THE HONOR ACT OF 2025

The Honor Our Promise to Veterans Act of 2025

Title I – Improvements to Care

SUBTITLE A – Scheduling.

Sec. 101. Timing for scheduling of appointments.

- Establishes specific thresholds for urgent care and non-urgent care appointments for direct care at Department of Veterans Affairs' (VA) facilities and VA-authorized care through the community care program.
    - For non-urgent care, scheduling must occur within 7 days of when care was requested (appointment may occur later).
    - For urgent care, an appointment must occur within 48 hours.
- VA must report to Congress quarterly outlining average scheduling times at each facility. This report must also include explanations and remediation plans to address any scheduling delays or insufficient networks.

Background: According to the Government Accountability Office (GAO), VA has struggled with ensuring timely scheduling of appointments. This section would set clear requirements for scheduling and require VA report to Congress when there are delays, explain the causes, and offer plans to address any problems.

Sec. 102. Consideration of telehealth in determining whether an appointment can be scheduled within the access standards of the Department of Veterans Affairs and limitation on availability of telehealth through community care.

- Allows a telehealth appointment to be counted towards access standards for direct care by VA, if the veteran consents to receiving the care via telehealth.
- Ensures veterans are not forced to utilize telehealth unless it is their choice or if it is the only option for care available at both VA and in the private sector.

Background: This section makes clear that a veteran will be offered community care if VA can only offer the care via telehealth unless the veteran would prefer or consents to receiving the care via telehealth at VA instead. When VA is only able to offer a telehealth option for care (or cannot provide in-person care in a timely manner) or a veteran would prefer to receive in-person care, veterans are often sent to the community instead. However, the private sector often only has telehealth options available, and often with longer wait times than VA. This section also ensures that, if telehealth is the only option available, the veteran is still receiving the soonest, best care.

Sec. 103. Informing veterans regarding access to care.

- Requires VA to provide more transparent information regarding their care options both at VA and in the community, including information on which providers are available, current wait times, and average drive times for the veteran to reach those providers.
- Improves VA wait times reporting to include more comprehensive and historic data and require community care wait times to also be publicly reported.

Background: VA has resisted this level of transparency in the past, insisting that data on community providers is unavailable. However, that is not the case – when schedulers coordinate with a community provider and a veteran to set up an appointment, they already provide the approximate wait time and drive time. This provision

would require the information to be provided to the veteran, thereby allowing the veteran to make the best decision possible.

SUBTITLE B – Provider Requirements.

Sec. 111. Extension of period for submittal of claims by health care entities and providers.

- Allows community care entities and providers a full year to submit claims to the VA for reimbursement and payment. This is an extension from the current 180-day requirement.

Background: Current law requires community care providers to submit claims for reimbursement within 180 days, or they are not paid for services they provided to veterans. According to data from Optum and Triwest - the Third Party Administrators (TPAs) of the community care network (CCN) – the lack of timely filing is the second highest reason claims are denied.

Sec. 112. Rating program relating to military sexual trauma for providers under Veterans Community Care Program of Department of Veterans Affairs.

- Requires the Secretary to establish a system of designating community care providers as "MST Aware" to allow veterans with military sexual trauma (MST) to make more informed choices about their care. Third Party Administrators who coordinate the CCN will be required to post a list of these providers on public websites and update it not less frequently than weekly.
- These providers will have taken a women veteran-specific training created by the Deborah Sampson Act, training modules related to military sexual trauma, and any other trainings the Secretary deems appropriate.

Background: A 2024 report from Disabled American Veterans highlighted issues with community care providers being less likely to recognize the importance of asking veterans about MST or using evidence-based treatments when MST is identified. Some veterans have reported speaking to community care providers with no knowledge in identifying or providing MST care. This section aims to incentivize community care providers to complete MST-related trainings to improve their knowledge of issues faced by many veterans and will help veterans make informed decisions when choosing a community care provider.

Sec. 113. Requirements relating to quality of community care providers.

- Requires TPAs to check the list of excluded providers developed by the Office of Inspector General of the Department of Health and Human Services to ensure they are not authorized by the TPAs to provide care for veterans through VA.
- Ensures former VA employees who depart after quality-of-care violations or during related investigations do not become authorized to care for veterans as private sector providers.
- Requires TPAs to more regularly and accurately update their lists of providers to show updated contact information and availability for appointments and new patients.

