unless the post-remand AOJ decision is appealed to the Board within 1 year, there is no system in place, and no practical system we can envision, to determine whether the AOJ has complied with the Board's remand. Under the AMA, claims are not automatically returned to the Board following a post-remand AOJ decision. Thus, the Board does not review those claims for compliance with remand instructions. Legacy claim remands are, of course, a diminishing percentage of all Board remands.

To the extent this provision relies on the duties imposed on the Board in section 2(d) with respect to remand compliance, please see our views expressed below on that section.

Should the Committee nevertheless decide to move forward with this provision, VA requests that the statutory language clarify whether the term "remand" encompasses both legacy remands and AMA remands.

VA cites concerns with the portion of section 2(c)(1) that would require VA to track and maintain information specifically for supplemental claims, including disaggregation between those filed within a year of the last VA decision (within continuous pursuit) and those filed outside of that period.

VA's Veterans Benefits Management System application is not designed to track the date of prior decisions for each issue in any given supplemental claim. While the required supplemental claims form asks the claimant to identify the specific issues and the date of the VA decision notice, this data is not recorded in VA systems and is used only by claims processors who are responsible for reviewing all claim submissions and evidence of record to determine if the claimant has maintained continuous pursuit.

Therefore, VA expresses concern with the current technological capabilities of the agency to comply with the statutory requirements for these reports given that VA's current systems do not capture this data. Appropriations would be necessary, but VA does not have a cost estimate at this time.

Summary: Section 2(d)(1) would expand the authority of the Board to aggregate claims that contain common issues of law or fact. The Secretary would be required to submit a report to Congress, every 5 years, on the aggregation of claims.

Section 2(d)(2) would require the Secretary to ensure substantial compliance with Board remands, except where the Board has determined that evidence added to the record after a remand is sufficient to resolve the underlying issues or where the remand decision was unnecessary, in which case the agency of original jurisdiction may "waive" the compliance requirement.

Position: VA does not support this provision.

Views: Section 2(d)(1) of the bill would provide the Chairman of the Board the authority to aggregate certain claims. Attempting to aggregate different Veterans' appeals would substantially alter the Board's case processes and would upend docket order rules in unfair ways for many Veterans with pending appeals.

First, this section would create a statutory conflict with 38 U.S.C. § 7107(a)(4), which requires the Board to decide each case before the Board "in regular order according to its respective place on the docket." Additional statutory language would be needed to address this tension and make clear how the Board can aggregate appeals without violating the docket order requirement. Similarly, statutory guidance would need to be provided on the timing applicable to a Veteran's right to a hearing and right to determine the scope of the evidentiary record in their case. *See* 38 U.S.C. §§ 7105(b)(3), 7107(c), 7113. It is unclear who would get the opportunity for a hearing before the decision on the common question, and what the evidentiary record would be for such a decision. Even with statutory rules explicitly addressing these disconnects, the aggregation of appeals with different evidence windows would add further confusion to the AMA system at a time when Veterans and representatives are still becoming familiar with the nuances of the AMA.

Second, the aggregation of different Veterans' appeals would be a sharp departure from the Board's longstanding role in evaluating the particular and unique facts and circumstances for each appeal that is filed at the Board. A claim for benefits is first adjudicated by the AOJ. If an adverse decision by the AOJ is appealed to the Board, the Board will review the claim de novo and decide all questions of law and fact necessary to adjudicate the claim for benefits. Aggregation would apply a legal or factual conclusion to an entire class of claimants, but without appropriate consideration of the specific and unique facts of each case. If the goal of this bill is efficiency, the Board is at its most efficient when it is resolving individual cases based on the particular facts at issue. This has been the Board's task for decades. In contrast, in addition to the agency's general authority to promulgate regulations interpreting statutory provisions, it is the VA Office of General Counsel (OGC) and the U.S. Court of Appeals for Veterans Claims (CAVC) that are tasked with issuing precedential opinions for common questions of law or fact. *See* 38 U.S.C. §§ 7104(c), 7261. To be clear, it would only delay appeal resolution if cases that are ready for adjudication

are: (1) paused by the Chairman in order to provide appropriate due process for aggregation, then (2) joined with other cases for a decision on the common question, and then (3) placed back in the queue for another decision on the particular facts of the individual case. This is because, even after aggregation, each appeal would have to be adjudicated on its own factual basis and would require independent analysis. The evidence of record for each individual case is still unique and would have to be evaluated individually. Therefore, aggregating appeals would not speed up the process for any Veteran. Also, we note that most appeals decided by the Board include multiple disability compensation claims. This dynamic will lower the system-wide productivity value of aggregation. Even if one claim is resolved via an aggregated case and removed from the original pending appeal, the other claims in the appeal must still be decided. The record still must be reviewed, and a decision still must be drafted. In addition, aggregation would require a significant amount of attorney and/or Board resources to determine what metrics would be applied in choosing cases for aggregation and on-going review of the Board's entire, transitory, pending inventory of approximately 187,000 cases to identify a common class of Veterans. We note concern that there would likely be a new cottage industry of cases related to disputes over whether someone should or should not have been included in an aggregated case, and those decisions might be subject to appeal, meaning additional delay, by years, of the underlying merits adjudication.

There are also significant technological resource concerns, as the Board's case-processing system (Caseflow) is not currently designed to docket, process, or otherwise track aggregated appeals. Aggregation would require the Board to completely revise its case management systems, to include integration with other VA systems, to allow this entirely new method of moving cases ahead of others. It would require both a complete overhaul of the Board's docketing system and would also require other potential changes for unforeseen consequences.

If Congress is nevertheless interested in granting the Board this authority, VA recommends adding the words "in the sole discretion of the Chairman" to the proposed new sentence of § 7104, such that "the Chairman may, in the sole discretion of the Chairman, aggregate such appeals." This would reinforce a principle that the word "may" already suggests that aggregation would be solely in the discretion of the Chairman. We also suggest, for purposes of promoting efficiency, that Congress consider adding a sentence that affirmatively states that any aggregation decision made by the Chairman is final and not subject to appeal to the court. Otherwise, the provision would invite litigation by claimants seeking to enforce a perceived right to aggregation.

Section 2(d)(2) would require the Secretary, "acting through a member of the Board," to ensure substantial compliance with any Board decision to remand a claim. The AOJ would be permitted to waive this requirement if a Board member determines that evidence added to the evidentiary record after the date of the Board remand decision is sufficient to resolve the underlying issues or such a decision was unnecessary. Respectfully, VA does not understand how this section would work—

namely, how the AOJ would waive the requirement based on a determination of a Board member who has no jurisdiction over, or involvement with, the claim at that point.

To the extent that this provision contemplates active oversight by a Veterans Law Judge of AOJ claims processing following a remand, such requirement would be grossly inefficient and resource intensive with little quantifiable benefit, given that the current system affords claimants who receive an AOJ decision on remand the right to appeal to the Board to correct any perceived AOJ error, including non-compliance with the Board's remand instructions. If the Board were required to review every claim it remands for AOJ compliance, as well as adjudicate AOJ requests for waivers, the Board estimates that the resource drain would effectively cut Board annual adjudications by at least half. Approximately 57,000 appeals adjudicated during FY 2023 included at least one issue remanded by the Board. Using that data as a benchmark, the provision would require at least 57,000 additional Veterans Law Judge reviews and opinions to be rendered per year, consuming valuable judicial resources.

This would lead to an exponential growth in pending appeals and impose additional delays on all cases. Overall, this would make the VA appeals system markedly less efficient, contrary to the purpose of the AMA and would be harmful to Veterans, particularly those who have already waited a long time for resolution of their appeals.

To the extent the intention of this provision is to ensure substantial compliance with Board remands, that duty is already part of binding caselaw. *Stegall v. West*, 11 Vet. App. 268, 271 (1998). If Congress wishes to codify that duty, it could simply state in the bill that "a remand by the Board imposes upon the Secretary a duty to ensure substantial compliance with the terms of the remand, absent a grant of the remanded issue."

Summary: Section 2(e) would expand the jurisdiction of the CAVC to certify classes with respect to claimants who are awaiting a Board decision, or who have received a Board decision and filed a supplemental claim within 1 year. This section would also allow the CAVC to remand questions of law or fact to the Board, while maintaining jurisdiction under a stay of judicial proceedings, where the Board has failed to (a) address an issue raised by the clamant (or the record) or (b) provide adequate reasons or bases.

Position: VA does not support this provision.

Views: Section 2(e) of the bill would revise 38 U.S.C. § 7252 to expand the jurisdiction of the CAVC. This expansion would not promote efficient claim resolution, would create confusion for and potentially prejudice Veterans, and is unnecessary.

This section would grant the CAVC jurisdiction over a claim currently being processed by VA, if it satisfies a class definition certified by the CAVC. This would create confusion for Veterans as to which entity has jurisdiction over their claim, not to mention delay if VA pauses claim processing to await the CAVC's decision. Veterans who have filed a notice of disagreement and expect Board review, or who have filed a supplemental claim and expect the VA regional office to review their new evidence (proposed § 7252(b)(1)(A)(ii) includes claimants who have chosen to file a supplemental claim rather than a CAVC appeal after a Board decision), would suddenly find that the CAVC, an entity which they may have chosen to avoid, has jurisdiction over and can issue a binding decision on their case. The bill provides no due process protection for such Veterans, who could find themselves personally bound by an unfavorable decision that they did not request, in a proceeding that they may not have known about. Although the bill refers to Veterans who "have not opted out" in proposed § 7252(b)(2), it provides no protections on opt-out procedures. Even if it did, it would be very confusing for a Veteran to weigh the advantages and disadvantages of opting-out, with high stakes for that choice, since an unfavorable class ruling personally binds class members, i.e., once the CAVC has decided the issue, the Veteran is permanently foreclosed from providing alternative arguments on it.

This expansion is also unnecessary, as the CAVC already has the authority to issue precedential decisions on common questions of law or fact. Through a precedential decision, it can create a binding rule of law that VA must apply to all claims currently being processed. Precedential decisions are more advantageous for Veterans, because unfavorable precedents can be distinguished, whereas unfavorable class action rulings are personally binding for class members. Meanwhile, favorable precedents are no less advantageous, on balance, than favorable class action rulings, as VA must abide by both.

Moreover, as a matter of efficiency, it is unclear the benefit of bestowing the CAVC with direct jurisdiction over claims currently pending with VA, as the Court's jurisdiction is to review Board decisions, 38 U.S.C. § 7252(a), not to decide pending claims in the first instance, which is prohibited by 38 U.S.C. § 7261(c). Thus, the CAVC would presumably be granted "supplemental jurisdiction," a term which may need to be better defined, over the claim to address a common question—but then remand it for the Board and possibly the regional office to address the case's individual facts in the first instance. If the claimant disagrees with the Board's or regional office's individual fact determinations, or on legal rulings outside the scope of the class issues, the case will then return to the CAVC a second time. This process would not promote efficient claim resolution.

Finally, this expansion of CAVC jurisdiction is contrary to the very well-documented and carefully considered legislation that originally created the CAVC in 1988, especially the debate about the appropriate jurisdictional scope of the court to review only "final" decisions by the Board. While the Senate had passed Veterans' judicial review bills in five previous sessions, the House did not pass such a bill until a compromise emerged (the Veterans' Judicial Review Act) that limited the nature of the

court that would be created: an appellate court that would be authorized to review questions of law and fact arising from a final agency action (a Board decision), but would not have jurisdiction over claims still proceeding through the "unique and desirable" administrative system, would not "have arrogated [ ] power" to "run the VA's claims system, and decide its cases for it," and could be singularly focused on Board decisions to avoid the "burden[ ]" and "delay" attendant with district court-like jurisdiction. S. Rpt. 100-418 (1988); H. Rpt. 100-963 (1988); 134 Cong. Rec. H9253 (October 3, 1988); 134 Cong. Rec. H10333 (October 19, 1988).

