STATEMENT OF
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DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE SENATE COMMITTEE ON VETERANS' AFFAIRS

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Good afternoon, Chairman Moran, Ranking Member Blumenthal, and other Members of the Committee. Thank you for inviting us here today to present our views on bills affecting VA's programs and Veterans' benefits. Joining me today is Mr. Al Montoya, Deputy Chief Operating Officer, Veterans Health Administration; Ms. Melissa Cohen, Acting Deputy Under Secretary for Policy & Oversight, Veterans Benefits Administration; and Mr. Kevin Friel, Executive Director, Pension & Fiduciary Service, Veterans Benefits Administration.

S. 124 Restore VA Accountability Act of 2025

The Department of Veterans Affairs (VA) **supports this bill, subject to amendments and the availability of appropriations.**

More specifically, VA supports additional statutory provisions to improve accountability, and VA supports this bill with modifications to address legal concerns, mitigate litigation risk, and ensure disciplinary actions taken are not overturned. VA has legal concerns regarding some of the language in the draft bill. As I will specifically address in my testimony today, VA is concerned that this bill will not resolve the extensive litigation and constitutional challenges that plagued the Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017's disciplinary authorities and, therefore, will further uncertainty and a continued pattern of overturned disciplinary actions. VA's concerns are informed by the experience of implementing those authorities since 2017.

Section 2 of this bill would give VA another authority with its own set of procedures to remove, demote, or suspend supervisors and management officials for performance or misconduct. This section would require VA to treat all supervisors, regardless of grade and salary level, the same as members of the senior executive service when carrying out disciplinary and performance-based adverse actions. Under this authority, supervisors would not be entitled to review by the Merit Systems Protection Board (MSPB), and the statute sets limits on the information that agency officials may consider when selecting the penalty.

Having multiple authorities for taking disciplinary action against employees, each with its own unique procedures and requirements for addressing performance and conduct deficiencies, has led to confusion regarding their administration and application

and adds additional risk to taking legally defensible actions. Additionally, we would welcome continued engagement regarding Section 2 to address needed technical revisions for the leave language under the proposed 38 U.S.C. § 712.

Section 3 of the bill would amend 38 U.S.C. § 713 to establish that the VA official's burden of proof when taking an action under this authority would be substantial evidence. This section also sets forth exclusive factors to be considered when determining the appropriate penalty. The amendments also limit the scope of judicial review of VA's chosen penalty such that a court cannot review the penalty except when a constitutional issue is presented. They also establish that the amendments would apply retroactively to the date of enactment of the Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017.

VA identified significant legal concerns with portions of these legislative amendments that carry significant legal risk. Those specific concerns are as follows:

- Substantial evidence as the statutory standard of proof, even with express statutory language, will be legally challenged and result in litigation. The Federal Circuit's discussion of the inappropriateness of that substantial evidence as a standard of proof for administrative decisions is legally problematic, as the Federal Circuit noted that there is no precedent for such a standard, citing Supreme Court jurisprudence. *See Rodriguez v. Dep't of Veterans Affairs*, 8 F.4th 1290 (Fed. Cir. 2021).
- The limitations on the factors that VA officials can consider when determining a penalty may lead to legal challenges as to whether all relevant factors can be considered under the statute when making penalty determinations. *See, e.g., Sayers v. Dep't of Veterans Affairs*, 954 F.3d 1370 (Fed. Cir. 2020); *Brenner v. Dep't of Veterans Affairs*, 990 F.3d 1313 (Fed. Cir. 2021); *Connor v. Dep't of Veterans Affairs*, 8 F.4th 1319 (Fed. Cir. 2021).
- The limitations on judicial review of the penalty (other than constitutional challenges) poses a lesser litigation risk, but VA does not believe the limitation is necessary, as judicial review standards have not previously been an impediment to VA actions and such challenges are likely to be constitutional.
- The retroactivity clause is likely to face legal challenges both as to its scope or applicability. When such clauses impact substantive rights, which the Federal Circuit has already opined that section 714 does, they must further a legitimate legislative purpose and by rational means (and cannot be harsh/oppressive or arbitrary/irrational) to meet due process requirements. *See Sayers*, 954 F.3d at 1380-1381(application of substantial evidence and preventing penalty mitigation impact substantive rights).

Section 4(a) of the bill would amend 38 U.S.C. § 714 to address the limitations imposed by the U.S. Court of Appeals for the Federal Circuit, MSPB, and the Federal Labor Relations Authority, which have significantly reduced the differences between section 714 and pre-existing title 5 disciplinary authorities. The amendments clarify that hybrid title 38 employees are covered by this authority, establish that the VA official's burden of proof when taking an action under this authority is substantial evidence, and

set forth exclusive factors to be considered when determining the appropriate penalty. The amendments establish that VA is not required to place a covered employee on a performance improvement plan prior to carrying out a performance-based action under section 714. The amendments also limit the scope of judicial review of VA's chosen penalty to only constitutional challenges; state that the authorities, as amended, would apply retroactively to the date of initial enactment of the Act; and clarify that the procedures of the entire section, rather than subsection (c), supersede any collective bargaining agreement if it is inconsistent with the authority.

VA has the same legal concerns with section 4 as identified in section 3, relating to (1) the substantial evidence standard of proof; (2) limiting factors for VA officials to consider when determining the penalty; (3) precluding judicial review of the penalty except for constitutional challenges; and (4) retroactive application of the authorities, as amended. VA has other legal concerns as well, including the effectiveness of the proposed language superseding collective bargaining agreements.

In summary, VA appreciates the support of its efforts to hold employees accountable and looks forward to working together to address the legal concerns presented to ensure disciplinary actions taken under the authority are not overturned. The legal concerns are impacted by *Loper Bright Enterprises v. Raimondo*, 144 S. Ct. 2244 (June 28, 2024), which established that courts will not defer to an agency's interpretation of ambiguous statutory language and will instead determine the best legal interpretation. Considering that decision, VA seeks as much clarity as possible in this bill, which will likely be interpreted in multiple judicial venues across the country given the judicial review provisions. It would be difficult for VA to continue to implement these authorities if Federal courts issued varying interpretations. VA seeks to avoid the legal risk, uncertainty, and litigation it experienced when implementing section 714 in 2017. The enactment of 38 U.S.C. § 712 as well as the proposed amendments to 38 U.S.C. §§ 713 and 714 will likely face the same gamut of legal challenges. VA's desired amendments would be aimed at limiting that litigation risk and ensuring clarity for implementation. VA would welcome the opportunity to engage in technical assistance to address these issues. VA will continue to take disciplinary action under applicable existing authorities, providing certainty and minimizing legal risk to VA, while working with Congress to address the legal risks identified in the bill.

Cost estimates are not available at this time.

S. 201 ACES Act

Section 2(a) of the bill would require VA to enter into an agreement with the National Academies of Sciences, Engineering, and Medicine (NASEM) under which NASEM would conduct a study on the prevalence and mortality of cancers among covered individuals. Section 2(b) would require this study to identify exposures associated with military occupations of covered individuals (including relating to chemicals, compounds, agents, and other phenomena), review the literature to determine associations between such exposures and the incidence or prevalence of

overall cancer morbidity, overall cancer mortality, and increased incidence or prevalence of certain cancers. The study would also have to determine, to the extent possible, the prevalence of and mortality from these cancers among covered individuals by using available data sources (which could include health care and other administrative databases of VA, the Department of Defense (DoD), and the individual Services), the national death index, and the study conducted under section 750 of the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 (Public Law 116-283). Section 2(c) would require NASEM, at the conclusion of the study, to submit to VA and Congress a report containing the results of the study required by subsection (b). Section 2(d) would define the term "covered individual" to mean an individual who served on active duty in the Army, Navy, Air Force, or Marine Corps as an aircrew member of a fixed-wing aircraft, including as a pilot, navigator, weapons system operator, aircraft system operator, or any other crew member who regularly flew in a fixed-wing aircraft.

VA supports this bill, subject to amendments and the availability of appropriations. While VA supports the intent of this bill, VA is concerned it could duplicate existing efforts that are already underway. We believe there may be ways to amend the bill, though, to enhance these current efforts, and we welcome the opportunity to discuss these with the Committee.

Pursuant to section 750 of the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 (Public Law 116-283), the Department of Defense (DoD), in conjunction with the Directors of the National Institutes of Health and the National Cancer Institute, must conduct a study on cancer among covered individuals (a term generally consistent with the definition above) in two phases. The DoD Military Aviator Cancer Study (MACS) is designed to satisfy these requirements. The existing study has several phases that are currently being executed by DoD and others. This ongoing work is examining cancer incidence, mortality and specific exposures that may be associated with cancer outcomes; the work is scheduled to continue through fiscal year 2029. DoD has worked with VA to secure VA health care data in support of the MACS study.

In addition, sections 2(b)(2) and 2(b)(3) of the bill would direct NASEM to focus on a prescribed list of eleven cancers. Although VA may expand this list, in consultation with NASEM, the bill may produce a report with inherent biases and limitations because the scope is unnecessarily limited to a specific set of eleven cancers, rather than studying all cancers. Other studies, such as MACS, are examining incidences of all cancers and will likely yield more meaningful results.

If this bill moves forward, we recommend it be amended to require VA to *seek to enter* into an agreement with NASEM, or another appropriate independent organization; this would be consistent with other, similar requirements and would provide VA flexibility in case it was unable to reach an agreement with NASEM.

Finally, we note that sections 502 and 505 of the Honoring our PACT Act of 2022 (Public Law 117-168) already require VA to (1) analyze VA clinical data to try to determine the association, if any, between medical conditions of Veterans and toxic exposure, and (2) conduct a study on the incidence of cancer in Veterans to determine trends in the rates of the incidence of cancer in Veterans. In this context, it is not clear that the additional study that would be required by the ACES Act would yield new information.

VA has other technical comments on this legislation that it would be happy to share with the Committee.

S. 275 Veterans' Assuring Critical Care Expansions to Support Servicemembers (ACCESS) Act of 2025

This bill contains three titles; title I contains six sections, title II contains three sections, and title III contains three sections.

VA strongly supports the intent of this bill and many provisions throughout; VA would like to work with Congress to ensure offsets are proposed or additional funding is appropriated for this effort. This bill is an important step in reaffirming VA's commitment to providing timely access to care and prioritizing Veterans. We do recommend a number of technical and clarifying amendments to ensure successful implementation.

Title I

Section 101: Section 101 would amend 38 U.S.C. § 1703B regarding VA's access standards to expand (by including mental health residential rehabilitation treatment program (MH RRTP) services) and codify (in law, rather than only in regulation) VA's existing access standards established in regulation at 38 C.F.R. § 17.4040. Specifically, it would create a new section 1703B(a) that would provide that covered Veterans would be eligible to elect to receive non-VA hospital care, medical services, or extended care services, excluding nursing home care, under section 1703(d)(1)(D) (the eligibility criterion for the Veterans Community Care Program (VCCP) based on VA's designated access standards) in certain situation. In general, enrolled Veterans would be eligible to elect to receive community care if VA determined, it could not schedule with respect to primary care, mental health care, or extended care services (excluding nursing home care) within certain parameters. VA could have to be able to not schedule an in-person appointment for the covered Veteran with a VA health care provider who could provide the needed service at a facility that is located within 30 minutes average driving time from the Veteran's residence (unless a longer average driving time has been agreed to by the Veteran in consultation with a health care provider of the Veteran) and within 20 days of the date of the request for such an appointment. These standards would apply unless a Veteran agreed to a longer average driving time or a later date, in consultation with a health care

provider of the Veteran (unless a later date has been agreed to by the Veteran in consultation with a health care provider of the Veteran).

With respect to specialty care, covered Veterans could elect to receive community care if VA could not schedule an in-person appointment with a VA health care provider at a facility that is located within 60-minutes average driving time from the Veteran's residence (with a similar exception for Veteran consent to a longer average driving time) and within 28 days of the date of request for such appointment unless a later date has been agreed to by the Veteran in consultation with a health care provider. The availability of telehealth appointments from VA would not be taken into consideration when determining VA's ability to furnish such care or services in a manner that complies with the access standards. VA could prescribe regulations that establish a shorter average drive time or period than those otherwise described above. Covered Veterans could consent to longer average drive time or later date, but if they did, VA would have to document such consent in the Veteran's electronic health record and provide the Veteran a copy of that documentation in writing or electronically. If a Veteran had an appointment cancelled by VA for a reason other than the request of the Veteran, VA would have to calculate the wait time from the date of the request for the original, canceled appointment.

Proposed section 1703B(b) would require VA to ensure that these access standards apply to all care and services within the VA medical benefits package to which a covered Veteran is eligible under section 1703 (except nursing home care) and to all covered Veterans, regardless of whether they are new or established patients.

Proposed section 1703B(c) would require not later than 3 years after the date of enactment of the Act and not less frequently than once every 3 years thereafter, VA to review the eligibility access standards established under the revised section 1703B(a) in consultation with such Federal entities VA determines appropriate, other entities that are not part of the Federal Government, and entities and individuals in the private sector (including Veterans who receive VA care, Veterans Service Organizations, and health care providers participating in the VCCP). It would also require VA to submit to Congress a report on its findings with respect to the review and such recommendations as VA may have with respect to eligibility access standards. Section 101 would also strike section 1703B(g), which allows VA to establish through regulation designated access standards for purposes of VCCP eligibility and would make other conforming amendments.

VA supports section 101, subject to amendments and the availability of appropriations. VA notes that section 101 would require VA to engage in consultation with various stakeholders; this could invoke the Federal Advisory Committee Act (FACA) and require VA to form multiple new Federal Advisory committees. VA recommends amending the bill's language to clarify that

consultation activities are exempt from FACA. In the alternative, the consultation requirements could be removed, which would also address this concern.

Finally, we note that while the language is close to VA's current regulatory language, we believe this could be written more clearly but to have the same effect. Proposed section 1703B(a) would be phrased as a negative - a covered Veteran is eligible if VA cannot schedule an appointment that meets certain wait-time and average driving time elements. This is consistent with how VA's current regulations read. We believe this would be clearer if the bill established standards that VA must meet as a positive obligation, while still allowing Veterans to choose to receive community care if VA cannot meet those standards. This reaches the same outcome, but it does so more clearly. Similar changes could be made to section 104, which refers to Veterans not having "met such standards," as opposed to VA not meeting such standards. The standards established under this section also create some ambiguity in terms of their applicability given further language in section 202 regarding access to covered treatment programs. We would appreciate the opportunity to discuss this with the Committee to determine how to amend the language to best reflect Congress' intent.