Background: There have been multiple instances of community care providers serving veterans despite having been investigated for or confirmed to have been providing poor quality of care or acting in a manner inconsistent with the requirements set for community care providers. However, they are not always expeditiously removed from VA's lists of authorized providers. This will require a more uniform, regulated process to ensure veterans are only receiving care—both at VA and in the private sector—from high-quality providers.

Sec. 114. Community care provider training requirements.

- Institutes more tangible requirements for CCN providers to meet basic training and quality standards – similar to those required of VA providers – to ensure high quality of care for veterans wherever they receive health care. Third Party Administrators will be required to create a database of community care providers showing which ones are up to date on trainings and other requirements of their contracts.

Background: GAO released a report in May regarding the poor monitoring and engagement of CCN providers taking required and recommended trainings offered by VA. It is vital that CCN providers be held to the same standards as VA providers, to ensure veterans get the same quality of care regardless of where they receive it. This is particularly critical for patients with specific needs and diagnoses such as post-traumatic stress disorder, MST, and chronic pain.

Sec. 115. Waivers for network adequacy.

- Requires TPAs to publish information regarding which geographical areas and types of health care they have received waivers from VA for failing to meet contractual network adequacy requirements.

Background: VA's CCN exists to ensure veterans receive care regardless of where they live. However, many rural, hard-to-reach, and underserved regions still suffer from lack of access to care due to low numbers of providers in general or inability of the TPAs to contract with the few available providers – leading TPAs to receive waivers from VA when failing to meet the network adequacy requirements in their contracts. This section will provide more transparent information to veterans regarding their access to care.

Sec. 116. Contracting requirements.

- Requires VA to hold TPAs and their CCN providers accountable for failing to abide by contractual requirements when providing care through VA.

Background: Current law gives VA the authority to remove providers from the CCN under certain circumstances, but this change would *require* VA to remove those providers under serious circumstances such as felony convictions connected to fraud or poor quality of care.

Sec. 117. Inspector General oversight authority for community care.

- Explicitly provides VA's Office of Inspector General (OIG) access to providers, facilities, and records of TPAs and CCN providers – similar to their authority to review and audit such entities of the Department.

Background: While OIG has conducted multiple investigations and issued reports related to care received by veterans through the CCN, it consistently struggles with obtaining access to CCN providers, facilities, and records in a fashion like OIG has at VA facilities. This makes it challenging for OIG to conduct investigations, provide specific recommendations for improvements to care and care coordination, and fulfill its oversight responsibilities.

Sec. 118. Requirement that health care providers under Veterans Community Care Program provide certain data.

- Requires CCN providers to provide VA with specific data to determine efficiency, effectiveness, quality, timeliness, and safety of care. Allows the Secretary to further define requirements and issue rules for waivers for providers if the Secretary determines the submittal of such data by that type of provider would not be appropriate or relevant or constitute too heavy of a burden on the provider.
- Requires Third Party Administrators to note responsive providers on a public database of providers updated not less frequently than weekly

Background: Public Law 115-182, the VA MISSION Act, required a focus on the quality of care provided to veterans in the community. The law references the ability of the Secretary to terminate TPA contracts for failure to meet access and quality standards and requires VA to develop an oversight mechanism to monitor the quality of care provided to veterans. Unfortunately, this area of the law has been hampered by a lack of focus on how to encourage community care providers to share quality (and other) information with VA. This section sets up the framework for the Secretary to ask for and receive information related to efficiency, effectiveness, quality, timeliness, and safety of care.

Sec. 119. Full practice authority for certain positions within the Department of Veterans Affairs.

- Allows full practice authority for physician assistants (PA) at VA. Currently this authority is afforded to providers who would fill similar roles and receive similar training as PAs, whereas PAs are still required to collaborate with a physician. This will massively expand the Department's ability to fill positions that are authorized to be PAs but currently cannot be filled due to this outdated supervision requirement.