Section 2(e) would further provide that class members may submit a supplemental claim, notice of disagreement (NOD), or request for higher-level review (HLR), during the period between the filing of the motion for class action and 60 days after the later of the CAVC's final decision "with respect to such claim" or "with respect to such motion for class action." At the outset, it is unclear what "claim" is being referred to in the language "with respect to such claim." More importantly, however, the intent of this subsection is unclear. If the intent is to broaden the timeframe for these claimants to submit their supplemental claims, NODs, and requests for HLR, VA recommends replacing the "may submit" language here with "shall not be prohibited from submitting" language. Even with that replacement, however, this subsection would create confusing timelines, as VA processors evaluating whether a supplemental claim, NOD, or request for HLR is timely might have to review all recent motions for class action at the CAVC, determine whether the claimant was within the class definition, and determine the date of the CAVC's final decision on the motion and the claim, all to determine timeliness. Such a task does not promote efficiency.

Moreover, on the issue of agency timelines, some Veterans may think they satisfy the class definition, that the CAVC has supplemental jurisdiction over their claim, and that they need not meet ordinary agency timelines, but—if they are wrong—their claim is final and there is no recourse. Again, the potential for confusion with supplemental jurisdiction outweighs any speculative potential benefits.

Section 2(e) would next permit tolling when a claim is decided by the Board during the period the CAVC is reviewing a motion for class action. If the Committee moves forward with this section, VA recommends replacing the word "if" with "until" to clarify the length of the tolling and inserting a comma between the terms "review" and "the deadline."

Finally, section 2(e) would authorize the CAVC to issue limited remands to the Board, while retaining jurisdiction, for purposes of addressing a relevant issue or providing adequate reasons or bases. We note that the CAVC has issued limited remands in rare instances, so the court may believe it already has such authority. This authority would disrupt Board efficiency and could also create a perpetual loop between the Board and the CAVC if the court continues to determine that the Board's reasons and bases are inadequate. This could have a similar effect as the remand loop between the Board and the AOJ experienced in the legacy process that the AMA was intended to cure. In addition, the Board would need to build new functionality in its

Caseflow digital management system to accommodate this type of remand, which would require significant resources.

We also note that the section is unclear as to what would happen if the limited remand results in a conclusion by the Board that there was a duty to assist error that needs to be corrected by the AOJ. It is unclear whether the Board could remand the case to correct that error, or whether the court would still have jurisdiction. The statute should directly address this eventuality.

If Congress is nevertheless interested in exploring this authority, VA recommends making this authority part of a 6-month pilot program to test its efficiency. VA also recommends that Congress require the CAVC to give the Board at least 180 days to issue its supplementary decision, to account for other Veterans' appeals that have been waiting. Finally, VA recommends that Congress preclude entitlement to Equal Access to Justice Act (EAJA) fees on the basis of the CAVC ordering a limited remand, so as to prevent potential manipulation. At present, only about 20% of the average of 8,000-10,000 appeals filed with the CAVC each year are reviewed by the court's judges. The remaining 80% are set aside and remanded to the Board for further adjudication by order of the Clerk pursuant to agreement of the parties. This generates approximately $45-50 million in EAJA fees per year, regardless of the fact that most remands ultimately do not lead to a changed result for the Veteran. If EAJA is not precluded from this limited remand authority, a similar trend is likely to appear.

Summary: Section 2(f) of the bill would require the Board Chairman to carry out a study to identify questions of law or fact the Board commonly considers for which precedential guidance would assist the Board in issuing final decisions on such appeals.

Position: VA does not support this provision.

Views: To the extent that the provision is intended to increase consistency across Board decisions, this is a burdensome and unnecessary means. The CAVC issues dozens of precedential opinions per year on commonly arising questions of law. In addition, the Board already has the authority to request an opinion from VA's OGC when it identifies a legal issue that warrants precedential guidance. And questions of fact are generally case-specific and not appropriate for precedential guidance.

Summary: Section 2(g) would require VA to enter into an agreement with a Federally funded research and development center (FFRDC) to assess modifying the authority of the Board to issue precedential decisions with respect to questions of law or fact.

Position: **VA cites concerns with this provision.**

Views: The complexity and scope of this proposal would require significant resources to enter into that contractual agreement – probably several million dollars, at a minimum – that could require resource trade-offs within the current Board budget. That does not account for the acquisition and legal resources needed to execute and monitor performance of the agreement. Because such a study would evaluate a potentially substantial change to the Board's adjudication of appeals, the time and personnel resources involved with those participating would be extensive. The evaluation and full consideration of various options would be a large and complex undertaking, especially given the Board's historic role of issuing nonprecedential decisions.

The section also would require VA to begin developing policies and procedures to implement the FFRDC recommendations no later than 90 days after receipt of the FFRDC assessment, and to complete such development 6 months thereafter. But the policies or procedures to implement recommendations could be significant and complex and would have to go through multiple levels of internal review, as well as potentially notice and comment rulemaking, to carefully debate and consider the revision and overhaul of various regulations, processes, and procedures. Thus, it would take significantly longer than 90 days and 6 months to begin developing and to complete the necessary policies and procedures required under this proposal.

VA also cites concerns with the assignment of authority to FFRDCs without clear statutory guidance on their role as determining authorities within VA. While an independent assessment of the feasibility of Board precedential decisions and the consolidation of appeals could yield valuable insights, the requirement for strict implementation of the findings appears to unduly restrict the Secretary's decision-making authority for final implementation, under which the Secretary considers the overarching needs of the agency.

Cost Estimate: VA does not have a cost estimate for this bill.

S. 2061 Molly R. Loomis Research for Descendants of Toxic Exposed Veterans Act of 2025

Summary: Section 2(a) of this bill would amend section 501 of the Honoring our Promise to Address Comprehensive Toxics Act of 2022, which generally sets forth the functions of the Toxic Exposure Research Working Group, to include a requirement that the Working Group establish a Federal interagency task force to conduct collaborative research activities.

Section 2(b) would amend section 501(c), which sets forth reporting requirements for the Working Group, to require a report, not later than 1 year from the date of enactment, containing a description of the collaborative research activities identified by the Working Group, the findings of the members of the Working Group with

respect to such collaborative research activities, and such recommendations as the Working Group may have for legislative or administrative action to improve collaborative research activities among members of the Working Group. Annually, during the five-year period covered by the Working Group's strategic plan, it would have to report to Congress a summary of the collaborative research activities carried out by the members of the Working Group and the findings of the members with respect to such activities, a progress report on implementation of the strategic plan developed by the Working Group, and the Working Group's recommendations for legislative or administrative action to improve collaborative research activities among the Working Group's members.

Section 2(c) would require the Working Group and the Agency for Toxic Substances and Disease Registry (ATSDR), not later than 180 days after the date of enactment, to establish an interagency task force to conduct research on the diagnosis and treatment of health conditions of descendants of toxic-exposed Veterans and maintain a publicly available website with information on the activities and findings of ATSDR, including a review of all relevant data to determine the strength of evidence for a positive association between a health condition researched and a toxic exposure risk activity based on the categories set forth under 38 U.S.C. § 1173(c)(2) (which sets forth four categories including sufficient, equipoise and above, below equipoise, and against).

Position: VA does not support the bill.

Views: This bill would duplicate work performed by the National Academies of Sciences, Engineering, and Medicine (NASEM). NASEM, an independent, non-government organization, has an agreement with VA to conduct extensive reviews of the health effects of military service, particularly focusing on Gulf War- and Vietnam-era-Veterans and their associated exposures. Their reports categorize the strength of association between military service and health outcomes into several levels, from sufficient evidence of a causal relationship to limited evidence of association.

Scientific evidence suggests that toxic exposure-induced generational effects have not occurred in military Service members who deployed to the Southeast and Southwest Asia theaters of operation. The Working Group has since established a framework for toxic exposures research that covers multiple categories, including environmental, occupational, situational, and training contexts. In this context, we believe current efforts satisfy the intended outcome of the bill.

Cost Estimate: VA does not have a cost estimate for this bill.

S. 2220 Fighting for the Overlooked Recognition of Groups Operating in Toxic Test Environments in Nevada (FORGOTTEN) Act of 2025

Summary: Section 2(a) of the bill would require DoW to expand the Individual Longitudinal exposure Record (ILER) to document all toxic exposures of members of the Armed Forces, including those that occur within the United States, so such

information can be available for VA when such members transition to civilian life. Information relating to all-hazard occupational data and environmental hazards that were known or found later to which the member was exposed, including through conducting any monitoring in an area in which the member may have been exposed, would have to be included.

Section 2(b) would require DoW to expand ILER to include medical encounter information relating to toxic exposures (such as diagnosis, treatment, and laboratory data) and medical concerns that should be addressed regarding possible toxic exposures for members of the Armed Forces so it can be available for VA when such members have transitioned to civilian life.

Section 2(c) would require DoW and VA to ensure that ILER is available, for purposes of improving internal processes, to VA and DoW health care providers, epidemiologists, and researchers, as well as VA disability evaluation and benefits determinations specialists.

Section 2(d) would require DoW to document in the Service records of a member of the Armed Forces whether such member served at a location where there was a potential of toxic exposure. In carrying out this requirement, DoW would have to ensure that service at any location that is classified would be protected from disclosure and could contain a box to be checked to indicate that a member of the Armed Forces served at a location where there was a potential for toxic exposure.

Position: VA defers to DoW in part on this section but otherwise supports this section, subject to the availability of appropriations.

Views: Sections 2(b) and 2(d) would establish requirements for DoW, and VA defers to DoW on those provisions. Sections 2(a) and 2(c) would generally reinforce current requirements regarding ILER, and VA supports these efforts. Capturing toxic exposure information in ILER allows VA to process claims under 38 U.S.C. § 1168 more accurately when a Veteran participated in a toxic exposure risk activity (TERA). Participation in a TERA can also establish eligibility to enroll in VA health care under 38 U.S.C. § 1710(e)(1)(G),

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Summary: Section 3 would state that members of the Armed Forces and DoW civilian employees who are or have been stationed or employed at a covered facility would be presumed to have been exposed to toxic substances. The term “covered facility” would mean any facility on the most recent list of facilities covered by the Energy Employees Occupational Illness Compensation Program Act of 2000 (EEOICPA) 42 U.S.C. § 7384 *et seq.*) published in the Federal Register by the Department of Energy.

Position: VA cites concerns with this section.

Views: VA strongly agrees that individuals exposed to radiation or toxic substances should be compensated for their losses, but we note that it is unclear what legal effect would result from Service members and civilians being "presumed to have been exposed to toxic substances." If the intent is for this presumption to result in the provision of benefits, the EEOICPA already provides a compensation program for the civilian men and women who, over the past 80 years, have performed duties uniquely related to the nuclear weapons production and testing programs of the Department of Energy and its predecessor agencies. Workers from certain Atomic Weapons Employers are also covered under the Act. In this context, section 3 may duplicate other provisions of law. VA defers to the Department of Labor on the exact nature of any overlap.

Summary: Section 4(a) would require DoW to classify the Nevada Test and Training Range (NTTR) as a location where contamination occurred. Section 4(b) would require the Air Force to establish a process to identify current and former members of the Armed Forces that were stationed at the NTTR since January 27, 1951. The Air Force would have to establish a process to permit current and former members of the Armed Forces to provide documentation of evidence of their assignment within the NTTR to assist the Air Force in identifying those current and former members. The Air Force would have to make all efforts to identify current and former members of the Armed Forces who were stationed at the NTTR and could not require current or former members of the Armed Forces to submit evidence of their stationing.