VA is working on a cost estimate for section 101.

Section 102: Section 102 of the bill would amend 38 U.S.C. § 1703(a) by adding a new paragraph (5) that would require VA to notify a covered Veteran in writing of the eligibility of the Veteran for care or services under this section as soon as possible, but not later than 2 business days, after the date on which VA is aware that the Veteran is seeking care or services and is eligible for such care or services under section 1703. VA would have to provide such Veterans periodic reminders, as it determines appropriate, of their ongoing eligibility under section 1703(d). VA could provide covered Veterans notice electronically.

VA supports section 102, subject to amendments and the availability of appropriations. VA agrees that Veterans should receive timely notice of their eligibility. However, meeting a 2-day standard will not be possible in all cases and trying to meet the 2-day standard would likely require VA to focus resources on meeting this standard instead of focusing on improving the timely scheduling of appointments for care. Also, while the bill would allow VA to provide electronic notice, there are some situations where even that would not be possible, such as emergency care.

We are concerned the requirement to provide this notice could result in confusion for Veterans in several ways:

- First, Veterans may not want to receive multiple notifications (for each appointment for each episode of care), but the bill would require VA to provide these. We recommend the bill allow Veterans to choose what notices they receive.

- Second, Veterans often choose VA for care or treatment that is provided over a period of time, such as cancer treatment or physical therapy. Once they have chosen VA care, continuing to remind them of community care eligibility could be misinterpreted and unwanted.

- Third, many Veterans schedule multiple, different types of appointments on the same day. If VA had to provide notice of eligibility for community care for all of these appointments, or nearly all of these appointments, this could increase the chance that Veterans might make mistakes with their scheduling, which could delay their care.

We would welcome the opportunity to discuss these concerns with the Committee to make technical amendments to this section.

VA does not have a cost estimate for section 102.

Section 103: Section 103 of the bill would amend 38 U.S.C. § 1703(d)(2) by adding new subparagraphs (F), (G), and (H). These amendments would require VA to ensure that criteria developed to determine whether it would be in the best medical interest of a covered Veteran to receive care in the community include the preference of the Veteran regarding where, when, and how to seek care and services, continuity of care, and whether the covered Veteran requests or requires the assistance of a caregiver or attendant when seeking care or services.

VA supports section 103. VA agrees that providers should consider a range of issues that are important to Veterans when determining whether community care is in their best medical interest. VA welcomes the opportunity to meet with the Committee to better understand the concerns this section is intended to solve and how we can incorporate and consider these factors along with existing factors that Veterans and their providers have experience in using, such as how soon or how close to home care can be provided. We want to ensure that amendments in this section do not cause confusion or result in worse clinical outcomes, and we seek ways to implement these factors in a way that would put Veterans first.

Section 103 is likely to result in additional cost for VA; these costs could be both discretionary and mandatory. However, VA does not have a way to accurately model or forecast the preference of a covered Veteran for where, when, and how to seek hospital care, medical services, or extended care.

Section 104: Section 104 of the bill would amend 38 U.S.C. § 1703 by adding a new subsection (o) that would require VA, if a request for care or services under the VCCP is denied, to notify the Veteran in writing as soon as possible, but not later than 2 business days, after the denial is made of the reason for the denial and how to appeal such denial using the Veterans Health Administration's (VHA) clinical appeals process. If a denial was made because VA determined the access standards under section 1703B(a) were not met, the

notice would have to include an explanation of the determination. Notice could be provided electronically.

VA supports section 104, subject to amendments. VA recognizes the concern underlying this section, and we are working to ensure we inform Veterans quickly when VA has made a decision that they are not eligible for community care. We have technical concerns with some of the language in this section that could create confusion for Veterans. We would be happy to provide technical assistance to the Committee.

VA is working on a cost estimate for this section.

Section 105: Section 105 of the bill would amend 38 U.S.C. § 1703 further by adding a new subsection (p) that would require VA to ensure that Veterans were informed that they could elect to seek care or services via telehealth, either through a VA medical facility or through the VCCP, if telehealth is available to the Veteran, is appropriate for the type of care or service the Veteran seeks, and is acceptable to the Veteran.

VA supports section 105, subject to amendments. While VA supports this section, it is unclear whether this section is intended to establish that a Veteran's preference to not receive care via telehealth would also be binding on how they receive care through the VCCP. If that is the case, that could result in network adequacy issues, as VA currently allows Veterans who decline VA administered telehealth to receive telehealth from a community provider. VA welcomes the opportunity to discuss recommended amendments to clarify this section.

VA does not anticipate additional costs for implementation of this section because it only requires additional information to be presented within discussions that are already occurring.

Section 106: Section 106 of the bill would amend 38 U.S.C. § 1703D to extend (from 180 days to 1 year) the period of time for health care entities and providers can submit claims to VA for payment for furnishing hospital care, medical services, or extended care services under chapter 17.

VA supports section 106, subject to amendments. VA generally supports a longer timely filing period, and VA would welcome the opportunity to discuss other potential amendments to section 1703D to clarify the scope of the applicability of this requirement. As written, section 1703D applies to all claims for payment under chapter 17; there are some variations in terms of timely filing for different programs under this authority, though. VA has also encountered situations where it has needed additional flexibility for these standards. VA's proposed amendments could provide VA enhanced authority to combat waste, fraud, and abuse. Consistency across these programs would also reduce

administrative burdens on VA, while also creating parity with other Federal programs (such as Medicare and TRICARE).

VA notes that its contracts for community care generally include a 180-day timely filing requirement. If the time period is extended, VA would need to renegotiate this part of its contracts.

VA is working on a cost estimate for section 106.

Title II

Section 201: Section 201 would define various terms for purposes of title II of this bill. It would define the term "covered treatment program" to mean a mental health residential rehabilitation treatment program (MH RRTP) of VA or a VA program for residential care for mental health and substance abuse disorders. The term would also include programs designated as domiciliary RRTPs, but it would not include Compensated Work Therapy Transition Residence programs. The term "covered veteran" would have the same meaning given in 38 U.S.C. § 1703(b) for purposes of the VCCP. The term "social support systems" would mean, with respect to a covered Veteran, a family member of the covered Veteran (including a parent, spouse, child, step-family member, or extended family member) or an individual who lives with the Veteran but is not a member of the Veteran's family; it would not include a facility-organized peer support program. Finally, the term "treatment track" would mean a specialized treatment program that is provided to a subset of covered Veterans in a covered treatment program who receive the same or similar intensive treatment and rehabilitative services.

VA has no objection to section 201 by itself, subject to amendments. This section would only define terms used in later sections. VA notes that the definition of "treatment track" is too broad and not aligned to the formal structure of MH RRTP services within VA, which includes bed sections formally defined for Domiciliary Substance Use Disorder, Domiciliary Care for Homeless Veterans, General Domiciliary, and Domiciliary Posttraumatic Stress Disorder. We would welcome the opportunity to discuss this concern with the Committee to make technical amendments to the bill.

VA does not anticipate additional costs for section 201.

Section 202: Section 202(a) would require VA, not later than 1 year after the date of the enactment of this Act, to establish a standardized screening process to determine, based on clinical need, whether a covered Veteran satisfies criteria for priority or routine admission to a covered treatment program.

Section 202(b)(1) would provide that, under the standardized screening process, a covered Veteran would be eligible for priority admission to a covered

treatment program if the covered Veteran meets criteria including certain identified symptoms or risk factors. In deciding under paragraph (1) that a covered Veteran meets criteria established by VA for priority admission to a covered treatment program, VA would have to consider any referral of a health care provider of a covered Veteran.

Section 202(c) would require VA, under the standardized screening process, to ensure a covered Veteran is screened not later than 48 hours after the date on which the covered Veteran (or a relevant health care provider) makes a request for the covered Veteran to be admitted to a covered treatment program. VA would also have to ensure a covered Veteran, if determined eligible for priority admission to a covered treatment program, is admitted to such program not later than 48 hours after the determination. VA would also have to ensure a covered Veteran is screened at an appropriate time for potential mild, moderate, or severe traumatic brain injury.

Section 202(d) would require VA, in making placement decisions in a covered treatment program for Veterans who meet criteria for priority admission, to consider the input of the covered Veteran with respect to the program specialty, subtype, and treatment track offered to the covered Veteran and the geographic placement of the covered Veteran. VA would also have to maximize the proximity of the covered Veteran to social support systems.

Section 202(e) states that if VA determined a covered Veteran was eligible for priority admission to a covered treatment program pursuant to the standardized screening process and VA was unable to admit the Veteran to a covered treatment program at a VA facility in a manner that complies with the requirements in subsections (c) and (d), VA must offer the Veteran the option to receive care at a non-VA facility that: (A) can admit the Veteran within the period required by subsection (c), (B) is a party to a contract or agreement with VA (or enters into a contract or agreement with VA) under which VA furnishes a program that is equivalent to a covered treatment program to a Veteran through such non-VA facility, (C) is licensed by a state; and (D) is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission. If VA determined a covered Veteran was eligible for routine admission to a covered treatment program, and VA was unable to admit the Veteran to a covered treatment program at a VA facility in a manner that complies with the access standards for mental health care established under 38 U.S.C. § 1703B, as amended, VA would have to offer the Veteran the option to receive care at a non-VA facility that meets conditions (B)-(D), above.

VA supports section 202, subject to appropriations. VA agrees with the intended outcomes of this section, and VA has already established policies that would satisfy several of the requirements of this section. We express some concern, relevant to both sections 202 and 203, about codifying current clinical practice into law, as this would likely limit VA's ability to incorporate new

advancements that may be inconsistent with the letter, if not the spirit, of this language. We would appreciate the opportunity to speak with the Committee and provide technical assistance to ensure that VA's central focus - ensuring Veterans receive high-quality residential treatment - remains. For example, VA currently recognizes community facilities accredited by either CARF or the Joint Commission for programs in the community but requires both for VA direct care programs. CARF standards are typically more specific for residential treatment, and if section 202(e)(1)(D) were enacted, this could bar VA from requiring community facilities to meet the more specific CARF standards expected from VA MH RRTPs. As VA improves its network of providers, both in number and quality, it may be able to raise the bar even higher in terms of quality providers by instituting more stringent requirements that would not harm network adequacy; however, the bill's language would prohibit such efforts.

Residential treatment is specialized, intensive treatment that is typically not available in every community. Consequently, Veterans' access to this treatment in the community can be limited. In FY 2024, Veterans who receive such care from programs in the community typically traveled on average 255 minutes to access residential treatment services (compared with 150 minutes average driving time for VA facilities). For highly specialized services, Veterans can travel even further.

VA has several technical concerns with some of the language, and we would be happy to work with the Committee to address them. First, this section refers to Veterans requesting MH RRTP care. MH RRTP is a form of domiciliary care, and domiciliary care includes additional requirements that must be met to receive such care (see, for example, 38 U.S.C. § 1710(b); 38 C.F.R. § 17.47). While Veterans can unofficially self-refer for MH RRTP, verification of their eligibility occurs during the screening process. If this language is not modified, VA would interpret this phrase considering these requirements. Further, VA is concerned with language codifying criteria for priority admission, which is a clinical decision. As written, the criteria include non-responsiveness to outpatient treatment, which is a general consideration for any residential admission. The presence of any one symptom listed by itself may not indicate the need for priority admission. Further, subsection (d), which requires VA to "consider" a range of factors in making placement decisions, is vague and would likely be very difficult to implement consistently or in a standardized fashion.

As noted above, it is difficult to read sections 101 and 202 together, and we would welcome the opportunity to discuss with the Committee how to most clearly state Congress' intent in this area.

VA recommends that if these requirements will continue to govern MH RRTP care (as appears to be the case) that this be codified in title 38, U.S.C., to allow for easier reference and amendment in the future.

VA does not currently have a cost estimate for section 202, but it is continuing to assemble the relevant data.

Section 203: Section 203 would impose a number of requirements related to VA's MH RRTPs. Subsection (a) would require VA to develop metrics to track (and require VA to track) performance by VA medical facilities and Veterans Integrated Service Networks (VISN) in meeting requirements for screening Veterans for covered treatment programs (under section 202) and timely admitting Veterans to such programs under such screening. The metrics would have to track the performance of medical facilities and VISNs with respect to routine and priority admissions to covered treatment programs.

Subsection (b) would require VA to develop a process for systematically assessing the quality of care delivered by VA and non-VA providers treating covered Veterans under this section in several ways.

Subsection (c) would require VA, when a covered Veteran needs residential care under a covered treatment program, to provide the Veteran with a list of locations at which the Veteran can receive residential care that meets (A) the standards for screening under section 202 of this Act and (B) the care needs of the Veteran, including applicable treatment tracks. VA would have to provide transportation, or pay for or reimburse the costs of transportation, for any covered Veteran who is admitted into a covered treatment program and needs transportation assistance from the Veteran's residence, a VA facility, or an authorized non-VA facility that does not provide the care to another facility that provides residential care covered under a covered treatment program; VA would also have to provide transportation, or pay for or reimburse the costs of transportation, back to the residence of the Veteran after the conclusion of a covered treatment program, if applicable.

Subsection (d) would require VA to develop a national policy and associated procedures under which covered Veterans, their representatives, or a provider who requests they be admitted to a covered treatment program (including both VA and non-VA providers) may file a clinical appeal if the covered Veteran is denied admission into a covered treatment program or accepted into a covered treatment program but not offered bed placement in a timely manner. The national policy and procedures would have to include timeliness standards for VA to review and make a decision on such an appeal; VA would have to respond to any appeal not later than 72 hours after receipt. VA would have to develop public guidance on how covered Veterans, their representatives, or their providers can file a clinical appeal if the Veteran is denied admission or the first date on which they could be admitted does not comply with the standards established under 38 U.S.C. § 1703B; the public guidance could include other factors as VA may specify. Paragraph (4) would provide that nothing in this subsection could be construed to grant a covered Veteran the right to appeal a decision to the Board of Veterans' Appeals.

Subsection (e) would require VA, to the extent practicable, to create a method for tracking availability and wait times under a covered treatment program across all VA medical facilities, VISNs, and non-VA providers throughout the U.S. VA would have to, to the extent practicable, make this information available in real time to VA mental health treatment coordinators, the leadership of each VA medical center and VISN, and the Office of the Under Secretary for Health.