Background: PAs are one of three healthcare professions – including physicians and advanced practice registered nurses – recognized by Medicare to provide both primary and mental health care in the United States. This section would bring VA in line with the authority already allowed by Medicare. PAs routinely furnish outpatient diagnoses and treatment of mental health disorders for Medicare beneficiaries as front-line providers and witness the mental health challenges their patients face daily. Expanding PA authority, and therefore utilization, would provide cost-effective, quality health care to veterans and decrease wait-times.

Sec. 119A. Treatment of psychologists.

- Moves psychologists from the Hybrid Title 38 hiring authority to full Title 38 hiring authority, which makes it easier for VA to hire psychologists, and for psychologists to earn higher pay. This brings psychologists under the same hiring statute as physicians (including psychiatrists), dentists, podiatrists, chiropractors, optometrists, registered nurses, physician assistants, and expanded-function dental auxiliaries.

Background: Psychologists have been on VA OIG's list of severe occupational staffing shortage list since its inception in 2015 and has been among the top five reported clinical severe occupational staffing shortages since fiscal year 2019. The most recent report, which was for fiscal year 2024, psychology topped the list of severe clinical occupational staffing shortages with sixty-one percent of facilities reporting a shortage having steadily trended upwards in each of the OIG's annual staffing shortage reports since 2020.

SUBTITLE C – Reports and Related Matters.

Sec. 121. Information on lessons learned to improve contracting for community care.

- Charges VA with developing a process for collecting best practices and learned experience to inform future VA contracting for the CCN.

Background: In 2025, VA is actively pursuing the first major re-negotiation of contracts for the CCN. As this process continues for years to come, it is critical VA prioritizes continued improvements to the CCN as opposed to maintaining the status quo.

Sec. 122. Analysis of impact of spending under veterans community care program on budgets of medical centers and veterans integrated service networks of the Department of Veterans Affairs.

- Requires VA to review its spending on community care versus VA direct care at the local and regional level and submit a report to Congress on this review.

Background: This section would highlight which regions and types of care are most frequently provided through the CCN.

Sec. 123. Study on recovery of revenue from private health insurers.

- Requires VA to conduct a study on maximizing opportunities to bill veterans' private health insurers for recoverable care claims, with focus on any additional staffing, resources, and systems which would be required to do this effectively at a large scale.

Background: Many veterans have, in addition to their VA health care, alternative forms of health care coverage through private insurance. If VA more aggressively pursued back billing those entities, it would ensure the veteran is still receiving the same high quality of care and utilizing their other coverage, while freeing up taxpayer dollars to fund expanded care for them and for veterans who do not have alternative forms of coverage.

Sec. 124. Matters Relating to Emergency Care.

- Requires VA to enlist an independent contractor to conduct a review of authorities related to emergency care provided by the Department, especially through the CCN as most VA facilities do not provide urgent or emergent care. This will include authorities related to transportation, payment for CCN providers, and eligibility for veterans. Following this review, a report will be provided to Congress on its results.
- VA will also be required to conduct a review of its tele-emergency program and ensuring it is consistently utilized and available nationwide.

Background: Many veterans have, in addition to their VA health care, alternative forms of health care coverage through private insurance. If VA more aggressively pursued back billing those entities, it would ensure the veteran is still receiving the same high quality of care and utilizing their other coverage, while freeing up taxpayer dollars to fund expanded care for them and for veterans who do not have alternative forms of coverage.

Sec. 125. Review of dialysis care furnished by the Department of Veterans Affairs.

- Requires OIG investigate the life-saving dialysis care provided both at facilities of the Department and through the CCN following various investigations of CCN providers that have uncovered extremely substandard care practices. The investigation will include quality of care, staffing, conformance with the law and government contracts, billing practices, and other aspects OIG deems relevant.
- Any recommendations for requirements the Department should enforce for CCN dialysis providers shall be tied to financial penalties for the providers if they are not met.

Background: Veterans are thirty-four percent more likely to need dialysis care than non-veterans. One in six veterans need dialysis multiple times per week to survive, and VA has spent billions to ensure veterans have access to that care through the very limited non-Department entities that provide this care. Despite investigations into these companies and reports of quality-of-care concerns, they are rarely held accountable. This provision will not interrupt veterans' access to dialysis care, but will hold these private sector entities accountable to provide this care at the standards set forth in law and in their agreements with VA.