Position: VA generally defers to DoW on this section.

Views: VA generally defers to DoW on this section, as it would establish requirements for that Department. However, we note that once DoW identifies the cohort of Veterans who served at the NTTR, VA could use this information to support the delivery of benefits and health care to eligible Veterans.

Summary: Section 5 would amend 38 U.S.C. § 1112(c)(3)(B), which defines the term "radiation risk activity" in the context of presumptions relating to certain diseases and disabilities, to include, at any time on or after January 27, 1951, onsite participation in any aspect of the development, construction, operation, or maintenance of a military installation (as defined in 10 U.S.C. § 2801) at a covered location at the NTTR. It would also add a new definition in § 1112(c)(3)(C) to define the term "covered location at the Nevada Test and Training Range" to mean a location at the NTTR where there was a potential of toxic exposure.

Position: VA cites concerns with this section.

Views: VA cites concerns with this section. The bill would define the term "covered location at the Nevada Test and Training Range" to mean a location "where there was a potential of toxic exposure," but the definition would qualify the new clause under the definition of "radiation-risk activity." If there is a reason why generalized "toxic exposure" is included as separate and distinct from radiation, VA recommends including that information and considering adding that exposure information outside of this radiation-specific statute. We also note that there is no end date for qualifying service at the NTTR; VA defers to DoW on whether there are continuing risks of radiation exposure, but including a specific exposure end date would allow for more precise implementation.

VA further recommends that DoW or the Department of Energy provide sufficient evidence to support the inclusion of service at NTTR as a radiation risk activity. Air sampling studies since 1963 have shown insignificant airborne plutonium levels at the nearest occupied workplace on the NTTR, below global levels detected after historical nuclear tests.

Summary: Section 6 would amend 38 U.S.C. § 1119, which generally deals with presumptions of toxic exposure, to amend the definition of "covered veteran" to include any Veteran who, on or after January 27, 1951, performed active military, naval, air, or space service while assigned to a duty station in, including airspace above, a covered location at the NTTR. It would define the term "covered location at the Nevada Test and Training Range" to mean a location at the NTTR where there was a potential of toxic exposure.

Position: VA cites concerns with this section.

Views: VA cites concerns with this section because it would amend the definition of "covered veteran" for purposes of section 1119, which generally establishes eligibility limited to service in the Southwest Asia Theater of Operations (on or after August 2, 1990, active service while assigned to a duty station in Bahrain, Iraq, Kuwait, Oman, Qatar, Saudi Arabia, Somalia, or the United Arab Emirates; and on or after September 11, 2001, active service while assigned to a duty station in Afghanistan, Djibouti, Egypt, Jordan, Lebanon, Syria, Yemen, or Uzbekistan). Including service in the NTTR with these cohorts would create confusion and unnecessary complexity for implementation of benefits for these populations. The proposal would also create operational challenges as VA systems currently use automation and streamlined procedures to increase claims processing efficiency; revising this definition would require burdensome procedural and system updates to separate Veterans who served at the NTTR from other "covered veterans." If Congress intends to move forward, creating a separate statutory authority defining the presumption of exposure for NTTR Veterans would be more effective and would avoid these concerns.

Summary: Section 7 would amend 38 U.S.C. § 1120, which generally establishes presumptions of service connection for certain diseases associated with exposure to burn pits and other toxins, to include, only in the case of covered Veterans described through the amendments made by section 6 of this bill, lipomas and tumor related conditions.

Position: VA cites concerns with this section.

Views: As noted in the discussion of section 6, VA recommends against including Veterans who served in the NTTR in the definition of "covered veterans." Creating a separate authority would again be clearer. Additionally, VA notes there is no proven connection between radiation exposure and lipomas. Causes of lipoma are thought to be genetic predisposition, trauma that may trigger lipoma growth, hormonal changes (such as seen in women during childbearing years), obesity, or several syndromes that are noted to have increased risk of lipomas as part of the disease. VA also notes it is unclear what it meant by "tumor related conditions."

Cost Estimate: VA does not have a cost estimate for this bill.

S. 2264 Advancing VA's Emergency Response to (AVERT) Crises Act of 2025

Summary: Section 2(a) of the bill would require VA to submit to Congress, within 180 days of enactment, a report outlining the roles and responsibilities of all offices within VA involved with emergency management. Section 2(b) would require VA, in preparing the report, to consult with the Comptroller General, VA's Inspector General, the Secretary of Homeland Security, and such other Federal agencies as the Secretary considers relevant to obtain insights from their experience and trends that they have found, and such recommendations they may have with respect to VA's management of emergency management functions. Section 2(c) would set forth the required contents of the report required by subsection (a).

Position: VA has no objection to this section, subject to the availability of appropriations.

Views: VA has no objection to this section but notes that a specific reporting requirement is unnecessary. VA can provide information to Congress upon its request, so legislation is unnecessary. VA routinely consults with interagency partners to obtain insights and identify areas for improvement regarding our emergency management programs and disaster operations support. These observations are regularly integrated into our continuous improvement efforts.

Additionally, VA has been conducting workforce optimization planning over the past year, including a review of emergency management roles and responsibilities across the enterprise to ensure an emergency management program that is enterprise

focused, regionally coordinated, and locally executed. VA expects to complete this review along with analysis of the feasibility and advisability of consolidating or centralizing key functions by the end of the year. VA can provide information to Congress upon its request once the analysis is completed.

Summary: Section 3(a) of the bill would require VA, within 180 days of enactment, to submit to Congress a report on VA's Regional Readiness Centers (RRC). Section 3(b) would set forth the required contents of the report required by subsection (a).

Position: VA has no objection to this section, subject to the availability of appropriations.

Views: VA has no objection to this section but notes that, in compliance with section 401 of the Joseph Maxwell Cleland and Robert Joseph Dole Memorial Veterans Benefits and Health Care Improvement Act of 2022 (division U of P.L. 117-328; 38 U.S.C. § 8121, note), VHA is standing down the RRCs that the Defense Logistics Agency (DLA) is operating in support of the personal protective equipment stockpile. VA anticipates an estimated $12M per year cost savings.

VA is required by section 401 to create and maintain a critical item list of medical supplies, equipment, and devices essential to patient care and emergency response. This list ensures VA medical centers (VAMC) maintain or obtain an adequate supply of mission-critical medical items, especially during supply chain disruptions, public health emergencies, or other disasters. VA is prohibited from exclusively relying on stockpile material and instead must use DLA's Warstopper Program as the first choice for response.

As noted in the discussion of section 3, VA can provide information to Congress upon its request, so legislation is not necessary. VA expects to sunset fully the two remaining RRCs by March 2026. The agreement with DLA for the warehouses will stay in place for emergency situations to allow for mobilization if necessary. Zero (0) RRCs will remain.

Summary: Section 4 of the bill would require VA to submit to Congress a report, not later than 90 days after enactment, on current limitations preventing the Federal Emergency Management Agency (FEMA) from providing fuel or other resources to VA during emergencies, whether VA requires congressional action to allow such resource sharing, whether VA has been able to coordinate with FEMA during prior emergencies or Fourth Mission activations due to a lack of authority, and whether VA requires Congressional action to address the lack of coordination with FEMA.

Position: VA has no objection to this section, subject to the availability of appropriations.

Views: VA has no objection to this section, but as noted with sections 2 and 3, VA can provide information to Congress upon its request, so legislation is not necessary

VA works in close coordination with FEMA and all interagency partners before, during, and after a disaster. VA provides liaisons to the National Response Coordination Center during incident response specifically to ensure coordinated resource sharing and a unified national response. Disruptions to fuel supply and fuel shortages in hard-hit communities following a disaster are common. These disruptions and shortages hinder or prevent local workforces and responders, including VA health care workers, from providing care and services to Veterans and disaster survivors. Although VA and FEMA have the means to obtain and distribute fuel to affected communities, VA does not have the authority to permit VA employees or responders to use VA-purchased fuel. Additionally, VA's workforce does not meet the definition of "responder" and has not been able to use FEMA "responder" fuel brought into affected communities. VA is working with FEMA to ensure a better understanding of how VA's health care workforce and other staff are activated as responders to meet the needs of Veterans and disaster survivors during and after an incident.

Cost Estimate: Veterans Affairs estimates $335,700 for the required reports.

S. 2309 Veteran Burial Timeliness and Death Certificate Accountability Act

Summary: Section 2 of the bill would state Congress' findings that states and counties have reported significant delays in the signing of death certificates for Veterans who pass away from natural causes, that such delays (caused by the refusal of, or postponement by, VA physicians) have, in some cases lasted as long as eight weeks, and that such delays prevent the timely burial of deceased Veterans and access to survivor benefits.

Section 3(a) of the bill would require VA physicians or nurse practitioners who are the primary care providers of a Veteran who dies of natural causes to certify the death of the Veteran not later than 48 hours after the physician or nurse practitioner learns of such death. It would further provide that if a VA physician or nurse practitioner could not comply with that requirement, a coroner or medical examiner in the jurisdiction where the death occurred could certify such death.

Section 3(b) would require VA, not later than 1 year from enactment and annually thereafter, to submit to Congress a report regarding compliance with subsection (a). Each report would have to include the percentage of cases in which a VA physician or nurse practitioner complied with subsection (a), the number of cases in which a VA physician or nurse practitioner could not comply, and an identification of the most common reasons why they were unable to comply.

Section 3(c) would provide a rule of construction that nothing in this Act could require any VA employee, including a physician or nurse practitioner, to take an action not in compliance with the laws, regulations, or requirements of the appropriate jurisdiction in which the employee is licensed or practicing, or in which a death may need to be certified.

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

Views: VA supports this bill, subject to amendments, because alleviating delays in the certification of a Veteran's death would support continued collaboration and information sharing between VBA and VHA in support of faster claims decisions for survivors. VA recognizes and has proactively implemented measures to address concerns this bill aims to address. On June 25, 2025, VA published VHA Notice 2025-03, "Survivors Assistance and Memorial Support," which provides a framework to ensure standardized clinical and operational processes, training, and oversight to support primary survivors and next of kin. This Notice addresses a number of the provisions outlined in the bill.

VA recommends amending the bill in two ways. First, the bill's requirements for VA physicians or nurse practitioners to certify a Veteran's death within 48 hours is unduly specific and would be difficult or impossible to meet in some situations. VHA Notice 2025-03 requires VA health care providers to sign death certificates within 2 business days of notification, adhering to state and local laws. This standard of 2 business days allows for necessary information gathering, accommodates providers' schedules, and respects state and local laws. Over 95% of Veteran deaths occur outside VA facilities, making timely completion complex due to the need for collateral history from various sources and other jurisdictional requirements. VA recommends changing the 48-hour requirement to a 2-business day requirement. Further changes may be needed to account for variations that may arise based on where the Veteran died.

In addition, this bill would exclude Physician Assistants (PA) from certifying death certificates. VHA policy includes PAs as certifying health care providers because PAs are trusted, licensed clinicians who significantly contribute to VA's health care system. VA recommends amending the bill to allow PAs to certify the death, in addition to physicians and nurse practitioners.

We also note that the reporting provisions outlined in section 3(b) would require enhancements to current data systems and pose significant operational challenges.

Cost Estimate: VA does not have a cost estimate for this bill.