Subsection (f) would require VA to update and implement training for VA staff directly involved in a covered treatment program regarding referrals, screening, admission, placement decisions, and appeals for such program, including all changes to processes and guidance under the program required by section 202 of this Act. This training would have to include procedures for the care of covered Veterans awaiting admission into a covered treatment program and communication with such Veterans and their providers. VA would have to ensure staff that are required to complete this training do so not later than 60 days after beginning employment in a position that includes work directly involving a covered treatment program and annually thereafter.
VA would have to track the completion of this training. VA would have to review and revise oversight standards for VISN and VHA leadership to ensure that VA facilities and staff are adhering to the policy on access to care of each covered treatment program.

Subsection (g) would require VA to ensure each covered Veteran who is screened for admission to a covered treatment program is offered, and provided (if agreed upon), care options during the period between screening and admission to such program to ensure the covered Veteran does not experience any lapse in care. For covered Veterans being treated for substance use disorder, VA would have to ensure there is a care plan in place during the period between any detoxification services or inpatient care received by the covered Veteran and admission to a covered treatment program; this care plan would have to be communicated to the covered Veteran, the primary care provider of the Veteran, and the facility where the Veteran is or will be residing under the program. VA, in consultation with covered Veterans and their treating providers, would have to ensure the completion of a care plan before Veterans are discharged from the program. The care plan would have to include details on the course of treatment for the Veteran following completion of treatment under the covered treatment program, including any necessary follow-up care. The care plan would have to be shared with covered Veterans, their primary care providers, and any other providers with which the Veterans consent to sharing the plan. Upon discharge of a covered Veteran from a covered treatment program at a non-VA facility, the facility would have to share with VA all care records maintained by the facility with respect to the Veteran and work in consultation with VA on the care plan.

Subsection (h) would require VA, not later than 2 years after enactment, to submit to Congress a report on modifications made to the guidance, operation, and oversight of covered treatment programs to fulfill the requirements of this section. Not later than 1 year after submitting this report, and not less frequently than annually thereafter during the period in which a covered treatment program is carried out, VA would have to submit to Congress a report on the operation of such programs. This annual report would have specific data elements that would have to be included, but VA would have to provide such data pursuant to applicable Federal law and in a manner that is wholly consistent with applicable Federal privacy and confidentiality laws.

Subsection (i) would require VA to update its guidance on the operation of covered treatment programs to reflect the requirements in subsections (b)-(h).

Subsection (j) would require VA to carry out each requirement under this section within 1 year of enactment, unless otherwise specified.

Subsection (k) would require the Comptroller General, by not later than 2 years after enactment, to review access to care under a covered treatment program for covered Veterans in need of residential mental health care and substance use disorder care.

VA supports section 203 subject to amendments and the availability of appropriations. VA agrees with many of the intended outcomes of this section and has already established such requirements through policy. We again caution that codifying current policy may limit VA's ability to innovate and adapt to the needs of Veterans in the future.

Regarding subsection (b), VA has developed ways to assess the quality of VA care, and we are working to apply these same standards for quality to non-VA providers to include the ability to evaluate the clinical outcomes of Veterans receiving residential treatment from both Department and non-department programs. VA can generally evaluate non-VA care as a whole or at a regional level, but we may not be able to evaluate the quality of specific providers in each of the areas listed (for example, provision of evidence-based treatments, clinical outcomes, completion of training in military competence for all providers in a residential program), which this language would seem to require.

Concerning subsection (c), VA acknowledges that residential rehabilitation treatment often involves extensive travel; current data indicate that Veterans receiving community residential treatment care are traveling 255 minutes on average to access such care, so providing transportation support can be critical to ensuring Veterans are able to access care. However, we do have technical concerns with this provision and would welcome the opportunity to work with the Committee to address them. For example, it is not clear that this language would allow VA to transport a Veteran, after the conclusion of a

covered treatment program, to a location other than the Veteran's original residence. Some Veterans may choose to change their residence during their treatment, but this language may bar VA from transporting them, which we do not support.

VA also recommends clarifying subsection (d)(4), which only establishes a rule of construction for Veterans' appeals, although paragraph (1) would require VA to establish policy and procedures for appeals from Veterans, their representatives, and their providers. This could be interpreted to allow for appeals to the Board by representatives and providers, although it is not clear that is the intent.

VA also cites concerns with the reporting requirements in this section. First, there is no current mechanism to determine participation in a treatment track, as defined by section 201, as data are captured at the official program level only. Second, the requirement to include recommendations under this report could be duplicative of or conflict with the recommendations VA provided under section 503 of the STRONG Veterans Act (Division V of P.L. 117-328).

VA welcomes the opportunity to discuss this section with the Committee.

VA is working to assemble the necessary data, but VA does not have a cost estimate for this section at this time.

Title III

Section 301: Section 301 would require VA, working with third party administrators (TPA) and acting through the Center for Innovation for Care and Payment (CICP), to develop and implement a plan to establish an interactive, online self-service module: (A) that would allow Veterans to request appointments, track referrals for care, and receive appointment reminders; (B) to allow Veterans to appeal and track decisions relating to denials of requests for care and services under VCCP and denials of requests for care and services at VA facilities; and (C) implement such other matters as determined appropriate by VA in consultation with TPAs. Within 180 days of enactment, VA would have to submit to Congress this plan. Following submittal of the plan, VA would have to submit to Congress quarterly reports for 2 years containing any updates on the implementation of the plan. This section could not be construed to be a pilot program subject to the requirements of 38 U.S.C. § 1703E. It would define TPA as an entity that manages a provider network and performs administrative services related to such network under 1703.

VA supports section 301, subject to amendments, and availability of appropriations. VA agrees that an interactive, online self-service module would be helpful to Veterans. However, we do have a number of technical concerns regarding the specific language and would welcome the opportunity to provide

technical assistance to the Committee. Additionally, we recommend against requiring VA to submit quarterly reports for 2 years, as this would be administratively burdensome and would divert resources from patient care. VA could instead provide briefings or updates as needed to Congress to ensure appropriate oversight at lower cost.

VA is working on a cost estimate for section 301.

Section 302: Section 302(a) would amend the CICP's authority in 38 U.S.C. § 1703E in 10 ways. First, it would relocate the CICP to be within the Office of the Secretary. Second, it would require the CICP to carry out such pilot programs as VA determines to be appropriate to develop innovative approaches to testing payment and service delivery models to reduce expenditures while preserving or enhancing the quality of care furnished by VA. Third, it would expand the intended scope of the payment and service delivery models to require VA to also determine whether such models increase productivity, efficiency, and modernization throughout VA. Fourth, It would require VA to include in the budget justification materials submitted to Congress for each fiscal year specific identification, as a budgetary line item, of the amounts required to carry out this section. Fifth, it would amend VA's authority to waive provisions to extend beyond subchapters I-III of chapter 17 of title 38, U.S.C., to include all of title 38, U.S.C., all of title 38 of the Code of Federal Regulations, and any policy documents of the Department. Sixth, it would state that before waiving any provision of title 38, U.S.C., VA would have to submit a request for approval to Congress. Seventh, it would require VA to carry out not fewer than three pilot programs concurrently. Eighth, it would require the Secretary to obtain advice from the Under Secretary for Health, the Special Medical Advisory Group, Integrated Veterans Care, the Office of Finance, the Veterans Experience Office, the Office of Enterprise Integration, and OIT in the development and implementation of any pilot program. Ninth, it would also require VA consult representatives from non-profit organizations and other public and private sector entities, including those with expertise in medicine and health care management. Finally, it would require VA to submit to Congress annual reports with a full accounting of the activities, staff, budget, and other resources and efforts of the Center and an assessment of the outcomes of the efforts of the Center.

VA supports section 302(a), subject to amendments and appropriations. VA would appreciate the opportunity to discuss with the Committee the underlying intent and objective of this section. VA is open to changes to the organizational structure or purpose of the CICP, but some of the proposed changes would raise significant concerns.

For example, the apparently expanded scope of the Center's authority would still be constrained by the current statutory focus on testing payment and service delivery models to reduce expenditures while preserving or enhancing the quality of care furnished by VA. It seems unlikely that VA could test payment

and service delivery models to determine whether these models (1) improve access, quality, timeliness, and satisfaction of care, (2) create cost savings for VA, and (3) increase productivity.

Further, the proposed amendments to CICP's waiver authority under § 1703E(f) create some ambiguity. The amendments to paragraph (1) would allow VA, subject to Congressional approval, to waive any requirements in title 38, U.S.C. (rather than only subchapters I-III of chapter 17), any requirement in title 38, C.F.R., and any handbooks, directives, or policy documents, but the amendments to paragraph (2) refer only to waiving "any provision of this title" (title 38, U.S.C.), leaving open the question of whether waivers of regulatory authority in title 38, C.F.R. or waivers of VA policies would not require a waiver approved by Congress. Given the importance and novelty of this authority, we recommend Congress be explicitly clear as to the limits of this authority.

Also, the bill would require VA to carry out a minimum of three pilot programs concurrently. VA has defined the term "pilot program" through regulation at 38 C.F.R. § 17.450(b) to mean pilot programs conducted under that section (and thus under § 1703E). These pilot programs are subject to Congressional approval, as noted earlier. To the extent Congress did not approve at least three pilot programs concurrently, VA would be in violation of this requirement (although the penalties for non-compliance are not clear). Additionally, the limitations imposed by section 1703E would still apply (such as the limitation on the total amount VA could expend in any FY), so the requirement to carry out at least three pilot programs could narrow the scope of programs the CICP could pursue given these other constraints. It is possible the drafters only intended the CICP to operate three programs concurrently, whether they were "pilot programs" that required Congressional approval or not; if that was the intent, we recommend revising the language to reflect that.

Finally, we note that, if the CICP is moved to the Office of the Secretary, the specific line item the bill would require for the CICP would need to be funded by the same account as the Office of the Secretary. This would either require a proportional increase to the budget for the Office of the Secretary or would require significant cuts to the existing Office infrastructure. We are also unsure how the shift from the Medical Services account to the General Administration account would affect the Center's ability to support the delivery of health care. We would appreciate the opportunity to discuss this and other issues further with the Committee.

Section 302(b) would require the Comptroller General, within 18 months of enactment, to submit to Congress a report on the efforts of the CICP in fulfilling the objectives and requirements under 38 U.S.C. § 1703E and containing such recommendations as the Comptroller General considers appropriate. **VA defers to the Comptroller General on section 302(b).**

Section 302(c) would require the CICP, not later than 1 year from enactment, to establish a 3-year pilot program in not fewer than 5 locations to allow enrolled Veterans to access outpatient mental health and substance use services through the VCCP without referral or preauthorization. **VA supports section 302(c), subject to amendments.** VA requests clarifying amendments to address the following concerns with section 302(c).

First, section 302(c) would seemingly conflict with section 1703(a)(3), which requires that covered Veterans only receive care through the VCCP "upon the authorization of such care or services by the Secretary." If Veterans could self-refer for care, unless VA were to issue a blanket authorization (and it is not clear that doing so would satisfy the requirements of 38 C.F.R. § 17.38(b), that VA determines the care is necessary to promote, preserve, or restore the health of the Veteran), it would still need to authorize this care individually.

Second, VA may need additional time for bilateral negotiation of VA's contracts, which are structured to rely upon an authorization from VA for care (other than walk-in care under section 1725A). More time may also be needed to develop a care coordination system. Participating health information exchange providers can already obtain VA health information, but not all VCCP providers participate in health information exchanges. In these situations, it is not clear how VA could coordinate the care of such Veterans, or even if VA would know that such care was being sought until after it was received. It is similarly unclear whether this pilot program would be intended to cover the full range of services - walk-in, regularly scheduled, emergent care - and how the pilot program would interact with or supersede other statutory authorities in these areas. It seems very likely that in at least many cases, VA would only be able to monitor patient safety and outcomes retroactively, which would make implementation of a value-based model even more difficult.

Third, VA has concerns with the required metrics, as it is unclear whether community providers could report the metrics VA would use for its own programs or other metrics adopted within the industry (such as standards developed by the Centers for Medicare and Medicaid Services (CMS)).

Finally, section 302(c) would require the CICP to carry out a pilot program under section 1703E, but it is not clear whether this supersedes the waiver process required by section 1703E(f) or not. It is also not clear how this would interact with the other amendments proposed to the CICP authority under section 302(a).

VA is working on a cost estimate for this section.

Section 303: Section 303(a) would require VA, within 1 year of enactment and not less frequently than once every 3 years thereafter, in consultation with Veterans Service Organizations, Veterans, caregivers of Veterans, employees,

and other stakeholders, to submit to Congress a report containing recommendations for legislative or administrative action to improve the clinical appeals process of the Department with respect to timeliness, transparency, objectivity, consistency, and fairness. Section 303(b) would require VA to submit to Congress an annual report with information about Veterans' eligibility for and use of the VCCP, along with other data on the operations of that program.

VA supports section 303, subject to amendments. While VA supports this section, VA does have technical recommendations for the Committee to ensure the report meets the apparent intent. Specifically, VA cites concerns with the proposed reporting of appeal volume and outcomes, which also appears to inaccurately describe some existing processes. For example, VA notes that requests for community care that are not approved do not amount to a denial of care - that care, so long as it is necessary, is still furnished directly by VA.

Subsection(a) would require VA to create an advisory committee subject to FACA, the National Records Act, the Privacy Act, the Freedom of Information Act, and the Government in the Sunshine Act. However, this section does not provide sufficient guidance to VA to establish, manage, or terminate this committee. The section would need to include an official name for the committee, the mission authority of the committee, the substantive objectives and scope for the committee, the size of the committee, the official to whom the committee would report, the reporting requirements for the committee, the meeting frequency of the committee, the qualifications for committee members, the types of committee members and their term limits, whether the committee is authorized to have subcommittees, the funding for the committee, and the record keeping requirements of the committee. Alternatively, the section could strike the requirement to establish an advisory committee, or specifically exempt the working group from FACA requirements, and avoid these issues altogether.

Further, the requirements in section 303(b) are duplicative of some of the required reporting under 38 U.S.C. § 1703(m). To the extent Congress needs this information, rather than creating a separate reporting requirement in a different law, we recommend amending section 1703(m) to include the new data elements Congress is seeking.

If amended, VA does not believe the costs would be significant.

S. 410 Love Lives On Act of 2025

This bill would amend 38 U.S.C. § 103(d) to provide that the remarriage of a surviving spouse shall not bar the furnishing of benefits under 38 U.S.C. §§ 1311 or 1562 to the surviving spouse of a Veteran.

The Department is still examining the bill and is unable to provide comprehensive views at this time.

Sections 3 and 4 of this bill pertain to the Department of Defense (DoD), and VA defers to DoD on those sections.