Sec. 126. Benefits for persons disabled by treatment under Veterans Community Care Program of Department of Veterans Affairs.

- Provides benefits to persons obtaining community care when harm, disability, or death is caused by CCN providers.
- Offsets whatever a veteran receives from a medical malpractice tort against the non-VA medical providers with the compensation provided by VA for any disability arising from the treatment from the non-VA provider.

Background: Veterans can file for compensation from VA if they suffered a new disability or if an existing disability worsened as the direct result of a VA provider's carelessness or neglect. These compensation claims are known as 1151 claims for the authorizing section of United States Code. Veterans who receive community care are not eligible for this benefit, although VA is responsible for monitoring the quality of care veterans receive in the community and the referral that was made to the community provider whose treatment caused the veteran harm. The offset is similar to other provisions of law preventing claimants from receiving double payments for the same damages. The offset will not reduce what VA pays in compensation, it only reduces any damages awarded from a tort claim against the non-VA provider and their medical insurance.

Title II – Staffing Matters

SUBTITLE A – Salaries.

Sec. 201. Modification of waiver for medical officer salaries.

- Allows VA to waive pay limitations on any physician of the Department providing direct care to veterans.

Background: Current law only allows the Secretary to waive pay limitations for 300 VA physicians. The Secretary has requested more flexibility for more providers, to help recruit and retain high-quality physicians for the Department.

Sec. 202. Increase of maximum amount of incentive pay for Department pharmacist executives.

- Increases the maximum amount of annual incentive pay for VHA pharmacist executives from $40,000 to $75,000.

Background: VA has requested this authority, as it consistently struggles to meet market rates for pharmacist executives with this woefully out of date pay cap. Without this increase, VA is challenged with maintaining its wide-reaching, cost-effective prescription drug program.

Sec. 203. Modification of special pay authority for nurse executives.

- Allows the Under Secretary for Health to define, through regulations, which VHA positions qualify as nurse executives for the purposes of special pay used for recruitment and retention.

Background: VA has requested this flexibility to ensure long-term retention and to assist with difficult recruitment for these critical VA nurse leaders.

SUBTITLE B – Recruitment and Retention.

Sec. 211. Inclusion of police officers of Department of Veterans Affairs as law enforcement officers.

- This section would add VA police officers to the definition of "law enforcement officer," to expand their eligibility for civil service retirement and the Federal Employees' Retirement System as federal law enforcement officers.

Background: Despite being highly qualified and extensively trained, VA police officers are not currently afforded the same access to retirement benefits as other law enforcement officers in the federal government. This adds to the already difficult task of recruiting and retaining VA police, who work every day to keep veterans and VA employees safe at VA facilities. Updating this authorization would significantly improve VA's ability to fill vacant police positions – consistently one of the top staffing shortage positions for the Department.

Sec. 212. Mentorship program for executive leadership teams at medical centers of the Department of Veterans Affairs.

- Allows VA to establish a peer mentorship program for members of executive leadership teams at VA medical centers (VAMCs).
- Employees eligible to participate in the program as mentees must be either new to their position or employed at a VAMC that is underperforming on quality metrics and will be paired with mentors who have been in their position for at least two years and who are employed at VAMCs reporting above average performance on quality metrics.
- Requires VA to report to Congress on the implementation of the mentorship program.

Background: During a May 11, 2022, Senate Veterans' Affairs Committee hearing entitled "Examining Quality of Care in VA and the Private Sector," Dr. Jonathan Perlin, President and Chief Executive Officer of The Joint Commission and former VA Under Secretary for Health, provided testimony regarding opportunities to increase the quality of care at VA, including through improvements for local leaders. Dr. Perlin recommended VA "establish a mentoring program that pairs its seasoned and successful administrators with less-seasoned colleagues, especially at hospitals that have had challenges."

Sec. 213. Requirement for equivalent role postings for vacant positions at Department of Veterans Affairs.

- Requires VA to automatically open job postings to all potentially qualified applicants by issuing dual or multiple postings for those vacancies. For example, this would require all primary care provider vacancies to issue job postings for physicians, nurse practitioners, and physician assistants.