S. 2328 Military Learning for Credit Act of 2025

Summary: This bill would allow an individual entitled to educational assistance under 38 U.S.C. chapters 30, 32, 33, 34, or 35 or any other provision of law providing educational assistance to a veteran or another individual in connection with the service of a veteran in the Armed Forces, to use educational benefits to cover the cost of covered examinations and assessments up to $500 to receive credit toward degrees awarded by institutions of higher learning for approved programs of education. The bill would require VA to charge the number of months of entitlement equal to the cost of the examination or assessment divided by the monthly rate of Veterans' educational assistance to which the individual is entitled at the time of the examination or assessment. This entitlement charge would not affect entitlement to educational assistance under a law administered by DoW, including entitlement under DoW's Tuition Assistance Program. The examinations and assessments that would be covered under this bill are the following: a DANTES Subject Standardized Test Program (DSST) examination; a College Level Examination Program (CLEP) examination; the National Career Readiness Certificate examination; any other examination of a similar nature to these specified exams; and an assessment by an institution of higher learning of a portfolio or written narrative by a student with supporting documentation that demonstrates prior military training or learning.

Position: VA supports this bill, subject to amendment and the availability of appropriations.

Views: Under current law, VA pays benefits to eligible beneficiaries for examinations and assessments as defined in 38 U.S.C. § 3452(b) to include "national tests providing an opportunity for course credit at institutions of higher learning (such as the … College-Level Examination Program (CLEP))." However, VA's current authority does not restrict payments to $500, and the bill would not amend or remove VA's existing authority to pay without restriction. If this bill were to become law without amendment to current law, there would be an inconsistency among the various statutes. The bill includes a $500 maximum payment for each examination or assessment. To ensure clarity, we recommend making explicit that this cap applies solely to payments made under this new authority and does not modify existing authority at 38 U.S.C. §§ 3452(b), 3315, 3315A, and 3315B. This avoids any unintended interaction with the current GI Bill provisions.

We suggest adding a new subsection (a) to read as follows: "Nothing in this section modifies existing authority found in 38 U.S.C. §§ 3452(b), 3315, 3315A, and 3315B." and redesignating all succeeding subsections accordingly.

Additionally, for individuals who want to use their educational benefits to cover the cost of examinations and assessments, it is unclear what is meant by basing entitlement charges on "the monthly rate of veterans educational assistance to which the individual is entitled" as required by section 2(d) of the bill. In fact, some beneficiaries do not receive any monthly payments. Instead, we recommend replacing the language in subsection (d) with language similar to the language in current statutes, such as 38 U.S.C. §§ 3315, 3315A, and 3315B, that base entitlement charges on a sum

certain. VA could work with the Committee to identify all the statutory provisions that would need to be changed to eliminate VA's current statutory authority to pay these benefits.

Additionally, in section 2(b)(1), this bill would identify chapters 30, 32, 33, 34, and 35 benefits as benefits that can be used to cover the cost of examinations and assessments. VA recommends Congress consider the removal of chapter 32 because currently no new beneficiaries can qualify for benefits under chapter 32. It is unclear whether chapter 1606 beneficiaries would be able to use their benefits for examinations and assessments under section 2(b)(2) of the bill, which would allow benefits under "any other provision of law providing educational assistance" to be used. As this statement is vague and seems to imply other educational assistance programs could qualify as well, VA recommends removing this provision.

Cost Estimate: VA does not have a cost estimate for this bill.

S. 2333 Health Records Enhancement Act

Summary: Section 2(a) would require, not later than 1 year from the date of enactment, VA and DoD to jointly take actions necessary to ensure that the health records of VA and DoD may be updated with observed health conditions and other relevant health information of a deceased enrollee by an individual designated by such deceased enrollee or, if no such individual is designated, an immediate family member of such deceased enrollee. Section 2(b) would require VA and DoD to jointly provide for a process by which an individual could make a designation for purposes of subsection (a). Section 2(c) would provide that any update would supplement information contained in the deceased enrollee's health records and could not modify information contained in such records. Section 2(d) would define the term "immediate family member" to mean the spouse, parent, brother, sister, or adult child of a deceased enrollee, or an adult person to whom the individual stands in loco parentis. The term "deceased enrollee" would mean an individual who, at the time of death, was enrolled in VA health care or was entitled to care under the TRICARE program as defined in 10 U.S.C. § 1072.

Position: VA supports the bill, if amended and subject to the availability of appropriations.

Views: The bill's restriction on modifying the health records of deceased Veterans, only allowing additions, conflicts with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. Under the HIPAA Privacy Rule, personal representatives of deceased individuals have the right to request amendments to health information, which include making corrections, deletions, or additions if they believe the information is inaccurate or incomplete (45 CFR § 164.526).

To ensure clarity and compliance, the bill should explicitly state that the prohibition on modifying records of deceased Veterans, while allowing only additions, is

notwithstanding the HIPAA Privacy Rule. This approach would ensure that any new, relevant information can be added to health records without altering or deleting existing data, thereby maintaining the original information documented at the time of care.

Cost Estimate: VA does not have a cost estimate for this bill.

S. 2397 Coordinating and Aligning Records to Improve and Normalize Governance for Our Veterans Health Act of 2025 (CARING for Our Veterans Health Act of 2025

Summary: Section 2(a) would require the USH to ensure that the Office of Integrated Veteran Care (IVC, or successor office): (1) develops guidance for the efforts of VAMCs in obtaining final medical documentation after a Veteran receives services from a community care provider pursuant to a referral from that VAMC; (2) establishes goals and related performance measures for VAMCs in obtaining initial and final medical documentation from community care providers; (3) establishes and monitors goals and related performance measures for the completion by such providers of core trainings and ensures that such providers complete the required training course; and (4) takes steps to ensure IVC and any contractor communicate clear and accurate information to such providers regarding the core trainings recommended or required by IVC, including whether such training is recommended or required.

Section 2(b) would require VA, not later than 120 days after the date of enactment and every 120 days thereafter until all of the requirements under subsection (a) are fully implemented, to report to Congress on the steps taken to implement those requirements.

Position: VA supports the intent of this bill, subject to amendments and the availability of appropriations, but does not support the bill as written.

Views: VA supports the intent of this bill and is working to improve the receipt of medical records from VCCP providers. However, VA believes the bill would duplicate existing requirements and could be overly prescriptive. VA is already mandated by 38 U.S.C. § 1703(a)(2)(A) to ensure the scheduling of medical appointments in a timely manner and to establish a mechanism to receive medical records from non-Department providers. Additionally, section 105(a)(1)(D) of the Senator Elizabeth Dole 21st Century Healthcare and Benefits Improvement Act (Public Law 118-210) requires VA to carry out a pilot program to improve the timely return of medical record documentation for care provided under the Veterans Community Care Program.

The upcoming Community Care Network (CCN) Next Generation contract is designed to encompass all of the requirements proposed by the bill and further VA's existing authorities.

Some aspects of the bill's text may benefit from further clarification. For example, section 2(a)(1) refers to “final medical documentation,” while section 2(a)(2) refers to both initial and final medical documentation.

Additionally, VA believes that administrative (primarily contractual), rather than legislative, solutions would be more effective in developing stronger enforcement mechanisms to ensure providers comply with medical record submission requirements. These alternatives would be better than legislation because they would be easier to alter if needed. VA is open to collaborating with the Committee to develop these appropriate solutions.

Cost Estimate: VA does not have a cost estimate for this bill.

S. 2683 Veterans Scam And Fraud Evasion Act of 2025 (VSAFE Act of 2025)

Summary: Section 2 of this bill would establish a new 38 U.S.C. § 325, subsection (a) of which would establish in VA a VSAFE Officer who would be responsible for fraud and scam prevention, reporting, and incident response plans at VA and serve as a central point of contact to direct Veterans to resources to prevent and mitigate fraud and scams.

Proposed § 325(b) would set forth the responsibilities of this Officer, which would include: (1) providing comprehensive communication from VA to VA employees and Veterans, their families, caregivers, and survivors during strategic and time-sensitive fraud and scam incidents; (2) establishing consistent guidance across VA for employees and Veterans, their families, caregivers, and survivors on how to identify, report, and avoid fraud and scam attempts; (3) promoting the VSAFE Fraud Hotline and VSAFE.gov website and identifying other identity theft resources available to Veterans, their families, caregivers, and survivors, including with respect to actions VA has taken to protect the identities of Veterans and their beneficiaries; (4) developing methods to monitor fraud and scam metrics within VA to provide internal and external reporting, establish advanced data analytics, and facilitate proactive and robust fraud and scam trend identification; (5) developing comprehensive training plans for VA employees fielding fraud and scam inquiries and reports; (6) coordinating with VA’s Office of Inspector General (OIG) and other Federal departments and agencies to create a whole-of-Government view within VA to improve fraud prevention efforts within VA, identify the proper avenues for Veterans to report fraud attempts and receive assistance, and identify opportunities for coordination with other Federal departments and agencies; and (7) consulting with Veterans Service Organizations (VSO) and state, local, and tribal governments, as necessary, to improve the understanding of fraud and scam risks within VA.

Proposed § 325(c) would provide that nothing in this section would authorize an increase in the number of full-time employees otherwise authorized for VA.

Proposed § 325(d) would establish a rule of construction that nothing in this section could be construed to limit OIG's authority as otherwise provided in title 38, U.S.C., or in chapter 4 of title 5, U.S.C. (commonly referred to as the Inspector General Act of 1978).

Section 3 would amend 38 U.S.C. § 5503(d)(7), which generally limits pension payments for certain Veterans, by extending the sunset date of this provision from November 30, 2031, to January 30, 2032.

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

Views: VA supports efforts to ensure that Veterans, their families, and all VA beneficiaries are not the victims of fraud or scams. In January 2023, VA created the VSAFE Officer to lead VA's efforts in alignment with current VA efforts to enhance coordination across VA and the Federal Government.

VA recommends the bill clearly establish the VSAFE Officer within the Veterans Experience Office (VEO); this placement would ensure appropriate prioritization of coordinated and unified fraud prevention and response both internally and externally. Furthermore, the position would support partnership engagement to increase access, build trust, and participate in conversations at the appropriate level needed for the program to effectively carry out initiatives across VA, including setting strategy, framework, policy, and other guidance within VA.

In 2024, VA established the VSAFE Fraud Hotline (1-833-38V-SAFE) and VSAFE.gov website as a whole-of-Government front door designed in collaboration with others to provide resources to protect and support Service members, Veterans, their families, caregivers, and survivors from fraud and scams.

VA has technical amendments to this section to ensure clarity of authority and purpose; we also note that 38 U.S.C. § 325 already exists (establishing VEO), so this bill would either need to create a new section in title 38, U.S.C., or the bill could amend 38 U.S.C. § 325 to include the VSAFE Officer if VA's recommendation above to include the VSAFE Officer in VEO is adopted. We would be happy to work with the Committee to ensure such amendments are incorporated into the bill.

Cost Estimate: VA does not have a cost estimate for this bill.

S. 2737 Veterans National Traumatic Brain Injury Treatment Act

Summary: Section 2(a) of the bill would require VA to implement a pilot program to furnish hyperbaric oxygen therapy (HBOT) to Veterans with traumatic brain injury (TBI) or posttraumatic stress disorder (PTSD) through health care providers who are not VA employees, Medicare providers, DoD, the Indian Health Service (IHS), or Federally qualified health centers.

Section 2(b) would require VA to select two Veterans Integrated Service Networks (VISN) in which to operate the pilot program.

Section 2(c) would require any medical facility at which a Veteran receives HBOT under the pilot program be accredited by the Joint Commission on Accreditation of Hospital Organizations (the Joint Commission), the Undersea and Hyperbaric Medical Society, or another appropriate organization that has expertise and objectivity comparable to that of the Joint Commission or the Undersea and Hyperbaric Medical Society.