S. 478 Veterans 2nd Amendment Protection Act of 2025

This bill would add a new section 5501B to title 38 of the United States Code, which would prohibit VA from transmitting the personally identifiable information of a beneficiary solely based on a fiduciary determination under 38 U.S.C. § 5502 to Department of Justice (DOJ) for use by National Instant Criminal Background Check System (NICS), unless there is an order or finding of a judge, magistrate, or other judicial authority of competent jurisdiction that such beneficiary is a danger to themselves or others.

VA supports this bill, subject to the availability of appropriations, but has concerns with some aspects of it.

VA notes that a person's entry in its fiduciary program is solely based on a finding that the person lacks the mental capacity to manage their VA benefits. The prohibition created by this bill would support a separate evaluative consideration regarding whether the beneficiary is a danger to themselves or others. Such consideration is not part of VA's determination to provide fiduciary services. Rather, VA's adjudication concerning the need for the appointment of a fiduciary is based on whether the beneficiary is capable of handling their own financial affairs. Under 38 C.F.R. § 3.353, a VA determination that a beneficiary cannot manage their own VA benefits is based upon a definitive finding by a responsible medical authority or medical evidence that is clear, convincing, and leaves no doubt as to the person's inability to manage his or her affairs, including disbursement of funds without limitation, or a court order finding the individual to be incompetent.

This bill would codify the prohibition for NICS reporting in the Consolidated Appropriations Act of 2024, Public Law 118-42 (CAA). Section 413 of Division A of the CAA prohibited the use of funds by VA to report certain Veterans who are deemed mentally incapacitated, mentally incompetent, or to be experiencing an extended loss of consciousness to NICS without a judicial determination that the person is a danger to himself, herself, or others. Prior to the CAA, VA was required to report to NICS all individuals determined unable to manage their funds based on regulations issued by the Bureau of Alcohol Tobacco, Firearms and Explosives (ATF) under 27 C.F.R. § 478.11, and guidance provided by DOJ in March 2013, entitled "Guidance to Agencies Regarding Submission of Relevant Federal Records to NICS."

This bill would relieve VA of determining when to provide a beneficiary's information to DOJ for the NICS database. However, VA notes that its enforcement of the Brady Act is a requirement stipulated by DOJ, and any alteration to that process should be clarified in this legislation. The Gun Control Act prohibits nine categories of persons from shipping, transporting, possessing, or receiving firearms and ammunition,

or transferring a firearm to such persons. Under 18 U.S.C. § 922(d)(4) and (g)(4), this includes any person who has "been adjudicated as a mental defective or who has been committed to a mental institution." The definition of "adjudicated as a mental defective" is implemented by DOJ under 27 C.F.R. § 478.11 and includes any individual who "lacks the mental capacity to contract or manage his own affairs." As such, VA recommends including legislative language that would clearly exempt an individual deemed incompetent for purposes of the VA fiduciary program under 38 U.S.C. § 5502 from being considered a mental defective under 18 U.S.C. § 922(d)(4) and (g)(4) on the basis of VA's determination. Without this clarification, Veterans/beneficiaries determined to need a fiduciary for VA purposes may still face possible criminal liability if they receive or possess firearms. Clarifying this issue in thebill would also alleviate concerns that this bill may lead to an increased risk for VA and the public in situations where an incompetent person could be considered a mental defective under DOJ's regulations but was not entered in the NICS database and, thus, could violate 18 U.S.C. 922(d)(4) or (g)(4) when transferring, receiving, or possessing a firearm or ammunition.

Additionally, VA understands that a beneficiary could still be considered a danger to themselves or others upon a finding or order provided by a judge, magistrate, or other judicial authority of competent jurisdiction. However, the bill does not specify timing, so it is unclear when a determination of the beneficiary's danger to themselves or others would need to be submitted by VA. VA requests clarity on when that information should be provided in relation to VA's determination to pay benefits to a fiduciary for the use and benefit of the beneficiary under 38 U.S.C. § 5502.

S. 607 Improving Veteran Access to Care Act

Section 2(a) of the bill would require VA, through the Veterans Health Administration (VHA) and the Office of Information and Technology (OIT), to establish an integrated project team (IPT) to improve the process for scheduling appointments for VA health care. Section 2(b) would state that the purpose of this section is to ensure VA delivers to VA patients and employees in a timely manner the scheduling capabilities developed by the IPT to immediately improve delivery of care, access to care, customer experience and service, and efficiency with respect to the delivery of care. Section 2(c) would establish four general objectives for the IPT: (1) to develop or continue the development of a scheduling system that enables VA patients and personnel to view available appointments for all care furnished by VA, including available appointments for all VA providers, available appointments at all VA clinics, hospitals, and other health care facilities; and available appointments at all offices providing patient care within the VA health care system, including primary care and all forms of specialty care; (2) to develop or continue the development of a self-service scheduling platform, available for use by all VA patients, which would have to enable patients to view available appointments and fully schedule appointments for all care furnished by VA at the facilities described above; if a referral is required, the platform would have to provide a method for the patient to request a referral and subsequently book an appointment if the referral is approved, and the platform would have to provide such patients with the ability to cancel or reschedule appointments; (3) to create a process through which all

VA patients can telephonically speak with a scheduler who can assist the patient to determine appointment availability and can fully schedule appointments on behalf of the patient for all care furnished by VA; and (4) to carry out such other functions, oversight, metric development and tracking, change management, cross-Department coordination, and other related matters as VA determined appropriate as it relates to scheduling tools, functions, and operations with respect to health care appointments furnished by VA.

Section 2(d) would require the IPT to carry out these defined objectives in consultation and coordination with the deployment schedule and capabilities with the deployment schedule and capabilities of the Electronic Health Record Modernization (EHRM) Program to ensure a smooth transition to using the tools and features, where relevant and appropriate, that may be created pursuant to this section, along with features in the EHRM Program. Section 2(d)(2) would establish a rule of construction that nothing in this subsection could be construed to require the IPT, VHA, or OIT to defer or delay the deployment of scheduling capabilities required by this section because of future potential planned capabilities of the EHRM Program.

Section 2(e) would require VA, not later than 180 days after enactment, to fully establish the IPT, and not later than 1 year after enactment, the IPT would have to complete the objectives under section 2(c). Section 2(f) would require VA, if it determined an objective or any feature or service in connection with that objective could not be implemented or otherwise incorporated into a final product, VA would have to submit to Congress a report within 45 days of that determination identifying the issue, explaining why it cannot be implemented or incorporated, and setting forth a plan for implementing this section without that objective, feature, or service. Section 2(g) would require VA, within 1 year and 2 years of enactment, to submit to Congress a report on VA's progress in fulfilling the requirements of this section. Section 2(h) would establish a rule of construction that nothing in this section could be construed to preclude or impede the ability of a Veteran to contact or schedule an appointment directly with a facility or provider through a non-online scheduling process, should the Veteran choose to do so.

Section 2(i) would define the appropriate committees of Congress to whom VA would have to provide reports, and the term "fully schedule", which would mean, with respect to booking an appointment, the appointment booking is completed, rather than simply requested.

VA supports this bill, subject to amendments. VA fully agrees that it can and should improve the patient scheduling experience. We are concerned, though, that specific legislation on this topic could prove problematic, as we have been and will continue to enhance scheduling capabilities, but this legislation could constrain our ability to address Veterans' needs and emerging issues.

VA previously established an IPT in 2022, and it appears this bill would duplicate some of the work done as part of that effort as well as other efforts. For example, VA is working to implement sections 131 through 134 of the Joseph Maxwell Cleland and Robert Joseph Dole Memorial Veterans Benefits and Health Care Improvement Act of

2022 (Division U of Public Law 117-328), which require VA to conduct a pilot program for Veterans eligible for the Veterans Community Care Program (VCCP) to use a technology that has certain capabilities to schedule and confirm medical appointments with providers participating in the VCCP.

Additionally, VA is already developing a scheduling approach that enables VA personnel and Veterans to view available appointments. It is not possible to view every available appointment at every VA facility in the country currently, but that also does not seem like a relevant or useful datapoint for Veterans or VA staff looking to schedule an appointment. If a Veteran lives and is seeking care in Anchorage, the availability of an appointment in West Palm Beach, Florida, is not particularly helpful. If such an appointment were scheduled, that could incur significant costs for travel reimbursement (if available) and complicated travel arrangements. As written, though, the bill would require the capability to see appointments at such distant facilities, which would likely be expensive and difficult to establish without clear benefit to Veterans. Limiting appointments to those that are within a reasonable distance of the Veteran's residence seems more appropriate.

VA is also working to develop a self-service scheduling platform, but not all of the objectives defined by the bill could be resolved solely through technology improvements. For example, some specialties require referrals, as noted by the bill, but in these cases, VA has found it makes more sense and results in better patient outcomes if these referrals are coordinated with the patient's primary care provider, as there may be other steps (such as imaging, lab work, etc.) that need to be completed before an appointment with the specialist would be productive. Similarly, scheduling for specialty care appointments often requires consideration of specific prerequisites, such as specialized space, equipment, document reviews, diagnostic testing, preliminary evaluations, or imaging. Schedulers and patients likely do not have all of the knowledge and information required to determine which appointment slots would be appropriate given these variables. At the very least, the bill should be amended to provide flexibility for complex situations.

VA has general concerns with a bill that would require the creation of an IPT, as VA already has the authority to do this. In terms of developing enhanced scheduling capabilities, VA recommends engaging in a human-centered design-based study that evaluates non-technical elements of the issue, such as position descriptions, staff incentives, agency policies, and additional required legislative changes (if any). Further, the bill is unclear as to whether the IPT could establish policy requirements for VA or if the IPT would only provide recommendations, subject to the review of the Secretary. If the intent is that the IPT's recommendations would be implemented as written, it would either be necessary for much more review to be completed before the IPT makes such recommendations (namely, a legal review to ensure VA has the authority to implement the recommendations, a fiscal review to ensure VA has the resources to implement the recommendations, and a policy review to ensure VA wants to implement the recommendations), or it would be necessary to accept the risk that the IPT may make recommendations VA cannot or will not implement. In the absence of any clarity from

Congress on this issue, VA would interpret the bill to require the IPT's recommendations be subject to the types of review described above.

VA also has concerns with the timeline the bill would establish; section 2(e)(2) would require the IPT to complete the objectives under section 2(c) by not later than 1 year after enactment. It is unclear if the objectives in section 2(c) would have to be fully implemented and operational at the end of this 1-year period, or if it would be sufficient for work to have begun on the identified objectives. It is unlikely that VA would be able to operationalize all of the objectives within 1-year of enactment.

Finally, VA has some technical comments on the bill it can share with the Committee if needed. For example, the bill uses both the term "patients" (which includes non-Veterans) and "veterans" (which does not include all patients); while using both terms might be appropriate, the bill appears to use them interchangeably. Additionally, the bill refers to care "furnished" by the Department; care furnished by VA also includes care delivered by non-VA providers. If the intent is to include non-VA providers, this would overlap with the requirements in Chairman Moran's bill regarding an external provider scheduling program, as well as the Veterans' ACCESS Act, which would require VA to develop a plan to establish an interactive, online self-service module to request appointments through VA and non-VA providers. The Committee should ensure that any bills it moves forward in this area are consistent and reconcilable with each other.

We look forward to working with the Senate Committee on further refining this legislation.

S. 610 Ensuring VetSuccess on Campus Act of 2025

This bill would expand the VetSuccess On Campus Program to ensure at least one counselor per State, regardless of the number of individuals in a State or at an educational institution who qualify to participate in the program. The bill would also give preference to educational institutions with the largest populations of students receiving educational assistance provided under laws administered by the Secretary.

VA supports this bill, subject to the availability of appropriations, but seeks an amendment. Section 3697B of title 38, United States Code, currently requires on-campus educational and vocational counseling to be administered by Vocational Rehabilitation Counselors (VRC) who provide services under 38 U.S.C. § 3697A. Under section 3697A, VRCs provide educational and vocational counseling and guidance, including testing and any other services determined to be necessary to increase employment opportunities, for Veteran Readiness and Employment (VR&E) participants. VRCs are hired by the VR&E program specifically for their skill and experience in assisting veterans with disabilities to return to work in suitable employment. This counseling should be provided by specialists with a unique understanding of both disability and vocational counseling.

The on-campus VRCs provide more on-campus benefits coaching and transitional support than educational and vocational counseling and spend significant time doing outreach or general VA benefits counseling as it relates to education, healthcare, and disability claims. VA requests that section 3697B be updated to allow benefits counseling on campus to be provided by a VA employee such as a legal administrative specialist (public contact or outreach specialist) rather than a VRC. VA recommends that VRCs continue to provide the educational and vocational counseling services described in section 3697A. However, transitioning the required benefits counseling on campus to employees with knowledge of VA benefits would expand the types of employees that could be hired for the program. This expansion would allow VA to recruit talent qualified to perform work that is more heavily utilized on campuses, such as outreach, applying for benefits, and coordinating on-campus services. In addition, it would allow the VR&E program to focus the limited availability of individuals qualified in the VRC profession to meet the growing demands for Chapter 31 benefit delivery.

The VR&E program needs VRCs to manage the increased workload from Veterans applying for Chapter 31 benefits and services, as well as Chapter 36. Following the enactment of Public Law 117-168, VR&E has experienced a 46% increase in claims since August 2023. This law improved access to care and benefits for those Veterans who were exposed to toxic substances during their service. When regional offices are provided with additional full-time equivalents (FTE), they focus on hiring VRCs for local growing workload demands, prioritizing the Chapter 31 caseloads to serve the highest number of Veterans and meet staffing ratio goals.

VR&E has struggled to meet the growing staffing demands, despite utilizing more flexible qualifying education requirements and targeted hiring initiatives. Expanding on-campus counseling to other types of employees would allow for VRCs' critical skills to be used towards serving the mission of the VR&E program. It would also allow FTE allocated by Congress to be filled more quickly if they do not need to meet the requirements of a VRC.

A cost estimate is not available at this time.

S. 611 Caring for Survivors Act of 2025

Section 2 of this bill would increase the dependency and indemnity compensation (DIC) rate in 38 U.S.C. § 1311(a)(1) from $1,154 to an amount equal to 55% of the monthly 100% disability compensation rate in effect under 38 U.S.C. § 1114(j). This increase would be effective for payments made after the date that is six months after date of enactment. For survivors whose DIC is predicated on the death of a Veteran before January 1, 1993, VA would be required, for months beginning after the date that is six months after date of enactment, to pay a monthly amount that is the greater of the following:

- The amount determined under section 1311(a)(3), as in effect on the day before the date of enactment.
- The amount determined under section 1311(a)(1), as amended by the bill.