Background: VA currently defers to individual facilities as to whether they issue job postings concurrently for the various clinicians qualified to fill the position. Many facilities choose not to because it isn't a requirement, which contributes to VA's extremely delayed hiring timelines and, often, a shortage of qualified candidates. This section would require the Department to do this in every instance possible—massively broadening the scope of candidates and ultimately speeding up the hiring process, especially for high-demand, versatile positions such as primary care and mental health care providers.

Sec. 214. Hiring Processes.

- This section establishes common sense processes and requirements for recruitment and retention of staff at the Department to speed up the currently extremely long hiring process to fill critical vacancies at VA. This includes—
    - Nationalized processes and timelines for hiring, assessing, and credentialing each position within the Department.
        - This would include required delegation of approval authority when a primary approving position is unavailable to avoid unnecessary delays.
    - Universal assessments for developing lists of shortage occupations that are tied to recruitment and retention incentives – a process that currently varies drastically by facility and results in VA competing with itself.
    - Authority for the Department to outsource core onboarding requirements, such as drug-testing, which are often delayed due to overwhelmed federal processing centers outside of VA's control.
    - Authority for electronic signatures on certain federal hiring forms – an authority delegated but not specifically authorized to the Department – which meets secure and modernized processes used in other areas of the federal government and private sector.

Background: Based on feedback from the Department, recommendations from GAO and OIG, and Committee oversight of the hiring process for VA, the authorities in this section are based on widespread challenges VA faces in its hiring process. Extensive delays often result in hiring timelines exceeding 180 days, during which time many candidates drop out of the process and veterans must be referred elsewhere for their essential care or go without essential benefits and services.

Sec. 215. Staffing Models.

- Requires VA to establish staffing models for each service and program within the Department.

Background: Universal staffing models, especially for VHA, will provide clear guidance to facilities for adequate staffing based on utilization and provide more transparency to veterans and Congress regarding the staffing and appropriations resources needed. This is a project VA has promised for years but has yet to complete.

Sec. 216. Telework Policy.

- Requires VA to establish a telework policy for all employees, which will include a default status for employees being allowed to telework with exemptions outlined for those whose work or low performance requires them to come into VA facilities to perform their duties.

Background: The current Administration has ordered all Federal employees to work in-person full-time at their assigned agency duty stations, abruptly ending existing telework and remote work arrangements. These arrangements had years of data supporting telework and remote work as maintaining or improving productivity, reducing cost to the taxpayer and the employee, and improving recruitment and retention for VA employees. As a result, VA is hemorrhaging even positions with temporary in-person work exemptions, because providers cannot count on this remote work flexibility at VA, but they are guaranteed that opportunity in the private sector. Positions that have been particularly impacted include mental health providers, radiology, IT experts, human resources, and telehealth providers generally.

SUBTITLE C – Education.

Sec. 221. Establishment of Start and Stay at VA program.

- Creates a two-fold program for existing medical support assistants (MSA) – who schedule appointments and handle some care coordination for veterans seeking care at VA and in the community – and new recruits to receive financial support for education:
    - The first is a scholarship program for individuals who have been MSAs for two years. Eligible individuals must commit to education in areas that directly relate to shortage positions at the Department and to returning as a VA employee for a certain period after completion of their education. They may also pursue part-time education and remain a full-time MSA to fulfill all or part of the service obligation.
    - The second is for potential employees to receive a one-time lump sum payment towards outstanding education-related loans not to exceed $40,000 in exchange for a minimum of three years of obligated service.

Background: MSA has consistently been a top shortage position for VA facilities nationwide. There are more than 30,000 at VA and there is a 62.6 percent retention rate. Currently VA has to replace more than one third of this critical workforce every year just to maintain the status quo. These retention concerns are exacerbated when, depending on the complexity of the position, it can take VA six months to fully train MSAs if the individual is new to the Department. In order for the CCN to function well and for veterans to receive timely scheduling for community care, VA must recruit and retain an adequate number of trained MSAs.

Sec. 222. Building and maintenance professionals education assistance program.

- Establishes a scholarship program for training and education required to fill critical engineering, maintenance, facilities, and other operational roles at the Department.