Section 2(d) would establish in the general fund of the Treasury the VA HBOT Fund; the sole source of monies for the Fund would be from donations received by VA for the express purpose of providing HBOT under the pilot program. Amounts in the Fund would be available to VA without FY limitation to pay for HBOT.

Section 2(e) would require the pilot program and VA HBOT Fund to terminate on the day that is 3 years after the date of the enactment of this Act.

Section 2(f) would define HBOT to mean hyperbaric oxygen therapy with a medical device either approved by the Food and Drug Administration (FDA) or issued an investigational device exemption by FDA.

Section 3 would require, not later than 1 year after the date of enactment, the Comptroller General to submit to Congress an update to the report the Comptroller General published on December 18, 2015, and titled “Research on Hyperbaric Oxygen Therapy to Treat Traumatic Brain Injury and Post-Traumatic Stress Disorder.” The update would have to include an assessment of clinical trials conducted since the publication of the 2015 report by VA, DoD, and private entities regarding the use of HBOT to treat TBI and PTSD.

Section 4 would amend 38 U.S.C. § 5503(d)(7), which generally limits pension payments for certain Veterans, by extending the sunset date of this provision from November 30, 2031, to October 30, 2034.

Position: VA does not support the bill.

Views: There is no scientific basis to support the clinical efficacy of HBOT as a treatment for PTSD, and there is a strong clinical basis that HBOT is not recommended for treating TBI. In this context, we are concerned that this bill could result in adverse health outcomes for participating Veterans and there is also little ability to monitor performance with definitive, evidence-based metrics. In addition, the bill would result in significant burdens on Veterans in terms of the time commitment involved in treatment and potential personal liability for portions of treatment that are not covered by VA (such as travel or room and board, if applicable). Further, the resources associated with

providing this treatment in terms of clinical and administrative time would mean fewer resources for evidence-based therapies for Veterans.

In 2017, VA initiated a clinical (non-research) program to evaluate the feasibility of referring Veterans diagnosed with PTSD (with or without a history of mild TBI) for HBOT treatment provided by DOW or community providers. This clinical program evaluation was designed to better understand the treatment protocol requirements and burdens on Veterans and VA in the context of PTSD treatment. The evaluation was not designed to examine or measure the efficacy of HBOT as a treatment for PTSD, TBI, or any other indication. VA proactively began the clinical program evaluation to understand the logistical and administrative requirements and barriers for providing this treatment for these indications, which are considered "off-label" because they have not been approved by FDA. VA's clinical program evaluation found that fewer than half of the Veterans referred completed the full course of HBOT treatment. Some Veterans were not interested in engaging or continuing treatment due to the treatment schedule (appointments are scheduled for 1 to 2 hours per day, 5 days a week, for 4 to 8 weeks), the need to travel, or the availability of evidence-based treatment alternatives. We anticipate that similar results could occur if this bill were enacted, in which case Veterans would be delayed in receiving evidence-based care to treat their conditions.

VA and DOW have developed evidence-based clinical practice guidelines (CPG) for both TBI and PTSD. The most recent update for the TBI CPGs was completed in June 2021, while the most recent update for the PTSD CPGs was completed in June 2023. The CPGs for PTSD found there is insufficient evidence to recommend for or against HBOT as a treatment for PTSD. The CPGs for TBI strongly recommend against the use of HBOT for the treatment of patients with symptoms attributed to mild TBI. Published results of scientifically rigorous VA and DOW research on TBI have repeatedly shown that HBOT has the same impact as a placebo and no clinically relevant long-term effects.[1][2][3][4][5][6] In addition to the lack of patient improvement, the use of HBOT after a mild TBI may have harmful impacts, including seizures. Emerging treatments are often marketed to patients struggling with chronic symptoms, and providers need to understand the potential negative impacts that referrals for unfounded treatments can have on the provider-patient relationship. The CPGs explain that when treatments do not work, it may lead to disappointment; damage to a patient's trust; an increased likelihood of the patient taking on a "sick role;" and even harm to the patient.

[1] Walker WC, Franke LM, Cifu DX, Hart BB. Randomized, sham-controlled, feasibility trial of hyperbaric oxygen for service members with postconcussion syndrome: Cognitive and psychomotor outcomes 1 week postintervention. Neurorehabilitation & Neural Repair. 2014;28(5):420-432.
[2] Cifu DX, Walker WC, West SL, et al. Hyperbaric oxygen for blast-related postconcussion syndrome: Three-month outcomes. Annals of Neurology. 2014;75(2):277-286.
[3] Wolf G, Cifu D, Baugh L, Carne W, Profenna L. The effect of hyperbaric oxygen on symptoms after mild traumatic brain injury. J Neurotrauma. 2012;29(17):2606-2612.
[4] Miller RS, Weaver LK, Bahraini N, et al. Effects of hyperbaric oxygen on symptoms and quality of life among service members with persistent postconcussion symptoms: A randomized clinical trial. JAMA Internal Medicine. 2015;175(1):43-52.
[5] Weaver LK, Chhoeu A, Lindblad AS, Churchill S, Deru K, Wilson SH. Executive summary: The brain injury and mechanism of action of hyperbaric oxygen for persistent post-concussive symptoms after mTBI (BIMA) study. Undersea & Hyperbaric Medicine. 2016;43(5):485-489.
[6] Boussi-Gross R, Golan H, Fishlev G, et al. HBOT can improve post-concussion syndrome years after mild traumatic brain injury - randomized prospective trial. PLoS One. 2013;8(11):e79995.

Given the evidence of harm in the literature and FDA's findings, the CPGs conclude that HBOT is not currently identified as a safe or effective treatment after mild TBI.

VA also has procedural concerns with this bill. Initially, the bill seems to establish a parallel program to VCCP for HBOT. Congress enacted VCCP to consolidate the various community care programs and to simplify eligibility by establishing a common set of criteria to determine when Veterans would qualify for community care. This bill appears to require VA to furnish this care exclusively through non-VA providers regardless of whether VA could furnish treatment for PTSD or TBI. The bill expressly excludes VA, Medicare, DoD, and IHS providers, as well as Federally qualified health centers. Given this narrow range of potentially eligible entities, it is not clear that VA would have any means to verify the quality of those providers or the quality of services they would furnish under this bill; while the bill would require accreditation, it would permit accreditation by the Joint Commission, the Undersea and Hyperbaric Medical Society, or another organization with expertise and objectivity comparable to such organizations. Additionally, this narrow scope of eligible providers could both limit Veterans' access to timely care and would very likely increase costs to VA as there would likely need to be a separate referral, scheduling, and follow-up process created for this authority. We recognize that there is a limited number of providers and HBOT treatment centers, but imposing additional restrictions would seem to make implementation more difficult and costly. Further, given that multiple treatments are often required and the limited number of providers, the likelihood that Veterans would need to travel to receive this care is high. This may be inconvenient and place a significant financial burden on patients.

The bill does not define which Veterans could receive care under this authority; it is unclear whether this is limited to enrolled Veterans or if another population would apply. Additionally, there are no criteria set forth in the bill to determine when HBOT would be offered to Veterans – whether this would be required to be a treatment of first resort or last resort; purely at the Veteran's election; or as otherwise clinically indicated. We emphasize that providers must determine that care is medically necessary and in the best interest of the patient to furnish it in accordance with current legal and ethical standards. We would infer these requirements would continue to apply if this legislation were to become law in the absence of specific language to this effect, but we recommend the bill include such requirements to reduce the potential for confusion. Given the CPGs described above strongly recommend against the use of HBOT for the treatment of patients with symptoms attributed to mild TBI, it is not clear that VA actually could refer such patients for treatment.

The funding mechanism proposed in this bill also raises significant questions and concerns. No other VA program operates under such parameters as proposed by this bill, so VA would need to develop new procedures and requirements to govern the use of an account like this. It is unclear whether there would be sufficient funds donated to VA to cover the costs of treatment. VA would need to wait until there were sufficient resources in the new HBOT Fund to support the delivery of care, which could delay VA's implementation of this (potentially by months or years). VA would need to develop

new processes and procedures to determine who would manage these funds in VA and how the funding would be distributed. It is also unclear whether a new administrative office would be needed to handle the financial aspects that are unique to this arrangement. This could result in additional oversight costs that would divert funds from Veterans' care.

We strongly encourage that if Congress wants to create a new program, it should fund this through conventional appropriations measures, rather than relying on donated funds that are dependent on voluntary contributions from third parties. This both ensures accountability for Congress (by ensuring Congress is responsible for funding these programs appropriately) and reliability for VA (by ensuring that there is a clear and dedicated resource pool for different programs).

VA defers to the Comptroller General on section 3.

VA notes that section 4 of the bill appears unnecessary, as it seems intended to provide a funding offset for the costs of the bill; however, because section 2(d) of the bill would create the HBOT Fund, this extension would not seem necessary.

Cost Estimate: VA does not have a cost estimate for this bill.

S. 2807 Restoring the Sanctity of Public Entombments, Cemeteries, and Tributes Act of 2025 (RESPECT Act of 2025)

Summary: This bill would amend the current applicability date for the authority to reconsider decisions of the Secretary of Veterans Affairs or the Secretary of the Army to inter the remains or honor the memory of a person in a national cemetery.

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

Views: VA shares Congress' view that this authority should be amended. This bill would expand VA's authority to reconsider previous interment and memorialization decisions by changing the applicability date for VA to reconsider such decisions under 38 U.S.C. § 2411(d), from on or after December 20, 2013, to on or after June 18, 1973 – the date of the enactment of P.L. 93-43, the "National Cemeteries Act of 1973," which established the National Cemetery System (now the National Cemetery Administration (NCA))—if VA finds the decedent committed a Federal or state capital crime or a Federal or state crime that would cause the decedent to meet the definition of a tier III sex offender under section 111 of the Sex Offender Registration and Notification Act (SORNA).

The bill attempts to align the applicability date of the reconsideration authority in 38 U.S.C. § 2411(d) with the National Cemeteries Act by repealing the applicability date in section 2(c) of P.L. 113-65, which made the reconsideration authority effective from

date of enactment for decisions made on or after December 20, 2013. However, because § 2411 as a whole only applies to applications for interment or memorialization made on or after November 21, 1997, *see* P.L. 105-116, section 1(c), changing the applicability date of subsection (d) could create confusion. In other words, the bill would make the applicability date of subsection (d) earlier than the applicability date of its parent section. Without also changing the applicability date of the parent section, it is unclear what effect this change would have.

That said, VA notes that if Congress were to change the applicability date of § 2411 as a whole to align it with the National Cemeteries Act, such a change would make § 2411's prohibition retroactive to 1973. This could create its own problems, as there may be persons who were buried or interred in a national cemetery prior to November 21, 1997, whose burial would then be in violation of the law. VA is willing and available to work with Congress on legislation to clarify these applicability date issues.

Additionally, the bill would eliminate foreseeable interpretive challenges or confusion regarding the effective date of SORNA in relation to the effective date of the National Cemeteries Act. It does this by replacing the requirement for an offender to actually be considered a tier III sex offender under SORNA with a requirement that the offender meet the definition of a tier III sex offender under that Act.

VA does not anticipate that the bill would create a significant impact on the operations of NCA. As a result of receiving inquiries about interments that VA could not reconsider because they occurred prior to December 20, 2013, NCA is aware of seven interments in VA national cemeteries that would be subject to reconsideration if this bill became law. VA believes that a statutory change to the applicability date may result in the public making VA aware of additional interments that may be subject to reconsideration.

Cost Estimate: VA does not have a cost estimate for this bill.