Section 3 of the bill would amend 38 U.S.C. § 1318(b)(1) to reduce, from ten years to five years, the period in which a Veteran must have been rated totally disabled due to service-connected disability in order for a survivor to qualify for DIC benefits. It would further provide that, where the period of continuous rating immediately preceding death is less than 10 years, the DIC payment shall be an amount that bears the same relationship to the amount otherwise payable under section 1318 as the duration of such period bears to 10 years."

VA supports the bill, subject to amendment and the availability of appropriations. The current DIC rate, which increases in accordance with any increase of benefit amounts payable under title II of the Social Security Act, *see* 38 U.S.C. § 1311(f)(4), is $1,653.07. *See* https://www.va.gov/family-and-caregiver-benefits/survivor-compensation/dependency-indemnity-compensation/survivor-rates/. The bill would adjust the rate to $2,107.22 (55 percent of $3,831.30, which is the 100% disability compensation rate in effect as of December 1, 2024). VA interprets this bill as allowing for the use of the current rate in effect under 38 U.S.C. § 1114(j), as well as any future increases, when calculating the DIC rate.

As to the provision requiring VA to pay the greater of the benefit under pre-amendment section 1311(a)(3) and proposed section 1311(a)(1), VA interprets the reference to section 1311(a)(3) as referring to the rates (including any cost-of-living adjustments (COLAs) in effect) at the fixed point in time of the day before the date of enactment, even if those rates are later changed. If that is not Congress's intent, an amendment to clarify section 2(b)(2)(A)(i) may be warranted.

Due to the extensive information system updates required to implement this bill and conduct oversight on said implementation, VA recommends that section 2(b)(1) be amended to an effective date of one year after date of enactment.

Section 3 would support the families of Veterans who had a total disability rating that existed for more than five years, but less than ten years, immediately preceding death. The bill is more generous than existing law by allowing some DIC for such families. However, this bill's concept of a reduced level of DIC could create complexity for survivor beneficiaries, the agency, and external partners.

First, the benefit provided to the families of Veterans with more than five years, but less than ten years, of total disability immediately preceding death would "bear[] the same relationship" to the full benefit amount as the length of the total disability rating "bears to 10 years." But, using a Veteran with five years and eight months of total disability rating as an example, Congress's intent is unclear whether VA should be providing 56.67% of the benefits it would provide for DIC based on ten years of total

disability, or if VA should round up to 57%, or to 60%. Clarification in the bill may be appropriate.

Second, VA does not currently provide a reduced level of DIC benefits in any scenario along the lines contemplated by this bill. This novel adjudication would be operationally difficult and appears to preclude automation, at least initially. VA is able to automate, and therefore expedite, provision of DIC benefits pursuant to section 1318 because VA has record of exactly how long a Veteran has received a total disability rating. This bill, however, would require VA personnel to confirm the length of total disability, determine DIC payment amount under section 1311, and then calculate a reduced DIC amount based on less than ten years of total disability. This calculation is further complicated by the incremental structure of section 1311, which allows VA to supplement the base rate when various conditions are met. It is not clear if, under the bill, the supplements would apply. For example, section 1311(b) allows VA to pay an additional $286 per month of DIC for each child of the deceased Veteran below age 18. It is not clear if the additional $286 (or a portion of that amount) would apply to the new section 1318 beneficiaries under the bill.

VA views the concept of a reduced level of DIC as being inconsistent with the intent of DIC and program integrity. As such, VA recommends removal of section 3(1) of the bill to allow section 3(2) of the bill to achieve the primary intent of DIC expansion. The effect of section 3(2) of the bill, on its own, would result in clearer and more consistent program application. VA recommends removing the novel adjudication calculations and solely retaining the expansion of DIC benefits to survivors of Veterans with a total disability rating by shortening the duration of time required for the disability to have been continuously rated. This would allow VA to continue quickly implementing the expansion while retaining the existing automation that allows the families of deceased Veterans to receive DIC benefits as quickly and accurately as possible.

The bill as written does not contain an effective date for section 3. VA interprets this to mean that any new benefit eligibility created by this section is effective from the date of enactment of the bill, and that the bill does not authorize retroactive payments. If that is not Congress's intent, an amendment to add an explicit effective date may be warranted. Should the bill be enacted as written, VA requests 18 months to implement; however, if clarification is provided regarding rate calculations VA requests 12 months to implement.

S. XXXX Veterans Fraud Reimbursement Act of 2025

This bill would improve the repayment by VA of certain misused benefits. It would amend 38 U.S.C. § 6107 in the pursuit of providing a streamlined reissuance process while shifting VA negligence considerations to program oversight.

The Department is still examining the bill and is unable to provide comprehensive views at this time.

S. XXXX External Provider Scheduling Program

Section 1(a) of this bill would establish a new section 1703H in title 38, United States Code, that would establish a national External Provider Scheduling (EPS) Program to assist VA in scheduling appointments for care and services under the Veterans Community Care Program (VCCP). The EPS Program would consist of technology that allows VA schedulers to view the schedules of VCCP providers and schedule, in real-time, appointments for care and services under that Program. VA would have to carry out the EPS Program through an existing contract entered into by VA, if feasible, or a new contract. VA would have to ensure the EPS Program (1) reduces the time (measured in days) from referral of Veterans to VCCP providers to the actual scheduling of appointments, and (2) reduces the time (measured in days and hours) for VA schedulers to schedule appointments for care or services under the VCCP. Not later than September 30 of each year (through 2028) to submit to Congress a report on VA's progress in establishing the EPS Program.

Section 1(b) of this bill would require VA to ensure the national EPS Program is available at all VA medical centers by not later than September 30, 2025. Section 1(c) of this bill would amend 38 U.S.C. § 1703, which established the VCCP, to amend the requirement that VA coordinate the furnishing of care and services by ensuring the scheduling of medical appointments for both VA providers and external providers (VCCP) refer to scheduling pursuant to the EPS Program under proposed section 1703H.

VA supports the bill, subject to amendments and the availability of appropriations. VA recognizes the benefits of implementing a centralized scheduling platform but recommends amendments to ensure compatibility with existing VA scheduling infrastructure, such as the VA Online Scheduling Application and alignment with other statutory requirements.

VA believes that the establishment of a real-time scheduling system for external providers will enhance the efficiency of scheduling Veteran care under the VCCP. This is in line with VA's ongoing commitment to reducing wait times and improving care coordination. By integrating scheduling capabilities directly into VA's existing systems, this program has the potential to significantly decrease delays between referral and appointment scheduling.

VA is already working to enhance EPS, which enables VA schedulers to book appointments directly into community providers' scheduling systems. This convenient and time-saving approach streamlines the scheduling process and enables timely care by decreasing the number of phone calls between VA staff, Veterans, and VCCP providers. However, VA does not require legislation to support EPS, and enacted legislation could limit VA's discretion to update these efforts in the future. Additionally, real-time scheduling for external providers relies upon the availability and willingness of community providers to participate and share their schedules, and both this availability

and willingness varies among the more than one million VCCP providers today. Consequently, VA would be unable schedule appointments with all providers through the EPS Program contemplated in this bill.

As noted in VA's discussion of the draft Improving Access to Care Act, this new authority would overlap with the requirements in that bill, and both bills would overlap with requirements already established in law. There may be similar overlap with several sections in the Veterans' ACCESS Act, specifically section 301 (which would require VA to develop a plan to establish an interactive, online self-service module to request appointments through VA and non-VA providers), as well as sections 101 and 202, which would expand eligibility for community care. Enactment of this bill, regarding a national EPS program, along with the Improving Access to Care Act and the Veterans' ACCESS Act, could complicate the implementation of each law. We recommend the Committee carefully consider how the proposed legislation would fit within the existing statutory requirements so that duplication and waste do not result.

We have technical recommendations on the bill as well. For example, proposed section 1703H(b) states that the EPS Program "shall consist of technology", but it would be unusual to describe technology as a Program. VA would likely need staff to maintain and update the technology; this would include both technical staff (to actually input the code required for the technology) and administrative staff to advise on the operations and policy of the Program. While these would be necessary, it is not clear that the language of proposed subsections (b) and (c) (regarding use of contracts) would authorize these additional resources. Subsection (c) would require VA to use a contractor, which may be a viable option, but we recommend against mandating the use of a contract in law. VA can provide technical assistance on these provisions if needed.

Further, proposed subsection (d) would require VA to ensure the Program reduces time to actual scheduling of appointments and the time for VA schedulers to schedule appointments, but this is unclear for two reasons. First, it is not clear what the baseline is: is it the date of enactment (i.e., VA must measure the time to schedule as of the date of enactment and ensure that the time to schedule remains below that threshold), or is it a continual requirement (i.e., VA must continue to reduce, every day, the amount of time it takes to schedule)? Further, what is the remedy for non-compliance? In other words, if VA is not able to reduce the time, whether permanently or even temporarily, is there a legal or financial consequence? Absent further amendments from the Committee, VA would interpret this language to require VA to reduce the time to schedule compared with the date of enactment, and that there would be no legal consequence if the time to schedule exceeded that baseline. We also do not believe the deadline, to make the national EPS Program available at all VA medical centers by September 30, 2025, is realistic. VA would be happy to work with the Committee to address these and other issues.

VA continues to develop a cost estimate for this bill.

S. XXXX Representing VA with Accuracy Act (REP VA Act)

This bill would establish a new section 6321 in title 38, United States Code, that would require VA, not later than January 1, 2026, to ensure that any call made to a Veteran by an employee or a contractor of VA regarding services or benefits furnished by VA is made from a single, well-known telephone number and uses caller identification branding that indicates to the Veteran that the call is from or on behalf of VA. Not later than January 1, 2026, VA would have to ensure the Veterans Health Administration (VHA) has at least one call center in each of the major time zones (Eastern, Central, Mountain, Pacific, Alaska, and Hawaii) for the United States to address concerns regarding appointments and referrals for VA health care. VA would not be required to have a call center in any location generally within a time zone that does not follow daylight time.

VA supports this bill, subject to amendments and the availability of appropriations. VA agrees with the intent of this legislation but is concerned this bill could raise significant challenges in implementing as written. VA looks forward to working with the Committee to amend this bill to ensure its efforts to make Veterans and others aware of VA's outreach do not present burdens on Veterans or divert resources in VA from benefit delivery and patient care.

VA fully agrees that providing clear means of communication, and clearly identifying that communication as being from VA, is important to ensuring that Veterans receive and respond to VA outreach. Currently, all Veterans Benefits Administration (VBA) employees and contractors are required to identify themselves as a VA employee (or identify their affiliation with VA) at the start of every outbound benefits-related call. This is a consistent protocol in place across all business lines of VBA. For example, when a VBA employee contacts a Veteran regarding their claim or other issue, they are required to complete either a higher-level review worksheet or a VA Form 27-0820, *Report of General Information*. VBA has worked with VBA-contracted examination vendors so that any call placed to a Veteran displays the telephone number and name of the exam vendor that VBA has shared with the Veteran through GovDelivery emails. This method allows for improved call acceptance rates and reduced opportunity for fraud or telephone number spoofing.

The requirements in section 2(a) are congruent with VA's current use of national branding of the VBA hotline (1-800-827-1000) and the VA Solid Start program (1-800-827-0611). VA's calls are placed from the same number with branded caller ID to ensure Veterans, survivors, and other stakeholders recognize the call is coming from VA. This method allows for improved call acceptance rates and reduced opportunity for fraud or telephone number spoofing.

An alternative approach may be to establish a single, national, and well-known phone number from which all outgoing calls made on behalf of VA show up on the recipient's device (for example, 1-800-827-1000 is a well-known VBA contact number). VBA anticipates that this approach will be more efficient, cost-effective, and require no changes to the workload management system already employed by the agency.

However, even if VBA makes every effort to standardize the caller identification branding, the Veteran still may not receive the correct caller information, because the call receiver's telecommunications carrier directs the displayed information.

We appreciate that the current draft addresses many technical issues VA previously identified with an earlier version. VA does have a number of concerns with this bill, though. Initially, the scope of the bill is too broad to be implemented as written. Proposed section 6321(a) would require VA to "ensure that any call made to a veteran by an employee or contractor of the Department regarding services or benefits" is made from a single, well-known telephone number. Contractors, particularly health care providers in the community, would be unable to use this single telephone number. We also have some concern that if there is a single phone number used as an outbound number "regarding services or benefits furnished by the Department", Veterans, family members, and survivors of Veterans who attempt to call that number back may be unable to reach the individual who can assist them. Calls regarding education benefits, memorial benefits, and health care (including both care furnished in VA facilities and through the Veterans Community Care Program) would all be received by a single number. The contractors conducting Compensation and Pension (C&P) examinations for VBA call from proprietary systems, and VA already provides the caller ID and contact information to Veterans for whom examinations have been requested. In accordance with the Veterans Benefits Improvement Act of 2024 (Public Law 118-196), VA is creating an outreach plan to ensure greater awareness of the vendor contact information. Additionally, VA's examination contractors also provide services to the Department of Defense, and thus they do not make calls solely on behalf of VA. This legislation could require these contractors to have to transfer between two or more phone systems, which increases the risk of errors and confusion.

By requiring a single number be used, VA anticipates Veterans and others will attempt to contact this number for information. The incoming call volume to this single number from individuals attempting to contact VA could be substantial, and the administrative requirements to ensure those calls are directed to the right resource would need significant resources to support. This could result in delayed benefits or appointments and a worse customer experience. In the case of missed calls, voicemails left with this number may be confusing or cause undue suspicions of fraud if the message instructs the Veteran to contact a telephone number other than what is displayed on their caller ID. It is important to note that, even if VA makes every effort to standardize the caller identification branding, the Veteran still may not receive the correct caller information, because the call receiver's telecommunications carrier directs the displayed information.

VA also notes that section 2(a) would only apply to Veterans; VA services and benefits are provided to spouses and children of Veterans and former Service members who have not attained Veteran status, among others. If VA only set up the system described in section 2(a) for Veterans, this would result in disparate treatment for survivors, other beneficiaries, and their representatives. Congress could address this

through use of another term, such as “claimant”, “beneficiary”, “interested person” or some other term. VA is available to provide technical assistance on this as needed.

Additionally, but related, the timeframe for implementation (by January 1, 2026) is not a sufficient amount of time to ensure total compliance with this requirement. VA could begin implementation by that date, but it would not be able to comply fully with the bill as written. If contractors are required to use this phone number, which again may not actually be possible, VA would need to renegotiate contract terms to ensure compliance; this would require time and additional cost to VA.