Background: VA's aging infrastructure requires extensive specialized maintenance from a shrinking list of qualified professionals. For example, many VA hospitals require multiple boiler plant operators to be on staff 24/7, but there are very few individuals who can fill these roles due to the constantly shrinking number of large facilities utilizing boiler plants. This program is targeted at ensuring there continues to be a reasonable number of qualified professionals trained in this field to service VA facilities many years away from transitioning to other electricity systems.

Sec. 223. Expansion of reimbursement of continuing professional education expenses.

- Requires the Secretary to reimburse a much wider range of health care staff to up to $1,000 each year in continuing professional education expenses. These newly eligible positions would include podiatrist, chiropractor, optometrist, registered nurse, physician assistant, licensed practical or vocational nurse,

medical technologist, pharmacist, psychologist, social worker, and more. VA currently only provides this reimbursement for physicians and dentists.

Background: Based on the VA FY22 Budget Submission request.

Sec. 224. Payment of licensure exam costs for recipients of scholarships from Department of Veterans Affairs.

- Requires VA to cover the costs of licensing examinations and certifications for any current VA health professional scholarship recipient.

Background: Based on public feedback, as seen in the Veterans Healing Veterans Medical Access and Scholarship Program Final Rule, published in the Federal Register in November 2019.

SUBTITLE E – Reports.

Sec. 231. Department of Veterans Affairs Personnel Transparency.

- Modifies an existing staffing report VA publishes quarterly to include more staffing data on a wider variety of positions.

Background: Especially amidst the current drastic changes to the workforce of the Department, it is critical that Congress and the public have consistent access to a full picture of staffing at the Department and how it may impact veterans' access to care and benefits.

Sec. 232.Report on Grow Our Own Program.

- Requires VA to issue an update to Congress on a pilot program geared towards hiring physician assistants authorized in Public Law 115-141, the Consolidated Appropriations Act, 2018. A final report on the pilot program was due in 2023 and never submitted to Congress.

Sec. 233. Provision of data on educational assistance programs of Veterans Health Administration.

- Requires VA to provide data on the number of participants, the amount of funds each fiscal year, etc., for graduate medical education programs, health scholarship programs, and any other educational assistance programs within the Veterans Health Administration.

Background: Due to damaging policies by the current Administration that are restricting research, putting aggressive limitations on external partners, and generally harming workforce recruitment and retention, there are reports of reductions in applicants and planned reductions in awards for these scholarship programs that are a lifeline for VA to maintain and grow its healthcare workforce.

Title III – Infrastructure Matters

Sec. 301. Definitions.

SUBTITLE A – Investing in Department of Veterans Infrastructure to Increase Capacity to Serve Veterans.

Sec. 311. Authorization of funding for certain land acquisitions for medical facilities of Department of Veterans Affairs.

- Allows VA to purchase land for medical facilities earlier in the acquisition and construction timeline, which will accelerate the delivery of new facilities.

- To ensure this authority is only used for fully mature and vetted projects, this provision would only apply to major medical facility projects that have been included in the five-year development plan as part of the President's Budget submission to Congress.

Background: This provision was requested by VA in its FY 2025 budget submission. Currently VA must wait until an entire major medical facility project is formally authorized by Congress before acquiring relevant land to build a facility – a process which can add additional years to a project's completion once approved. This deprives VA from acquiring land when an opportunity arises in a relevant real estate market for a planned project. VA's National Cemetery Administration already has this flexibility. The Appropriations Committee has already made changes in appropriations law to facilitate this policy change, but this authorization language is needed to make the parallel change in Title 38.

Sec. 312. Detachment of congressional committee approval requests of major medical facility leases from annual budget submission of Department of Veterans Affairs.

- This section would allow VA to submit a request for Congress' approval of a major medical facility lease at times other than the yearly budget submission.

Background: This provision was requested by VA in its FY 2025 budget submission. Current law requires VA to submit all its requests for Congressional approval of major medical facility leases in the one-time yearly presidential budget submission. After that submission, VA's authorizing committees review the submissions and – if they deem them appropriate – approve them, which allows VA to proceed with formal competitive procurement. This provision would keep that approval process in place but also allow VA to submit requests, as needed, at other times of year in instances where a need for new medical space quickly emerged, such as after a natural disaster or other emergency. Allowing VA this flexibility will increase efficiency and improve VA's ability to respond to veterans' needs for modern facilities in a timely manner.