S. 3033 Improving Access to Care for Rural Veterans Act

Summary: Section 2(a) would require VA to require that each VA medical facility enter into a partnership with a hospital in a rural area. Each partnership entered could include an agreement for the provision of telehealth, co-location, or leasing of space or equipment, training, care coordination, emergency services (including transportation), or other services as determined appropriate. The purpose of these partnerships would be to provide greater access to care for Veterans in rural areas and to reduce costs to all entities within the partnership.

Section 2(b) would allow VA to waive the requirement under subsection (a) with respect to a medical facility for a period of up to five years, subject to such requirements as VA may establish, if VA notifies Congress of the waiver at least 48 hours before the waiver takes effect. VA could renew a waiver with respect to a medical facility only if VA,

in consultation with the head of the medical facility, evaluated the need for the waiver and determined that waiver was necessary.

Section 2(c) could require VA, not later than 180 days after the date of enactment, to provide a briefing to Congress on VA's plans for implementing the requirement in subsection (a). This briefing would have to include a timeline for implementation; an identification of the VA official responsible for oversight and implementation; an update on the establishment of any office, task force, or personnel assignments to support implementation; a description of VA's plan for oversight of such requirement; a standardized form or forms to be used for waivers and an explanation of the criteria for eligibility for a waiver; and such other information as VA considers to be of interest to Congress.

Section 2(d) would require VA, not later than two years from the date of enactment, and biennially thereafter, to submit to Congress a report on the operation and performance of these partnerships. The report would have to include new partnerships established since the date of the last report (or enactment), existing partnerships, and an assessment of the success of all partnerships in delivering services to Veterans in rural areas.

Section 2(e) would require VA to ensure that all VA medical facilities that are seeing patients are compliant with subsection (a), or have received a waiver under subsection (b), by not later than 3 years after the date of enactment. For any new facilities established after the date of enactment, VA would have to ensure such facility is compliant with subsection (a), or has received a waiver under subsection (b), by not later than 3 years after the date on which patients are first seen at the facility.

Section 2(f) would state the requirements and authorities under this section would be in addition to, and separate from, the authority under 38 U.S.C. § 8153 (which generally authorizes VA to share health care resources between VA and non-VA facilities, providers, or entities).

Section 2(g) would define various terms, including the term "partnership," which would mean a leasing or co-location agreement, a memorandum of understanding, a partnership agreement, an employment contract, an independent contractor agreement, a service agreement, or any other similar agreement. The term "rural" would have the meaning given that term under the Rural-Urban Commuting Areas (RUCA) coding system of the Department of Agriculture.

Position: VA does not support the bill.

Views: VA fully supports working with community hospitals, particularly in rural areas, to expand access to care for Veterans and other beneficiaries. VA has contracts, either directly or through a TPA, with many such hospitals that allow them to furnish care to eligible Veterans. VA also has academic affiliate agreements with institutions in rural areas to support the coordination and sharing of health care resources.

However, VA has several key concerns with the bill, as it would require VA to enter into "partnerships," which appear to be a different type of arrangement than the contracts or agreements described above. First, while the bill states the purpose of a partnership would be to "provide greater access to care for veterans in rural areas and to reduce costs to all entities within the partnership," this is unclear on several levels. Initially, it is not apparent that only Veterans would be able to receive care under these partnerships. If a rural hospital, for example, agreed to provide care to Veterans, it may also ask the VA facility to see or furnish care to non-Veterans. It is unclear if this type of arrangement would be permissible. Moreover, the bill would establish two purposes (increasing access for Veterans and reducing costs for all entities within the partnership), but these purposes may be incompatible in at least some situations. It may require VA to increase expenditures so that a rural hospital would provide treatment to eligible Veterans. Further, if a partnership included five parties, and costs were reduced for four of them but not for the fifth, such an arrangement would appear to be contrary to the purpose provision in section 2(a)(3), even if all parties would benefit, albeit to varying degrees. It is not clear if this type of arrangement would be permissible.

Second, the bill focuses on creating "partnerships" and defines the term, but it does so in a way inconsistent with general principles of Federal contracting. Partnerships generally, although not exclusively, do not involve the exchange of funds, and it is unclear whether the bill intends for VA or rural hospitals to exchange funds. Several identified forms of a partnership – such as leases, employment contracts, and independent contractor agreements – would presumably do so, although others – such as a memorandum of understanding – may not. VA recommends a clearer term – even a more general term – be used, such as "agreement" so that VA could use the correct instrument for the applicable type of relationship.

The bill is also unclear as to what types of hospitals would be able to enter into these agreements in the first place. The bill does not define which entities are eligible beyond subsection (a)(1), which merely requires they be "a hospital in a rural area." VA operates many hospitals in rural areas, as do other Federal entities (including DoD). It is unclear if a VA medical facility could enter into an agreement with another VA medical facility to satisfy the requirements of this bill, so long as one or more of those facilities was a "hospital in a rural area."

Additionally, the scope of VA facilities subject to the requirements this bill would establish is unclear. The bill refers to "each medical facility of the Department," but that could include a number of smaller facilities that may lack the infrastructure or support to enter into such agreements. If the intent is to include only VAMCs or VA health care systems (at the exclusion of community-based outpatient clinics or similar facilities), we recommend the bill clearly state that.

Section 2(f) is also unclear. It purports to establish this authority as independent from VA's health care resource sharing authority under 38 U.S.C. § 8153, but it does not explain what this new authority is or what this being independent of § 8153 means.

Section 8153 is a critical authority VA uses frequently to contract for health care resources. Agreements entered into under the authority of § 8153 are subject to the Federal Acquisition Regulations (FAR). We strongly recommend against any provision that might otherwise limit or curtail the authority under § 8153, but it is not apparent if that is the intent of this language. If this is simply stating that VA can use § 8153 to enter into agreements under this section, but that it is not required to do so, the language is unnecessary. If the intent of this provision is to create a non-FAR based contracting or agreement authority, that raises a host of concerns in terms of procurement rules that would require significant additional discussion.

VA also has concerns with the bill's definition of rural as having the meaning given that term in the Department of Agriculture's RUCA coding system. We believe a clearer definition would state that an area is considered rural if it has a code other than 1 or 1.1 in the RUCA coding system.

Cost Estimate: VA does not have a cost estimate for this bill.

S. 3119 Fisher House Availability Act of 2025

Summary: This bill would amend 38 U.S.C. § 1708, which allows VA to furnish certain persons with temporary lodging in a Fisher house or another appropriate facility. Specifically, it would amend § 1708(a) to remove the condition that temporary lodging be in connection with the examination, treatment, or care of a Veteran under chapter 17 or in connection with benefits administered by VA. It would also amend § 1708(b), which defines which persons can receive lodging under subsection (a). It would clarify one provision, in subsection (b)(2), which refers to eligibility for family members of Veterans. Under a proposed § 1708(b)(3), on a space-available basis, VA could provide temporary lodging to eligible individuals (which would be defined as members of the Armed Forces, regardless of duty status, or any individual on active duty) who must travel a significant distance to receive care or services at a VA or non-VA facility. Family members (and others who provide the equivalent of familial support) of eligible individuals could also receive temporary lodging when accompanying such eligible individuals for such care. Under a proposed § 1708(b)(4), on a space-available basis, VA could provide temporary lodging to family members of Veterans who must travel a significant distance for the family member to receive care or services at a VA or non-VA facility, as well as the Veteran and others who accompany such family member and provide the equivalent of familial support for the family member during the receipt of such care or services. Finally, under a proposed § 1708(b)(5), on a space-available basis, VA could provide temporary lodging to family members of eligible individuals who must travel a significant distance for the family member to receive care or services at a VA or non-VA facility and the eligible individual and others who accompany such family member and provide the equivalent of familial support for the family member during the receipt of such care or services. Effectively, these changes would allow VA, on a space-available basis, to furnish temporary lodging when eligible individuals receive care, when Veterans' family members receive care, and when eligible individuals' family

members receive care. This lodging would be available for both the patient and the family members (or those providing the equivalent of familial support).

The bill would amend what is currently § 1708(e) (but would be redesignated as subsection (d)) to require that VA's regulations include provisions establishing criteria for providing access to temporary lodging facilities on a space-available basis under subsection (b)(3)-(5), as described above.

Finally, the bill would amend what is currently § 1708(c), but which would be redesignated as § 1708(e), providing definitions for this section, to define the term "eligible individual" as described above. It would also amend the definition of "Fisher house" to include a reference to the Fisher House Foundation, Inc., as well.

Position: VA supports this bill, subject to the availability of appropriations.

Views: VA supports allowing Fisher Houses to provide lodging, on a space available basis, to Service members who receive care at VA facilities and their families. This has been a longstanding practice at VA, most recently adopted through VHA Directive 1107, Department of Veterans Affairs Fisher Houses and Other Temporary Lodging (October 19, 2023), but current law is ambiguous in this respect. We appreciate that this draft includes recommended technical edits from VA to ensure that all Veterans, Service members, and their families could receive temporary lodging under § 1708 when either the Veteran, Service member, or family member requires care.

Cost Estimate: VA does not have a cost estimate for this bill.

S. 3303 Leveraging Integrated Networks in Community for Veterans Act (LINC VA Act)

Summary: Section 2(a) of this draft bill would require, not later than 1 year after the date on which VA submits to Congress the report required by section 201(k)(1) of the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (the Hannon Act; 38 U.S.C. § 1720F, note), VA's Center for Innovation for Care and Payment to carry out a pilot program under which VA would establish community integration network infrastructure to provide services for Veterans.

Section 2(b) would require VA, in carrying out the pilot program, to establish a new or enhance an existing interoperable technology network that enables the coordination of public and private providers and payors of services for Veterans, including services such as nutritional assistance, housing, health care (including preventive health intervention, chronic disease management, and behavioral health care), transportation, job training, child development or care, caregiving and respite care, disability assistance, suicide prevention, sexual assault services, legal aid, and DoD transition programs, and other services as determined by VA. The new or existing network would also need to include additional program elements.

Section 2(c) would require VA to carry out the pilot program at not fewer than one facility in each VISN.

Section 2(d) would require VA, in carrying out the pilot program, to coordinate with existing community networks.

Section 2(e) would require VA to track the accuracy of referrals of Veterans to community networks under the pilot program, the response time of providers to which such Veterans are referred, and the outcome of the initial meeting between a Veteran and a provider.

Section 2(f) would require VA, not later than 3 years after amounts are first appropriated to carry out the pilot program, to submit to Congress a report indicating the social service needs of Veterans reflected by the use of services under the community integration network infrastructure established under the pilot program.

Section 2(g) would require the Comptroller General to conduct an evaluation that measures the overall impact of the community integration network infrastructure with respect to changes in individual and population health outcomes among Veterans, changes in access to health care or social services among Veterans, and such other factors as the Comptroller General considers appropriate.

Section 2(h) would define terms for purposes of this Act. Paragraph (1) would define the term “community integration network infrastructure” to mean infrastructure used to enable the coordination, alignment, and connection of covered entities for purposes of communication, service coordination, and referral management of services, with respect to services specified in subsection (b)(1)(A). Section 2(h)(2) would define the term “covered entity” to mean any community-based organization that accepts referrals from health care organizations and that provides services described in subsection (b)(1)(A); public or private health care provider organizations; public or private funded payors of health care services (including home- or community-based services); state, local, territorial, or tribal health and social services agencies; state public housing authorities or housing finance agencies; public health information exchanges or public health information networks as defined by VA; or other similar entities as determined by VA.

Position: VA supports the intent of section 2 subject to the availability of appropriations, but cites concerns with the language as drafted.