Regarding section 2(b), we would appreciate the opportunity to discuss the Committee’s concerns to identify areas where we can work together to improve Veterans’ experiences. VA believes that the bill, as drafted, includes specific requirements that would increase costs to VA, even though VA’s current efforts seem to address the immediate focus of this bill. VHA operates clinical contact centers (CCC), also known as VA Health Connect, which is a coordinated system of diverse, dedicated, and Veterans Integrated Service Network (VISN)-aligned administrative and clinical professionals. CCC provides Veterans dedicated access to care and services virtually (e.g., by phone, video, chat, email) to address acute and episodic care. CCC administrative and clinical staff deliver a range of health care services with 24-hour access, and their goal is to attain “first contact resolution” of needs. CCC serves as an extension of VA medical facility-based health care teams and work collaboratively to ensure continuity of care and care coordination using clinical decision support tools.

It is VHA policy that Veterans receiving VA health care have access 24 hours a day, 7 days a week to care via telephone and other virtual modalities to obtain clinical and administrative information, clinical triage, and medical care services through CCCs serving Veterans in every VISN in every U.S. time zone, as well as Guam and the Republic of the Philippines.

In Alaska, for example, the Veterans Integrated Service Network (VISN) 20 VA Health Connect Call Center takes in all calls for Veterans who have clinical concerns, medication needs, and primary care scheduling. In addition, the VA Alaska Health Care System (HCS) has a local community care department call center that can address and route any referral or concerns about internal and external referrals. In Hawaii, the VISN 21 Clinical Contact Center provides virtual contact services for Veterans in Hawaii. These services include scheduling for primary care appointments only, while the VA Pacific Islands HCS supports scheduling for mental health and specialty services, including referrals. VA is concerned that the resources needed to establish dedicated call centers in these time zones could be better used enhancing the services VA can provide.

VA does not have a cost estimate for this bill but anticipates that a contract for caller identification branding would cost approximately $7.4 million. We further note that VA Insurance programs are funded through policyholder premiums, but these programs use multiple phone numbers that display when calls are made. VA’s Insurance

programs would need to change systems to have a single, well-known phone number display when a Veteran is called. Because the program is funded by premiums, these premiums would increase to account for the new requirements.

S. XXXX Veterans' Claims Act of 2025

This bill would reinstate criminal penalties for charging unauthorized fees for presenting, preparing, or prosecuting VA benefits claims. The bill would also expand when fees could be charged, who could become accredited by VA, and the related obligations on VA.

The Department is still examining the bill and is unable to provide comprehensive views at this time.

S. XXXX VetPAC Act of 2025

Section 2(a) of this bill would create a new section 7310B in title 38, United States Code, establishing a Veterans Health Administration Policy Advisory Commission (the Commission). The Commission would be composed of 17 members appointed by the Comptroller General; at least 2 members would have to be Veterans. Proposed section 7310B(b) would further define the qualifications of members of the Commission and would include information regarding ethical disclosure of certain information. Proposed section 7310B(c) would set forth terms regarding the period of appointment for members of the Commission and how vacancies would be addressed. Proposed section 7310B(d) would require the Commission to meet at least annually and would require a majority of the members of the Commission to constitute a quorum (although a lesser number of members could hold hearings). Proposed section 7310B(e) would provide for the appointment of a Chairman and Vice Chairman of the Commission.

Proposed section 7310B(f) would set forth the duties of the Commission; these would include reviewing VHA operations and preparing reports for Congress based on these reviews. The Commission would have to conduct periodic reviews of a range of topics, including but not limited to information technology (IT) infrastructure at VA medical facilities, referrals to care in VA and non-VA facilities through the Veterans Community Care Program (VCCP), access and wait times at VA and non-VA facilities through the VCCP, quality of care in VA and non-VA facilities through the VCCP, workforce issues, patient satisfaction and customer service at VA and non-VA facilities through the VCCP, the training of health care providers and standards of care at VA and non-VA facilities through the VCCP; the long-term budgetary outlook of VHA; procurement of supplies at VA medical facilities; VA's research program; hospital construction, leasing, and capital requirements; and the interaction of care under the Medicare Program, the Medicaid Program, the TRICARE Program, commercial health plans, and VA health care. In carrying out these requirements, the Commission would have to review the effect of policies under title 38 on the delivery of health care to Veterans and assess the implications of changes in health care delivery for Veterans in

the United States (US). If VA or the VA Office of Inspector General (OIG) submitted a report to Congress that is required by law and relates to policies for health care furnished under the laws administered by VA, VA would have to transmit a copy of that report to the Commission as well. In carrying out its requirements, the Commission would have to consult periodically with the chairmen and ranking members of the Committees on Veterans' Affairs of the House of Representatives and the Senate (HVAC and SVAC) regarding the agenda of the Commission and its progress toward achieving that agenda. The Commission could conduct additional review and submit additional report to Congress from time to time on such topics as may be requested by the Chairman and members as the Commission determines appropriate. The Commission also could conduct special studies requested by the chairmen and ranking members of HVAC and SVAC as the Commission determines appropriate. Before making any recommendation to Congress, the Commission would have examined the budget consequences of such recommendations, directly or through consultation with appropriate expert entities. The Commission would have to submit to Congress a report by March 15 of each year containing the results and recommendations of its review of VHA's operations. Recommendations included in these reports may be included if a simple majority of the members of the Commission vote to include the recommendation in the report.

Proposed § 7310B(g) would allow the Commission to employ and fix the compensation of an Executive Director and other personnel; it could also seek assistance and support as may be required in the performance of its duties from appropriate departments and agencies of the Federal or State governments. Additionally, it could enter into contracts or make other arrangements as necessary for the conduct of the work of the Commission without regard to section 3709 of the Revised Statutes (41 U.S.C. § 5) and could make advance, progress, and other payments that relate to its work. Finally, the Commission could provide transportation and subsistence for individuals serving the Commission without compensation and prescribe such rules and regulations as necessary with respect to its internal organization and operation. The Commission would have to utilize existing information collected and assessed either by its own staff or under other arrangements; carry out, or award grants or contracts for, original research and experimentation, if existing information is inadequate; and adopt procedures allowing any interested party to submit information for use by the Commission in making reports and recommendations. The Commission could secure directly from any relevant department or agency of the US health care information the Chairman determines would be helpful to enable the Commission to carry out this section, and the head of a US department or agency would have to furnish information requested on an agreed upon schedule or not later than 180 days after the date of the request.

Proposed § 7310B(h) would set forth terms and conditions for compensation and travel expenses for members of the Commission, as well as establish rules regarding the treatment of personnel for purposes of pay and employment benefits, rights, and privileges. Proposed § 7310B(i) would permit Federal employees to be detailed to the Commission without reimbursement and without interruption or loss of civil service

status or privileges. Proposed § 7310B(j) would state the Commission would provide to the Comptroller General, the Congressional Research Service, and the Congressional Budget Office unrestricted access to all deliberations, records, and non-proprietary data of the Commission within 30 days after such access is requested. Proposed § 7310B(k) would require the Commission to submit requests for appropriations in the same manner as the Comptroller General normally does, but such amounts appropriate for the Commission would be separate from amounts appropriated for the Comptroller General. There would be authorized to be appropriated such sums as may be necessary to carry out this section.

Finally, section 2(c) would require the initial appointments of members of the Commission to be made not later than 280 days after the date on which amounts are first appropriated to the Commission.

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

We note the Commission's scope of review and responsibilities would seemingly be very similar to those conducted under the quadrennial VHA review required by 38 U.S.C. § 7330C and the decennial independent assessments of health care delivery systems and management processes under 38 U.S.C. § 1704A. These current efforts, in addition to those reviews conducted by OIG, the Government Accountability Office, the Office of the Medical Inspector, and the Office of Special Counsel, may already provide the oversight and information the Commission would gather at no additional cost.

We have some concerns that, if not well coordinated, the Commission could impede VA's ability to respond quickly to address Veterans' needs if it is requesting information or conducting investigations while VA is attempting to respond to a new problem.

We also have technical comments on the bill. First, placement of this authority in subchapter I of chapter 73 of title 38 does not seem appropriate; the other sections in that subchapter refer to the organizational structure and functions of VHA itself, while the Commission would not be a part of VHA. Placement in chapter 73 leads to a statutory conflict with provisions related to authorities of the VA Secretary and is inconsistent with apparent Congressional intent. *See, e.g.* 38 U.S.C. §§ 7306(a)(12), 7306(f), and 7421(b)(9).

Second, section 2(f)(3) would require the Commission to review the effect of policies under title 38 on the delivery of health care to Veterans and assess the implications of changes in health care delivery for Veterans in the US; however, VA is not limited to only providing health care in the US. Through the Foreign Medical Program, and pursuant to amendments made by the Compact of Free Association Amendments Act of 2024 (Title II, Division G, of Public Law 118-42), VA can furnish care outside the US in certain circumstances. If the intent is to exclude this care, no

changes to the bill are needed; if this was not the intent, the bill should be amended accordingly.

Finally, the Commission does not appear to be subject to the Federal Advisory Committee Act (5 U.S.C. § 1001 et seq.). In this regard, the Commission's work would not generally be publicly available, and so this could raise concerns from a viewpoint focused on public transparency.

S. XXXX Veterans Mental Health and Addiction Therapy Quality of Care Act

Section 2(a) of this bill would require VA, within 90 days of enactment, to seek to enter into an agreement with an independent and objective organization outside of VA to conduct a study on the quality of care difference between mental health and addiction therapy care delivered by VA providers compared to non-VA providers across various modalities, such as telehealth, inpatient, intensive outpatient, and residential treatment. The organization would have to submit to Congress and publish on a publicly available website a report containing the final results of the study. Section 2(b) would require VA to ensure the organization is able to complete these requirements by not later than 18 months after the date the agreement is entered into. Section 2(c) would require the report to include an assessment of the amount of improvement in health outcomes from start of treatment to completion, including symptom scores and suicide risk using evidence-based scales (including the Columbia-Suicide Severity Rating Scale); whether VA and non-VA providers are using evidence-based practices in the treatment of mental health and addiction therapy care, including criteria set forth by the American Society of Addiction Medicine; potential gaps in coordination between VA and non-VA providers in responding to individuals seeking mental health or addiction therapy care, including the sharing of patient health records; implementation of Veteran-centric care; whether Veterans with co-occurring conditions receive integrated care to holistically address their needs; whether providers monitor health outcomes continually throughout treatment and at regular intervals for up to 3 years after treatment; and the average length of time to initiate services (including a comparison of the average length of time between the initial point of contact after patient outreach to the point of initial service, as measured or determined by VA).

VA supports this bill, subject to amendments and the availability of appropriations. VA certainly appreciates and understands the interest in ensuring that Veterans receive high quality mental health and addiction therapy care; indeed, VA already has the authority to compare VA and non-VA mental health and substance use disorder (SUD) care and VA already evaluates the quality of its programs under several existing authorities and reports its findings to Congress under several laws. We believe the bill could be amended to build on some of these requirements to assemble the requested information.

VA regularly conducts robust reviews of its mental health and SUD care. For example, since 2013, VA has been required to provide to Congress semi-annual reports on developing and implementing measures and guidelines for mental health services,

pursuant to section 726 of the National Defense Authorization Act for Fiscal Year 2013 (Public Law 112-239; 38 U.S.C. § 1712A, note). Since 2015, VA has been required to provide for the conduct of an evaluation of the mental health and suicide prevention programs carried out by VA, pursuant to 38 U.S.C. § 1709B, as added by section 2 of the Clay Hunt SAV Act (Public Law 114-2). VA submits annual reports to Congress with this information, which requires elements similar to those set forth in this bill, such as metrics that are common among and useful for mental health practitioners, the effectiveness of mental health and suicide prevention programs, the cost-effectiveness of these programs, and patient satisfaction. Further, since 2016, VA also has been required to submit annual reports to Congress under 38 U.S.C. § 1706(b)(5) to determine compliance, by facility and Veterans Integrated Service Network (VISN), with requirements under § 1706(b) that includes information on "recidivism rates associated with substance-use disorder treatment". Additionally, under section 104(e) of the Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act (Public Law 118-210), VA is required to conduct an audit, through one or more contracts with a non-VA entity, on the quality of care from VA, including through non-VA health care providers. Between these four reporting requirements, we believe VA could provide much of the information this bill would require. To the extent there are elements that would not, VA believes it would be easier to examine this information as part of its compliance with existing statutes, which could include conducting a study that addresses the elements of the draft bill with external independent review of VA's analyses. Of note, the marginal cost to do so as part of current efforts would likely be much less than the costs of an entirely new study. VA will work to address the concerns underlying this bill in its implementation of existing statutory requirements, such that further legislation would not be necessary.

Similar to comments on the External Provider Scheduling bill and the Improving Access to Care Act, this bill would overlap with provisions in the Veterans' ACCESS Act, which could impair the ability of the non-VA organization contemplated this bill to make valid comparisons and assessments. VA recommends the Committee consider carefully how these provisions would interact if both were enacted to ensure there is no frustration of purpose between them.

VA has technical comments on this bill we can provide to the Committee upon request. Element (6) under subsection (c), which would require an assessment of whether providers monitor health outcomes continually throughout treatment and at regular intervals for up to three years after treatment, in particular is problematic. For example, this requirement would require bilateral contract modifications to compel providers to track and report certain information, which would increase VA costs and would not necessarily result in consistent data. Additionally, Veterans may have different choices in terms of where to receive care over time, and this could interfere with the non-VA organization's ability to determine whether providers continue to monitor patients over time. These and other factors could compromise the ability to make meaningful conclusions on outcomes. We would appreciate the opportunity to discuss this further.

S. XXXX Servicemembers and Veterans Empowerment and Support Act of 2025

This bill contains three titles and a total of 12 sections. Each section is discussed in detail below.

While the discussion below provides VA's views on each section, **VA generally supports the draft bill, subject to the availability of appropriations**, which is aligned in many ways with VA's significant efforts to improve the provision of health care and benefits related to MST. VA appreciates that this version of the bill incorporates revisions VA previously recommended through technical assistance and testimony.