Views: VA strongly agrees with the need to engage communities to develop and promote resources for Veterans and other beneficiaries; many of the areas of focus identified in the bill are important issues facing the Veteran community. However, there are several key undefined elements of the proposed pilot program. The bill describes a wide range of potential entities that could participate; however, it is unclear whether the bill intends for VA to have a role in vetting organizations or providers participating in the

network, and if so, how VA would do so fairly and competently. Similarly, if the intent is to ensure that only enrolled Veterans are participating in the pilot program, for example, we would have a clear means of ensuring VA can provide such support and services. If this is intended to allow any Veteran or former Service member to use these resources, it is unclear whether VA would need to evaluate and determine eligibility, and if so, how it would do so. It is unclear if the pilot program is meant to operate by VA referring Veterans to specific providers or if this is intended to be a self-referral model; if the latter, the tracking requirements in subsection (e) would likely be very difficult to meet.

It is unclear if organizations would need to have a license or be approved through some type of accreditation process to ensure that Veterans are accessing safe, legitimate, and quality service providers; this would make sense, but it would involve significant administrative expense in areas where VA has comparatively little experience. It is similarly unclear what level of participation or interest there would be among potential community organizations and providers; it may make more sense to conduct a market assessment or analysis before requiring VA to construct and operate a network if no entities or providers are interested in participating in the first place. Finally, the intended outcomes are not clear. Presumably, facilitating connections between Veterans and providers, and between different providers, is intended to provide a greater network of support for Veterans and their families, but it is not clear how VA would measure these outcomes. Again, given the societal nature of many of the issues addressed in the bill, defining discrete outcomes or metrics would likely be difficult and imprecise.

Beyond these general concerns, the bill presents implementation challenges for VA in several areas. First, the bill is unclear as to whether VA would be able to establish the type of network required by section 2(b) of the bill, particularly within 1 year of enactment. The type of interoperable technology network could be incredibly complex and expensive to develop, implement, and maintain, given the variability in terms of services, providers, and resources of those providers to meet the needs of Veterans participating in this program; this is even more complicated given the need to exchange personal health information and other sensitive data across multiple networks, which can raise substantial privacy and security concerns. VA would need to execute new agreements, including data security agreements, with external parties to ensure compliance and protection; this would add both time and cost to the project. Given the responsibilities of other Federal agencies, as well as local and state governments, integration and coordination are critical. The impact to information technology (IT) development and sustainment resources would be significant and, if not fully funded in addition to existing priorities, would likely be devastating to other projects. The specificity of the bill in several areas – for example, identifying specific ICD-10 codes – would exacerbate the difficulty of implementation and increase cost. Additionally, community entities would also likely face resource challenges in connecting to and using the IT networks VA would create.

The bill could also more clearly address the various statutory requirements related to collecting and sharing information by VA and non-VA parties using the exchange.

We would appreciate the opportunity to discuss the intent of this proposal. VA is in the process of implementing the Assessing Circumstances & Offering Resources for Needs (ACORN) screening tool to proactively identify and address deficits in health-related social needs (HRSN) impacting Veterans' health and wellness. HRSNs (also identified as social determinants of health/social risks) are social and economic aspects that affect the health and well-being of Veterans and their families, caregivers, and survivors. Some examples include homelessness, food insecurity, unemployment, social isolation and loneliness, and transportation. Proactive screening is the first step in identifying and offering clinical interventions where authorized and appropriate, including community resource referrals to address unmet HRSNs. The ACORN screening tool has been implemented at 86 VAMCs in at least one clinical care setting.

Summary: Section 3 would require VA to collect from Veterans enrolled in VA care, as part of routine screenings conducted under the laws administered by VA, information related to social determinants that may factor into the health of such Veterans. The information would have to include standardized definitions for identifying social determinants of health needs identified in the ICD-10 diagnostic codes Z55 through Z63, Z65, and Z75 (as in effect on the date of enactment). The definitions would have to incorporate measures for quantifying the relative severity of any such social determinant of health need identified in an individual.

Position: VA supports the intent of section 3 subject to the availability of appropriations, but cites concerns with the language as drafted.

Views: As noted above, VA is working to implement the ACORN screening tool to identify and address deficits in health-related social needs, and this may address some of the intended outcomes of this section. However, VA does not have the capacity to collect the data required by this section, as this would require Bidirectional Health Information Exchange (BHIE) capabilities with community facilities, which would likely come at significant expense. Also, as noted above, VA's efforts through the ACORN Initiative may already address some of the intended outcomes of this section. VA believes it would be more prudent to wait for the results of this effort before imposing system-wide requirements that may present cost and implementation challenges without being more effective.

Additionally, as a technical matter, section 3 appears to create a permanent requirement for VA to collect information related to social determinants of health for VA health care enrollees. VA recommends that any permanent requirements be included through an amendment to chapter 17 of title 38, U.S.C., to allow for ease of reference and identification.

Cost Estimate: VA does not have a cost estimate for this bill.

S. XXXX Sharing Essential Resources for Veterans Everywhere Act (SERVE Act)

Summary: Section 2(a) would require DoD and VA, not less frequently than annually, to conduct outreach to increase awareness among Veterans enrolled in VA health care of the ability of those Veterans to receive care at military medical treatment facilities (MTF). Section 2(b) would require VA to ensure training for staff and contractors involved in scheduling, or assisting in scheduling, appointments for care under the VCCP specifically includes training regarding options for referrals to DoD facilities and providers. Section 2(c) would amend 38 U.S.C. § 1703(g), which generally authorizes VA to establish a tiered network of VCCP providers so long as VA does not prioritize providers in a manner that limits the choice of covered Veterans to select an eligible provider from whom to receive care. This amendment would require VA, subject to paragraph (2) (described above as preserving a Veteran's choice of provider) to consider DoD a preferred provider.

Section 2(d) would require DoD and VA to develop and implement action plans at covered facilities to expand the partnership between VA and DoD with respect to the provision of health care, improve communication between VA and pertinent command and director leadership of MTFs, increase utilization of military MTFs with excess capacity, increase case volume and complexity for graduate medical education (GME) programs of DoD and VA, improve resource sharing agreements or permits between DoD and VA (which would also ensure lessened barriers to shared facility spaces), and increase access to care for enrolled Veterans in areas in which an MTF is located that is identified by DoD as having excess capacity. The action plans would have to include: streamlining the credentialing and privileging of health care providers to provide health care for beneficiaries in DoD and VA medical facilities; expediting access to DoD installations for VA staff and beneficiaries; including in-kind or non-cash payment or reimbursement options for expenses incurred by either DoD or VA; allowing eligible Veterans to seek certain services at MTFs without referral or preauthorization from VA, for which reimbursement to DoD would be made; designating a coordinator within each covered facility to serve as a liaison between DoD and VA and to lead the implementation of such action plan; monitoring the effectiveness of such action plan on an ongoing basis, including establishing relevant performance goals and collecting data to assess progress toward these goals; and prioritizing the integration of relevant IT and other systems or processes to enable seamless information sharing, referrals, and ancillary orders, payment methodologies and billing processes, and workload attribution when VA personnel provide services at DoD facilities or vice versa. Before implementing any action plan at a covered facility, DoD and VA would have to ensure that approval of the action plan is obtained from the co-chairs of the VA-DoD Joint Executive Committee, the local installation commander for the DoD facility, and the VAMC director with respect to any VA facility. Not later than 90 days after the date of enactment, DoD and VA would have to submit to Congress a report containing the

required action plans. Not later than 1 year after submitting this report, DoD and VA would have to submit to Congress a report containing a status update on the progress of implementing the required action plans and recommendations for developing subsequent action plans for each facility with respect to which there is a sharing agreement in place.

Section 2(e) would require DoD and VA to ensure there is a lead coordinator at each DoD and VA facility, as the case may be, with respect to which there is a sharing agreement in place. DoD and VA would have to maintain on a publicly available website a list of all sharing agreements in place between DoD and VA medical facilities.

Section 2(f) would require DoD and VA to carry out this section notwithstanding any limitation or requirement under 10 U.S.C. § 1104, which is DoD's general authority regarding health care resource sharing with VA, or 38 U.S.C. § 8111, which is VA's general authority regarding health care resource sharing with DoD.

Section 2(g) would permit DoD and VA to use funds available in the DoD-VA Health Care Sharing Incentive Fund established under 38 U.S.C. § 8111(d)(2) to implement this section.

Section 2(h) would provide a rule of construction that nothing in this section could be construed to require Veterans to seek care in DoD facilities.

Section 2(i) would amend 38 U.S.C. § 5503(d)(7), which generally limits pension payments for certain Veterans, by extending the sunset date of this provision from November 30, 2031, to April 30, 2032.

Section 2(j) would define various terms, including the term "covered facility," which would mean an MTF as defined in 10 U.S.C. § 1073e(j) or a VA medical facility located nearby such an MTF.

Position: VA supports the intent of this bill, subject to amendments and the availability of appropriations, but does not support the bill as drafted.

Views: VA strongly supports collaboration between VA and DoD to promote the health and well-being of those who wear and have worn the uniform. The two Departments have a long history of collaboration and will continue their work in this area. We welcome the opportunity to discuss this work with the Committee and to explore ways of further strengthening this collaboration. However, VA has concerns with the bill as drafted. Initially, VA seeks clarity on the proposed amendment to § 1703(g) that would require VA to consider a DoD provider to be a "preferred provider." This could result in longer travel or wait times for Veterans than may be available through VA's community care network. This could also strain DoD facilities, particularly given that other provisions seem to focus more specifically on MTFs with excess capacity (see, e.g., subsection (d)(1)(F)). However, section 2(h) seems to expressly prohibit VA

from requiring Veterans to seek care in DoD facilities. The term “preferred provider” usually means either a provider that would receive a request to furnish services before other providers or a provider who receives preferential terms (such as higher payment rates). VA seeks clarity on whether the bill intends for VA to provide preferential terms to DoD.

We also have some concern that the bill, in attempting to integrate operations between the two Departments, could create confusion as to whether a Veteran at an MTF is receiving VCCP care (if a VA provider, for example, were furnishing such care). VA’s regulations for the VCCP currently state that if a provider is an employee of VA, they may not furnish care under the VCCP when acting within the scope of their VA employment.

Additionally, one critical element of the required action plan includes allowing eligible Veterans to seek care at MTFs, as well as allowing DoD-eligible individuals to seek care at VA facilities, without referral or prior authorization from VA. If DoD or VA then refer eligible individuals visiting their respective facilities to a community provider for follow-up care, the authority, covered services, and community funding, would need to be defined to provide clear guidelines for VA and DoD.

VA is concerned that DoD providers may not know how to apply the complex web of VA legal authorities that determine individual Veterans’ eligibility and their authorized medical benefits, which differ from DoD’s eligibility and benefits. Without prior authorization from VA, Veterans could be responsible for costs that neither DoD nor VA would be authorized to pay. VA seeks further guidance on how this authority is intended to be interpreted relative to 10 U.S.C. § 1104 and 38 U.S.C. § 8111. VA would be open to discussing concerns within a larger framework in consultation with DoD and the committee to determine the best path forward.

If Congress wishes to create conditions under which certain Veterans can access certain services without prior authorization, we recommend against doing so in § 1703.

VA also has technical concerns and comments with the bill. We would appreciate the opportunity to meet with the Committee to discuss these concerns.

Cost Estimate: VA does not have a cost estimate for this bill.

S. XXXX Get Justice-Involved Veterans Behavioral Assistance and Care for Key Health Outcomes to Maintain Empowerment Act (Get Justice-Involved Veterans BACK HOME Act)

Summary: Section 2(a) of the bill would require VA to carry out a pilot program to furnish mental health care to incarcerated Veterans, with a priority given to Veterans with a service-connected disability relating to PTSD, TBI, or military sexual trauma (MST). Section 2(b) would require VA to carry out the pilot program at not fewer than five facilities, which would have to represent large and small facilities and urban and

rural settings; they also would have to have already established separate housing units for Veterans. Section 2(c) would require VA to develop the pilot program in coordination with relevant state or Federal agencies responsible for the incarceration of Veterans. Section 2(d) would require VA, in carrying out the pilot program, to provide incarcerated Veterans telemental health services, if the facility at which the Veteran is incarcerated has necessary infrastructure for the provision of such services. If the provision of telemental health services was not feasible, VA would have to provide incarcerated Veterans under the pilot program mental health services through the use of mobile mental health units close to the facility at which the Veteran is incarcerated or mental health services through other means. Section 2(e) would require VA to furnish mental health care under the pilot program through the use of VA health care providers; VA could not use non-VA health care providers. A health care provider furnishing mental health care under the pilot program would have to provide treatment and assessment of medical conditions. A health provider could not provide an assessment or evaluation of current or future disability claims. VA would have to create a hub of health care providers that only provide care to incarcerated Veterans and operate separately from any medical facility or VISN. Section 2(f) would define the terms incarcerated Veteran, MST, service-connected, Veteran, and Vet Center.

Position: VA does not support this section.

Views: VA appreciates that the current draft of this bill has addressed some of the technical concerns VA previously identified, but VA still has concerns with the current version of the bill. VA's regulations at 38 CFR § 17.38(c)(5) provide that VA does not furnish, as part of the medical benefits package, "hospital and outpatient care for a veteran who is either a patient or inmate in an institution of another government agency if that agency has a duty to give the care or services." This regulation, in turn, is based on 38 U.S.C. § 1710(h), which states, "Nothing in this section requires the Secretary to furnish care to a veteran to whom another agency of Federal, State, or local government has a duty under law to provide care in an institution of such government." The bill appears intended to countermand this language in § 1710(h), but if that is the intent, it should do so clearly.

Additionally, the bill would require VA to furnish care to incarcerated Veteran, but access to incarcerated persons is subject to the jurisdiction of the correctional facility itself, so if the facility refused to provide access, VA would fail in its obligation here through no fault of its own. Further, even within correctional facilities, there may be varying levels of security that could interfere with VA's capacity to furnish care (and could present a risk to VA employees providing care in person, if that were authorized) and an available option.

VA has other technical comments and concerns with this section, including concerns over how tort claims would be handled and liability assigned. The bill is also unclear, in section 2(b), as to whether the correctional facilities would need to have already established separate housing units for Veterans or if VA facilities would have to do so; we presume the correctional facilities were intended, but we recommend

clarifying this. Additionally, it is unclear whether the bill intends to apply copayment requirements otherwise applicable under chapter 17 to care furnished under this section; we recommend the bill clearly address this issue (including whether this is care provided pursuant to § 1710).

Summary: Section 3(a) would establish a new 18 U.S.C. § 4015 regarding housing for incarcerated Veterans. Proposed § 4015(a) would require the Director of the Bureau of Prisons to, wherever feasible, establish dedicated wards or housing units for incarcerated Veterans in Federal correctional institutions to provide an environment conducive to the discipline, structure, and order familiar to Veterans to facilitate more effective mental health treatment, peer support, and rehabilitation efforts. Proposed § 4015(b) would require the head of each institution with a Veteran housing unit to collaborate with local VA facilities to ensure that, with respect to the Veteran housing unit, correctional staff are trained regarding the needs of Veterans, resources are allocated for their needs, and rehabilitation programming is tailored to their needs. Proposed § 4015(c) would require the Director of the Bureau of Prison to, at a minimum, create structured Veteran-focused programs if the Federal correctional institution lacks the capacity or resources for a Veteran housing unit. Section 3(b) would make a clerical amendment to reflect the amendment made by subsection (a).

Position: VA defers to the Bureau of Prisons (BOP) on this section.

Views: VA defers to the BOP on this section, as it would establish new requirements for the BOP Director.

Summary: Section 4 of the bill would amend 38 U.S.C. § 5313(a), which generally establishes limits on payment of compensation and dependency and indemnity compensation to persons incarcerated for conviction of a felony, by adding a new paragraph (3). Proposed § 5313(a)(3) would require VA to ensure that, for any individual whose receipt of compensation or dependency and indemnity compensation is interrupted pursuant to § 5313(a)(1) for a period of incarceration, resumption of such payments resume automatically after the end of such period of incarceration.

Position: VA cites concerns with this section.

Views: VA notes that it currently has provisions in place for the resumption of benefit payments following a Veteran's release from incarceration. Pursuant to 38 CFR §§ 3.665(i) and 3.666, VA must resume payment of the released Veteran's award from the date of release from incarceration if VA receives notice of release within 1 year following release; otherwise, VA must resume the award from the date of receipt of notice of release.

Also, VA presumes the term “automatically” used in section 4 means that benefits will resume on the calendar date of release from incarceration without the claimant being required to submit documentation of his or her release. VA identifies that the proposed language for 38 U.S.C. § 5313(a)(3) would require system updates and enhancements to applicable computer matching agreements (CMA). The current CMAs with the BOP and SSA do not result in VA being notified upon a beneficiary’s release from incarceration.

VA notes that there is no effective date provided within the draft bill. As such, VA understands these changes would be effective upon enactment. Necessary system and form updates may impact implementation timelines if the proposed bill is enacted. If enacted, VA estimates these updates would take approximately 24 months to be completed.

Additionally, VA identifies that an automatic resumption of benefits upon release from incarceration would not allow VA an opportunity to verify a claimant’s continued eligibility for benefits. Automatic resumption as proposed may invite an increase in improper payments under the Payment Integrity Information Act of 2019, as a beneficiary’s eligibility would be subject to financial, dependency, or disability status changes that may have occurred during incarceration.

VA notes that the bill as drafted would create disparate treatment for beneficiaries who are incarcerated while in receipt of Veterans’ or survivors’ pension, as the bill is silent on this issue. If the proposed language of the bill is expanded to include the pension program, then an amendment to 38 U.S.C. § 1505 would be required. VA notes that 38 U.S.C. § 5313 applies only to disability compensation and DIC.

Lastly, VA reiterates that benefits are currently restored back to an effective date congruent with the date of a beneficiary’s release from incarceration, as long as VA is notified of the release within 1 year of the event, per 38 CFR §§ 3.665(i) and 3.666.

Summary: Section 5 of the bill would make technical changes to section 302 of part C of title I of the Omnibus Crime Control and Safe Streets Act (34 U.S.C. § 10132). In addition to making technical changes, proposed § 10132(c) would add a new paragraph (15) that would authorize the Bureau of Prisons to collect and analyze comprehensive information concerning incarceration of Veterans. Proposed § 10132(g) would add a paragraph requiring, not later than 180 days after enactment of subsection (g)(2), and annually thereafter, the BOP Director to submit to Congress a report describing the data collected and analyzed under § 10132 related to Veterans who are incarcerated in state and Federal Prisons.

Position: VA defers to the Department of Justice on this section.

Views: VA defers to the Department of Justice on this section because it would affect responsibilities for the Bureau of Prisons.

Cost Estimate: VA does not have a cost estimate for this bill.

S. XXXX Commission on Equity and Reconciliation in the Uniformed Services Act

Summary: Section 2(a) would establish the Commission on Equity and Reconciliation in the Uniformed Services (referred to as the "Commission"). Section 2(b) would set forth more than 15 duties the Commission would be responsible to perform.

Section 3(a) would require the Commission to be composed of 15 members, who would have to be appointed not later than 30 days after the date of enactment; it also would define who would appoint such members (including members of the Executive Branch and Legislative Branch). Section 3(b) would require that all members of the Commission be persons who are exceptionally qualified to serve on the Commission by virtue of their education, training, activism, or experience, particularly in the fields of advocating for LGBTQ+ members of the uniformed services. Section 3(c) would state that Commission members would serve for the life of the Commission; vacancies in the Commission would not affect the powers of the Commission and would be filled in the same manner in which the original appointment was made. Section 3(d) would require the President to call the first meeting of the Commission not later than 30 days after the later of the following: the date of enactment or the date of the enactment of an Act that makes appropriations to carry out this Act. Section 3(e) would require eight members of the Commission to establish a quorum. A lesser number could hold hearings.
Section 3(f) would require the Commission to elect a Chair and Vice Chair from among its members who would serve in that position for the life of the Commission.
Section 3(g) would allow each member of the Commission to be compensated at a rate not to exceed the daily equivalent of the annual rate of basic pay in effect for a position at level IV of the Executive Schedule under 5 U.S.C. § 5315 for each date during which the member is performing Commission duties. If a member of the Commission is a full-time officer or employee of the United States or a Member of Congress, they would receive no additional pay, allowances, or benefits for their service to the Commission. Each Commission member would receive travel expenses.

Section 4(a) would allow the Commission to hold hearings for purpose of carrying out the provisions of this Act. Section 4(b) would allow any subcommittee or member of the Commission to, if authorized by the Commission, to take any action which the Commission is authorized to take. Section 4(c) would allow the Commission to acquire directly from the head of any department, agency, or instrumentality of the executive branch of the Federal Government, available information which the Commission considers useful in the discharge of its duties. All departments, agencies and instrumentalities of the Executive Branch would be required to cooperate with the Commission and furnish all information required by Commission to the extent permitted by law.

Section 5 would set forth various administrative provisions regarding the Commission, including staff appointments and compensation, applicability of civil service laws, procurement of services from experts and consultants, agreements for procurement of financial and administrative services, and authority to enter into contracts.

Section 6 would require the Commission to terminate 90 days after the date on which the final report is submitted.

Section 7 would authorize to be appropriated necessary sums to carry out this Act. Amounts available to the Commission would remain available until the termination of the Commission.

Section 8 would define the terms “servicemember” and “uniformed services” to have the same meaning given those terms in 50 U.S.C. § 3911 and 10 U.S.C. § 101, respectively.

Position: VA does not support the bill.

Views: VA does not support the bill because it would establish a new commission with broad investigative and oversight authorities that extend beyond VA’s mission and statutory responsibilities. The proposed Commission’s structure, authorities, and operational requirements could create duplicative processes, jurisdictional conflicts, and administrative burdens without improving the services or benefits VA provides to Veterans.

The Commission’s duties in Section 2(b) encompass more than 15 functions, many of which involve direct oversight, review, and acquisition of information from multiple Executive Branch agencies, including those outside VA’s jurisdiction. VA’s statutory role is focused on providing health care, benefits, and memorial services to Veterans and their families. The Commission’s mandate to address broad questions of equity and reconciliation across all uniformed services extends into military policy and personnel actions that are under the purview of DoD and other agencies. Creating a new, multi-agency oversight body would overlap with existing offices—such as the Office of the Inspector General, and congressional oversight committees—potentially leading to conflicting recommendations and inefficiencies.

VA also has technical concerns with the bill. For example, section 3(c) states, “A vacancy in the Commission…shall be filled in the same manner in which the original appointment was made.” However, this could create confusion in some situations. The first eight members, for example, would be appointed by the Chair and Ranking Members of different Congressional committees. However, the parties that control those Chairs and Ranking Members are subject to change based on the composition of Congress. Consequently, if control of one chamber changed from one Congress to the next, and a vacancy occurred in the second Congress, one party may end up being able

to select both representatives on the Commission by previously having been the Chair and now being the Ranking Member (or vice versa). It is also unclear whether funding for the Commission would be obtained from appropriations made available to VA or if separate funds would be appropriated specifically to the Commission. VA would not support the diversion of funds Congress has appropriated for VA to the Commission instead.

Cost Estimate: VA does not have a cost estimate for this bill.

Conclusion

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