Section 101: Section 101 would require VA, not later than 1 year after enactment, to submit to Congress a report on military sexual trauma (MST) in the digital age. The report would have to include a comprehensive evaluation and assessment of current VA statutes, regulations, and agency guidance relating to MST for the purposes of access to health care under chapter 17 of title 38, United States Code (U.S.C.) and compensation under chapter 11 of title 38, U.S.C. The evaluation and assessment would need to identify gaps in coverage for health care and compensation eligibility relating to MST involving online or other technological communications and the feasibility and advisability of expanding health care and compensation for trauma that is nonsexual in nature involving online or other technological communications. It would also need to include recommendations for revising statutes, regulations, and agency guidance in response to this evaluation and assessment. In carrying out the evaluation and assessment, VA would have to consult Veterans Service Organizations and such other stakeholders as VA considers relevant and appropriate. MST would be defined, with respect to eligibility for health care, to have the meaning given that term in 38 U.S.C. § 1703D(f), as would be added by section 301 of the bill; with respect to eligibility for compensation, it would have the meaning given that term in 38 U.S.C. § 1166A(i), as would be added by section 203 of the bill.

VA has no objection to this section.

VA has no objection to this section because it is only a reporting requirement. Previously, VA has agreed with examining online or other technological communications in the context of MST, and both the Veterans Health Administration (VHA) and the Veterans Benefits Administration (VBA) have coordinated to identify gaps in this area that could be the basis for this report. VHA and VBA have developed recommendations considering the value and application of an institutionally recognized definition of "technological abuse." One statutory gap identified by VHA and VBA involves VBA's definition of MST in 38 U.S.C. § 1166(d)(2) and VHA's definition of sexual harassment under its MST treatment authority under 38 U.S.C. § 1720D(f). The definition of MST, in proposed section 1166A(i), aligns with VHA's and VBA's recommendations.

VA notes that the consultation requirement under subsection (c) could implicate the Federal Advisory Committee Act (FACA; 5 U.S.C. § 1001, *et seq*.). If VA instead

consulted through notices in the Federal Register or public meetings, VA could avoid needing to take steps to comply with the FACA.

VA further notes that the bill would establish two separate definitions for the term MST, one in section 1720D(f) (as would be added by section 301 of the bill) and one in section 1166A(i) (as would be added by section 203 of the bill). While these definitions are similar, they are not identical. Both would include physical assault of a sexual nature, battery of a sexual nature, or sexual harassment, but when and where these events occurred would differ. For purposes of section 1720D(f), it would include these events if they occurred on duty, regardless of duty status or line of duty determination, while under section 1166A(i), these events would have to have occurred while the Veteran was serving in the active military, naval, air, or space service. Additionally, the populations covered would vary as well. For purposes of section 1720D(f), any member of the Armed Forces would be included, while members of the Armed Forces would not be included under section 1166A(i). Former members of the Armed Forces, which would be defined as a person who served on active duty, active duty for training, or inactive duty training, and who was discharged or released therefrom under any condition that is not a discharge by court martial or a discharge subject to a bar to benefits under 38 U.S.C. § 5303, would be included under section 1720D(f) but not under section 1166A(i). While VA acknowledges that the two different definitions reflect differing requirements for provision of health care versus provision of compensation benefits, the use of these two varying definitions in part of a single comprehensive assessment and evaluation could make coordination and review more complicated. The Committee might consider adding a single definition to 38 U.S.C. § 101 reflecting that MST includes physical assault of a sexual nature, battery of a sexual nature, or sexual harassment, and then providing criteria for application of such definition in updated 38 U.S.C. § 1720D and 38 U.S.C. § 1166A to reduce confusion.

VA estimates the additional costs for this section would be minimal.

Section 201: Section 201 would define, for purposes of title II of this bill, the term MST as having the meaning given that term in 38 U.S.C. § 1166A(i), as would be added by section 203 of this bill.

VA has no objections to this section.

VA has no unique objections to this section because it simply adopts a definition for a term used throughout this title. VA noted some concerns with applying two different definitions of MST in the discussion of section 101 above, though.

VA does not have a cost estimate for this section.

Section 202: Section 202 would amend 38 U.S.C. § 1166(d) to define the terms “covered mental health condition” and MST to have the meanings given those terms in section 1166A(i), as would be added by section 203 of this bill.

VA has no objection to this section.

VA notes that conditions other than a covered mental health condition may result from MST. VA recommends considering amending 38 U.S.C. § 1166(a)(1) to state, "The Secretary shall establish specialized teams to process claims for compensation for a condition, which includes a covered mental health condition based on military sexual trauma experienced by a veteran during active military, naval, air, or space service."

VA does not have a cost estimate for this section.

Section 203: Section 203 would create a new 38 U.S.C. § 1166A, regarding evaluation of claims involving MST. The proposed section 1166A(a)(1) would require VA to consider in claims for a covered mental health condition related to MST: 1) a diagnosis of such mental health condition by a mental health professional; 2) a link, established by medical evidence, between current symptoms and MST; and 3) credible supporting evidence, in accordance with subsections (b) and (c) that the claimed MST occurred. The proposed section 1166A(a)(2) would require VA to record in full the reasons for granting or denying service connection in such cases.

Proposed section 1166A(b)(1) would prescribe that evidence from sources other than the official records of the Department of Defense (DoD) regarding the Veteran's service or evidence of a behavior change following the MST event may corroborate the Veteran's account of the trauma. Proposed section 1166A(b)(2) would provide examples of such evidence.

Proposed section 1166A(c)(1) would state that evidence of behavior change following MST is one type of relevant evidence that could be found in sources described in subsection (b). Proposed section 1166A(c)(2) would provide examples of behavior changes that may be relevant evidence of MST.

Proposed section 1166A(d) would prohibit VA from denying an MST-related disability compensation claim for a covered mental health condition without first advising the Veteran regarding evidence that may constitute credible corroborating evidence of MST and allowing the Veteran an opportunity to furnish such evidence or advise VA of potential sources of such evidence.

Proposed section 1166A(e) would state that, in reviewing a claim for compensation for a covered mental health condition based on MST that was incurred in or aggravated by active military, naval, air, or space service, for any evidence from non-military sources or evidence of behavior changes, VA would have to submit such evidence to such medical or mental health professional as VA considers appropriate, including VA clinical and counseling experts, to obtain an opinion as to whether the evidence indicates that MST occurred.

Proposed section 1166A(f) would require VA to ensure that each document provided to a Veteran related to an MST-related disability compensation claim includes contact information for an appropriate point of contact within VA.

Proposed section 1166A(g) would require VA to ensure that all MST-related disability compensation claims are reviewed and processed by a specialized team established under section 1166.

Proposed section 1166A(h) of the bill would include a rule of construction prohibiting VA from construing this section as supplanting the standard of proof or evidence required for claims for posttraumatic stress disorder (PTSD) based on non-sexual personal assault, which VA would continue to define in regulation.

Proposed section 1166A(i) would define the term "covered mental health condition" to mean PTSD, anxiety, depression, or other mental health diagnosis that VA determines to be related to MST and which may be service-connected under 38 U.S.C. § 1110. The term "mental health professional" would mean a provider in the field of mental health who meets the credential, licensure, education, and training requirements established by the Secretary. The term MST would mean, with respect to a Veteran, a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment that occurred while the Veteran was serving in the active military, naval, air, or space service.

Finally, section 203(b) of the draft bill would require VA, within 180 days of the date of the enactment of the bill, to implement an informative outreach program for Veterans regarding the standard of proof for evaluation of MST-related claims, including requirements for a medical examination and opinion. Targeted outreach would be required to the extent practicable, to Veterans who submitted a claim relating to MST that was denied.

VA supports this section, subject to amendments.

VA generally supports this section but has identified several provisions that should be amended for clarity.

VA supports the broadened application of using credible supporting evidence, to include non-DoD evidence and evidence of behavior changes (alternative sources), with a link and diagnosis of any covered mental health condition in claims related to MST. In regulation, VA permits use of such credible supporting evidence with a link and diagnosis of PTSD in claims related to personal assault. Pursuant to 38 C.F.R. § 3.304(f)(5), this evidentiary standard is applied to claims for PTSD based on personal assault, which includes traumatic events beyond MST. The draft bill would create a separate standard for non-PTSD mental health conditions for a personal assault, other than MST.

VA recognizes that other mental health conditions beyond PTSD may be associated with a personal assault. As written, this proposed section would limit application of alternative sources of credible supporting evidence for a covered mental health condition other than PTSD to a claim only related to MST, not any personal assault, which is more limiting than VA's current regulation. To better serve this population, the VA's Office of General Counsel (OGC) recommended use of "personal trauma" rather than "personal assault." In VA's Adjudication Procedures Manual (M21-1), MST is identified as a subset of personal trauma. M21-1 defines personal trauma, for the purpose of disability compensation claims, as broadly referring to stressor events (also referred to as "personal traumatic event") involving harm perpetrated by a person who is not considered part of an enemy force. VA requests additional discussion with the Committee regarding the scope of proposed section 1166A.

VA notes that proposed section 1166(c)(1) states that evidence of behavior change following MST is one type of relevant evidence that may be found in sources described in subsection (a), but subsection (a) does not describe sources of evidence. If the intent is to indicate that evidence of behavior changes may be found in the "nonmilitary sources of evidence" in subsection (b), VA suggests striking "such subsection" and replacing it with "subsection (b)."

Finally, VA notes the proposed rule of construction in proposed section 1166A(h) may be unnecessary as the evidentiary threshold that allows use of credible evidence aligns with the current regulation.

VA does not have a cost estimate for this section.

Section 204: Section 204 would amend 38 U.S.C. § 1165 to require VA to ensure that Veterans who require a medical examination in support of a claim for compensation for a mental or physical health condition that resulted from MST (as defined in section 1166A(i), as would be added by section 203 of this bill) to request that the examination take place at a VA medical facility by a qualified VA employee rather than at a location designated by a VA contractor that performs such examinations on VA's behalf. VA would have to grant any request by a Veteran if a VA medical facility is available within 100 miles of the Veteran's home, and VA could not issue a decision on a claim before the requested examination is complete (or notice, as described below, is provided). If a VA medical facility is not available within 100 miles of the Veteran's home, VA would have to notify the Veteran and provide the Veteran the opportunity to have an examination completed by a VA contractor or to complete the examination at a VA medical facility further than 100 miles from the Veteran's home.

VA has no objection this section.

VA has no objection to this section because VA generally supports allowing Veterans to choose where to receive their disability examinations. This section supports a Veteran-centric approach to claims processing.

However, this section would require changes to MST claims processing and require additional effort on the part of claims processors to ensure VA notifies Service members and Veterans of all options, which may cause delays in claims processing. Further, claims processors are required to check the Examination Request Routing Assistant (ERRA) tool and, if the nearest VHA facility has the ability and capacity to complete the examination required, route the request to VHA as it is always the preferred location for examinations.

VA notes that the requirements regarding the locations of VA medical facilities relative to a Veteran's home vary in several ways from how VA determines access for purposes of health care. First, for purposes of health care access, VA uses average driving time, not total number of miles, as a more accurate measure of how accessible a VA facility is. Second, the proposed section 1165(c)(2)(A) describes a VA medical facility as "available", but it does not define this term. It is unclear if a facility would be considered "available" if it were open and operational but incapable of scheduling a medical examination due to the lack of providers, or if it would be available if there were providers who could perform the examination but not in a reasonable period of time. If Congress does not further define what "available" is, VA would interpret this as a delegation of authority to VA to define these parameters, but we recommend Congress expressly state this to ensure any challenge to the Department's interpretation is afforded appropriate review by a court under Loper Bright. Third, for health care access, VA identifies facilities that are within certain average driving times of the Veteran's residence, while section 1165(c)(2)(A) and (3)(B) refer to "the veteran's home". Some Veterans may not have a home, or they may have more than one home; VA has found that use of the term "residence" provides more flexibility to ensure that these calculations can be made and that they are meaningful as well.

VA does not have a cost estimate for this section.

Section 205: Section 205(a) would require VA to establish a board to review correspondence relating to MST. The board would consist of VA employees who are experts in MST and mental health, with at least one appointed from among VHA mental health providers, one expert from VBA on sexual assault and sexual harassment, and one expert on sexual assault and sexual harassment from the Board of Veterans' Appeals. The board would have to review standard correspondence from VA to individuals who have experienced MST for sensitivity and ensure the correspondence treats such individuals with dignity and respect while not re-traumatizing them. The term "individual who has experienced MST" would mean an individual who has filed a claim for compensation under chapter 11 of title 38, U.S.C., Veterans who have been awarded compensation under such chapter relating to MST, or members of the Armed Forces (including a member of the National Guard or Reserve), former members of the Armed Forces, or Veterans who are receiving care from VA relating to MST.

Section 205(b) would amend 38 U.S.C. § 5103 to add new subsection (c) requiring that any written correspondence under that section to an individual who has experienced MST includes contact information for VBA and VHA MST coordinators, the

Veterans Crisis Line, the VA health care facility closest to where the individual resides, and the Vet Center closes to where the individual resides. Information on the eligibility of the individual for services provided through the Vet Center a definition of Vet Center meaning the term in 38 U.S.C. § 1712A(h) would be included. Section 205 would also amend 38 U.S.C. §§ 5104, 5104B, and 7104, to require the same information.

VA does not support this section.

VA does not support this section because it is unnecessary.

VA appreciates the recommendation to establish a board to review correspondence related to MST, however, it would be duplicative of current efforts. VA has an established workgroup that consists of members from VHA, VBA, and the Veterans Experience Office (VEO), who review MST-related language used in correspondence sent by VA and in work products. This workgroup collaborated on the implementation of section 2(b) of Public Law 117-300, which required audit and modification of the denial letters sent with claims involving MST. VA expanded this effort to include all decision notices and language used in rating narratives. The group is continuing its work with recommendations to improve language used in other sent correspondence that involves MST. VA notes there is a separate effort with a broader scope of reviewing all letters to be trauma informed and in plain language.

VA also implemented section 2(a) of Public Law 117-303. VA includes information on the Veterans Crisis Line, information on how to make an appointment with a mental health provider, information on available resources relating to MST (including information on VHA MST Coordinators), and information on how to make an appointment with mental health providers trained in MST issues and peer support specialists in certain correspondence. This language is included in MST development letters, examination appointment notification letters, and decision notice letters. VA already includes this information in correspondence sent to MST claimants throughout the claim process.

Section 205(a)(4) would define an individual who has experienced MST. Subparagraph (C) would state, “a member of the Armed Forces (including a member of the National Guard or Reserves), former member of the Armed Forces or a Veteran who is receiving care from the Department relating to military sexual trauma.” VA recommends providing clarity with use of the term “receiving care from the Department.” As written, there is ambiguity with what constitutes as “receiving care.” VA recommends considering expanding this language to a Veteran who is enrolled in the patient enrollment system under 38 U.S.C. § 1705 or eligible under 38 C.F.R. § 17.37 to receive care notwithstanding the failure to enroll in VA health care.

VA notes that the requirements to provide contact information for the Vet Center closest to where the individual resides may miss other Vet Center resources, such as Outstations or Mobile Vet Centers, which may be able to offer the same Readjustment Counseling Services the individual is eligible to receive and requires but closer to home.

We also note that, unlike section 204, these amendments refer to the individual's residence, not home. We recommend referring to the residence, as noted in the discussion of section 204 above.

VA does not have a cost estimate for this section.

Section 206: Section 206 would require VA to conduct a study on the quality of training provided to VA personnel who review MST-related disability compensation claims and the quality of VA's procedures for reviewing the accuracy of the processing of such claims. The study would be required to include, with respect to the quality of such training, whether VA ensures personnel complete such training on time, whether the training has resulted in improvements to the processing of MST claims and issue-based accuracy, and recommendations for improving the training. The study would be required to include, with respect to the quality of procedures for reviewing the accuracy of MST claims, whether the procedural comport with generally accepted statistical methodologies to ensure reasonable accuracy of such reviews, whether the procedures adequately include mechanisms to correct errors found, a summary of quality assurance reviews and reports, and recommendations to improve these procedures. VA would be required to submit to Congress a report detailing its findings with respect to this study not later than one year after the date of enactment.

VA does not support this section.

VA does not support this section because it would duplicate existing efforts.

Section 206 would require a study on training and processing MST claims. VA recognizes the importance of specialized training for personnel who review compensation claims related to MST. VA currently tracks the effectiveness of our trainings through data received from claims processors through completion of Level 2 Assessments, which is consistent with the Kirkpatrick Model. VA tracks error trends found in Individual Quality Reviews by the MST Operations Center and provides feedback from special focus reviews by personnel trained in quality. VA utilizes this information to update training content to align with trending needs. Requiring completion of a study on training and processing MST compensation claims would be duplicative of similar efforts routinely conducted by VA.

VA does not have a cost estimate for this section.

Section 207: Section 207 would require the Under Secretary for Benefits (USB) to conduct annually a special focus review on the accuracy of the processing of MST-related disability compensation claims. Each review would include a statistically significant, nationally representative sample of all VA claims for benefits relating to MST filed during the prior fiscal year, the accuracy of each such decisions, the types of benefit entitlement errors found, disaggregated by category, trends from year to year, and training completion rates for personnel who process MST claims.

If the USB found, pursuant to the review, that an error had been made with respect to a Veteran's entitlement to a benefit, VA would return the claim to the appropriate office for reprocessing to ensure the Veteran receives an accurate decision. Finally, section 207 would amend section 5501(b) of Public Law 116-315 by replacing "through 2027" with "until the date described in section 207(d) of the Servicemembers and Veterans Empowerment and Support Act of 2025," and include as a requirement in the report required by that section the findings of the most recent special focus review. In section 207(d), the special focus review requirement would sunset if the accuracy rate found in the review was 95% or greater for five consecutive years.

VA does not support this section.

VA does not support this section because it would duplicate current efforts.

Subsection (a) would require VA to conduct an annual special focus review, which would duplicate current efforts. VA understands the importance of reviewing claims related to MST for accuracy. VA currently completes an annual MST special focus review to determine accuracy on the processing of mental disorder claims due to MST, which were denied benefits within the preceding fiscal year. The results of these reviews are detailed in an annual report with accuracy comparisons to previous years. VA does not believe additional reporting requirements are needed.

Subsection (b) would require the correction of identified errors. Errors noted within the special focus review are recorded by category. Any errors in processing cited during the review are returned for correction. VA notes any error identified during a quality review or special focus review for any claimed condition is returned for correction.

VA does not have a cost estimate for this section.

Section 208: Section 208 would require VA to establish a workgroup on medical examinations for claims for disability compensation under chapter 11 for disabilities related to MST. The workgroup would have to include staff of VA's operations center for MST who have experience reviewing the quality of medical examinations in support of claims for disability compensation under chapter 11; staff of VA's Medical Disability Examination Office; Veterans service officers who have experience with claims for compensation related to MST; medical examiners who have experience with such claims; staff of the Veterans Experience Office (VEO); and such other individuals as VA considers appropriate. Not later than 180 days after enactment, the workgroup would have to review the quality of medical examinations for claims related to MST, review the feasibility of minimizing re-examinations for conditions relating to MST, and submit to the Under Secretary for Benefits and the Secretary recommendations on how to eliminate re-traumatization of individuals who file such claims and reduce the over-development of such claims. Within 1 year of enactment, the workgroup would have to submit to Congress a report with the views of the workgroup on efforts by VA to eliminate re-traumatization of individuals who file claims related to MST, legislative

proposals to improve the experience of such individuals in pursuing such claims, the recommendations described above, and the plan of the Under Secretary for Benefits to implement such recommendations. Within 1 year of enactment, the Under Secretary for Benefits and the Secretary would have to review the submitted recommendations and implement the recommendations they determine would improve the claims process for individuals who file claims related to MST.

VA does not support this section.

VA does not support this section because it is unnecessary.

While VA appreciates the intent of section 208 to establish a workgroup on medical examinations for MST disability compensation claims, as discussed above, VA has an established, collaborative workgroup that meets weekly to assess MST-related work products and processes. Workgroup members include mental health professionals from VHA, and employees from the Outreach, Transition, and Economic Development staff, VEO, Compensation Service, Office of Field Operations, the MST Operations Center, the Medical Disability Examination Office, and the Office of Administrative Review. This group reviews VA's work products, discusses means of improvement, and implements trauma-informed practices. Recent deliverables include revising decision notice letters to include trauma-informed language, updating text used in rating notification decisions, and developing language to use in VA correspondence that gives information on VHA resources, VA exams, information on MST resources, and the Veteran's Crisis Line. Veteran Service Organizations are briefed on the deliverables prior to release, so valuable stakeholder input may be incorporated. Additionally, VA has concerns with being able to properly resource this section.

Additionally, the workgroup would appear to be subject to FACA given the involvement of Veterans service officers and medical examiners, who may not be VA employees. If this was not Congress' intent, we recommend the bill clarify that FACA would not apply to this workgroup.

We also note that, as written, it would appear the workgroup would make recommendations to Congress without review or concurrence by the Secretary or the USB. This would be unusual and could result in the workgroup making recommendations that do not have the support of senior VA leadership. We recommend clarifying how these recommendations would be presented to Congress and urge that the Secretary submit these recommendations on behalf of the workgroup.

VA does not have a cost estimate for this section.

Section 301: Section 301 would amend 38 U.S.C. § 1720D to include a definition of MST that would be generally consistent with current law; it would also revise the definition of a "former member of the Armed Forces" to refer to a person who served on active duty, active duty for training, or inactive duty training, and who was discharged or released therefrom under any condition that is not a discharge by a court-martial or a

discharge subject to a bar be benefits under 38 U.S.C. § 5303. Current law defines the term “former member of the Armed Forces” to include Veterans (under 38 U.S.C. § 101) and individuals with other-than-honorable discharges described in 38 U.S.C. § 1720I(b).

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

VA supports this section because it would expand eligibility for MST services for certain former Service members.

Currently, if a former Service member experienced MST but does not qualify as a Veteran under 38 U.S.C. § 101 (which generally requires service in the active military, naval, air, or space service with a discharge or release therefrom under conditions other than dishonorable), they can only qualify for MST treatment and counseling under 38 U.S.C. § 1720D if they meet the definition of the term “eligible individual” under 38 U.S.C. § 1720I(b). This definition requires the individual (1) be a former member of the Armed Forces (including the reserve components), (2) was discharged or released while serving in the active military, naval, air, or space service under a condition that is not honorable but not a dishonorable discharge or a discharge by court martial, (3) not be enrolled in VA health care, and (4) have served in the Armed Forces for a period of more than 100 cumulative days and either deployed in combat or experienced MST while serving in the Armed Forces. Eligible individuals under § 1720I(b) can receive an initial mental health assessment and the mental or behavioral health care services authorized under chapter 17 to treat the mental or behavioral health care needs of the former Service member, including risk of suicide or harming others.

This definition is limiting in two ways that the proposed bill would address. First, under section 1720I(b)(4)(A)(i), the individual must have served in the Armed Forces for a period of more than 100 cumulative days. This would no longer be a requirement if section 301 were enacted. Second, eligible individuals under section 1720I(b) are only eligible for an initial mental health assessment and mental or behavioral health care services under chapter 17; they are not also eligible for non-mental or behavioral health care. Under section 1720D, however, VA can treat the physical health conditions, as appropriate, of eligible former Service members.

While VA generally supports this expansion, we do have technical comments on this section. Threshold eligibility, particularly regarding character of discharge issues, is complicated, and we believe further discussion with the Committee would be appropriate to ensure that all intended barriers to accessing care related to MST under section 1720D are removed. Specifically, VA is concerned that an individual may have been discharged by court-martial, but VA may nonetheless determine that an exception to the bar to benefits applies; this could result in the individual meeting the definition of “veteran” for purposes of 38 U.S.C. § 101. The bill’s language would seem to preclude such an individual from qualifying under proposed § 1720D(f)(1)(A).

VA does not have a cost estimate for this section.

Section 302: Section 302 would require VA, not later than 14 days after the date on which a Veteran submits a claim for disability compensation to VBA for a disability related to MST, to send a communication to the Veteran with (1) the contact information for the nearest MST coordinator for the Veteran at VBA and a description of the assistance such coordination can provide; (2) the contact information for the nearest MST coordinator at VHA and a description of the assistance such coordinator can provide; (3) the types of services that individuals who have experienced MST are eligible to receive from VA, including the nearest locations, including the nearest Vet Center, and the contact information for such services; (4) the contact information for the Veterans Crisis Line established under 38 U.S.C. §1720F(h); and such other information on services, care, or resources for MST as VA determines appropriate. The term "military sexual trauma" would have the meaning given that term in 38 U.S.C. § 1166A(i), as would be added by section 203 of this bill, and the term "Vet Center" would have the meaning given that term in 38 U.S.C. § 1712A(h).

VA does not support this section.

VA does not support this section because it is unnecessary given VA's implementation of other recently-enacted laws.

While VA supports ensuring clear and open communication with Veterans, we do not believe another requirement in law in this area would be helpful. VA has been implementing the requirements of Public Law 117-271 (sometimes referred to as the VA Peer Support Enhancement for MST Survivors Act) and the MST Claims Coordination Act (Public Law 117-303). Under the former, VA ensures that it is including, in forms for claims for compensation related to MST, an option for a Veteran to elect to be referred to a VHA MST coordinator; VA is also ensuring that VA peer support specialists receive annual training on how to provide peer support regarding MST and annual training for MST coordinators in VHA and VA peer support specialists. Under the latter, VA has been providing outreach letters, information on the Veterans Crisis Line, information on how to make appointments with mental health providers, and other information relating to MST for Veterans who have pending compensation claims related to MST.

VA currently requires the inclusion of similar information to what would be required by this section in an MST development letter, in the exam appointment notification letter, and the decision notice letter. Because VA already requires similar language to be included in a development letter to the MST claimant, sending a separate, dedicated correspondence within 14 days of receipt of claim would be duplicative. VA notes that sending multiple pieces of correspondence with similar information to an MST claimant may be overwhelming.

VA also notes difficulty with requiring specific information about the nearest MST coordinator. VBA would likely be required to use the address of record for benefits, which may or may not align with the Veteran's preferred VHA facility. Rather than only providing specific contact information for the nearest MST Coordinator, VA recommends

providing the MST claimant with broad information on MST Coordinators, so they have a choice of who to contact. Providing choice to a survivor of MST is a key element in trauma-informed practice.

On a technical level, VA notes that the prior concern, namely regarding two separate definitions of MST (between sections 1166A and 1720D), applies here as well. For example, the bill would require VA to provide information on "the types of services that individuals who have experienced military sexual trauma are eligible to receive", but in defining MST more narrowly under proposed section 1166A(i), this creates some ambiguity as to whether individuals eligible for care related to MST under section 1720D would be included under this provision. Similarly, VA's prior comment on the specific definition of "Vet Center" in 38 U.S.C. § 1712A is relevant here as well given that other resources could also provide Readjustment Counseling Services.

VA does not have a cost estimate for this section.

Section 303: Section 303 would require VA, in coordination with DoD, the Department of Homeland Security (DHS), and the Department of Transportation (DOT) to ensure that each individual who withdraws from, or otherwise does not complete service at, a service academy is provided information on their potential eligibility for care and counseling related to MST from VA and the option to receive copies of the individual's service treatment records or military personnel records that document MST, reporting forms from DoD, DHS, or DOT on sexual assault or sexual harassment for which the individual was the victim, and any investigative reports into MST that occurred during the individual's service in the Armed Forces and for which the individual was the victim. VA, in coordination with DoD, DHS, and DOT would have to conduct a targeted outreach campaign for individuals who withdrew from, or otherwise did not complete service at, a service academy during the 80-year period preceding the date of enactment, to provide those individuals with the information described above. The term "military sexual trauma" would, with respect to eligibility for care, have the meaning given that term in 38 U.S.C. § 1720D(f), as would be added by section 301 of the bill, while with respect to eligibility for compensation, it would have the meaning given that term in 38 U.S.C. § 1166A(i), as would be added by section 203 of this bill. The term "service academy" would mean the U.S. Military Academy, the U.S. Naval Academy, the U.S. Air Force Academy, the U.S. Coast Guard Academy, and the U.S. Merchant Marine Academy.

VA supports this section, subject to amendments.

Specifically, VA recommends the other Departments listed here have primary responsibility with VA support, instead of VA having primary responsibility. VA recommends consulting with DoD, DHS, and DOT to obtain official positions on responsibilities.

VA generally agrees with providing information and conducting outreach to individuals who withdrew from or did not complete service at a service academy.

However, other Federal Departments, such as DoD, DHS, and DOT, would have better resources to identify these individuals and would potentially have a previous relationship with the individual as well.

As written, this would require notice and outreach to all individuals who withdrew from, or otherwise did not complete service at, a service academy, including individuals whose withdrawal or termination from the service academy had no basis related to MST. It may be more appropriate for DoD, DHS, and DOT to review which individuals did not complete service at a service academy, due to MST, and provide VA a list of individuals who should be contacted. This would reduce operational demands and avoid confusion that may result from informing people of benefits for which they may be ineligible. For example, individuals who were discharged from such an academy for malfeasance unconnected to MST should not receive this notice and outreach.

VA does not have a cost estimate for this section.

Conclusion

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