Sec. 313. Improvement of capital asset staffing of Department of Veterans Affairs.

- Directs VA, within one and a half years, to ensure it has relevant dedicated positions/offices guided by a staffing model at each VAMC, regional, and central office locations, to oversee planning and management of all construction-related projects.
- This section also requires VA to regularly solicit the views of veterans and VA's workforce as it relates to VA facilities in a specific region, to inform the Department's future infrastructure planning.

Background: This provision is intended to address the uneven infrastructure/capital asset management staffing at VHA facilities across the country, as well as those at the regional and central office levels. Some facilities have robust staff to plan and manage construction projects and others do not, leaving the planning and delivery of projects inconsistent across the country. Well qualified and sufficient staff are needed to achieve highly effective infrastructure project performance across the nation. The section also requires VA to regularly collect the views of veterans and VA employees and use that information to plan for how to improve or build new VHA infrastructure, as well as relevant capital asset processes, to better serve veterans. This responds to recommendations from a June 2019 GAO report.

Sec. 314. Development of performance metrics of capital asset management by Department of Veterans Affairs and monitoring for improvement.

- Directs VA to develop, within one year of enactment, meaningful goals and metrics to assess and monitor the performance of its capital asset management programs to guide infrastructure decisions in alignment with VA's mission and budget.

Background: This provision is tied to a recommendation from a 2021 GAO report. Fundamentally, if VA is going to improve its performance in infrastructure projects and management, it needs to set meaningful goals

and metrics, monitor results, and make reforms to improve outcomes. This section directs VA to set up such a metrics system.

Sec. 315. Expansion of membership of the Capital Asset Planning Committee.

- Directs expansion of the existing Department of Defense (DoD)-VA Joint Executive Committee (JEC) Capital Asset Planning Committee membership by adding representatives from the Indian Health Service (IHS) and Department of Health and Human Services (HHS).

Background: The JEC was established by Congress to provide senior leadership of both VA and DOD a forum for collaboration and resource sharing to meet the interagency needs of veterans and servicemembers. An existing group within the JEC is called the VA and DoD Capital Asset Planning Committee, and it was created to provide a formalized structure to facilitate cooperation and collaboration between the Departments that are mutually beneficial in achieving an integrated approach to planning, design, construction leasing, and other real property-related initiatives for medical facilities. This provision directs VA and DoD to add representatives from IHS and HHS to this Committee to improve the coordination of federal health care facility planning, since IHS and HHS are some of the largest federal healthcare stakeholders outside of DoD and VA. Their participation in this Committee may improve federal coordination, collaboration, and resource allocation for health facilities.

Sec. 316. Authorization of appropriations.

- Provides an authorization of appropriations for three key VA construction accounts: Minor Construction, Major Construction, and Grants for Extended Care Facilities, commonly known as the State Home Construction Grant Program.

- For any year in which VA does not include the requested authorized level of funding in their annual budget request, this section requires VA to include in their budget submission to Congress a justification for why the requested funding levels are sufficient to meet VA's infrastructure needs, which projects will not be funded based on the requested levels, and indicate whether the infrastructure request that appears in VA's final budget submission matches those VA submitted to the Office of Management and Budget.

Background: Across several administrations of both parties, VA has been unable to officially request enough infrastructure funding to tackle the Department's well documented infrastructure needs for modern medical facilities, renovations, and cemeteries. For example, VA's FY 2025 budget identified a need of $47.2 - $52.2 billion for Major Construction and $34.1-$37.7 billion in Minor Construction over ten years. VA's annual enacted budget for these accounts usually totals $3 billion. Given the number of projects in VA's waiting list of validated projects, these funding levels, left unchanged, make it impossible for VA to even incrementally accomplish its modernization. Similarly, the backlog of grant applications from States for construction of State Veterans Homes regularly reaches $1 billion, though typical requested and enacted annual appropriations are often around $150 million. This section is intended to provide clear authorization and direction for sustainable and predictable funding levels, derived from VA's own budget documents, for these critical accounts. The longer Congress waits to take decisive action, the more VA infrastructure upgrades will cost taxpayers in the long term. More importantly, not upgrading those older VA facilities will hamper the ability to deliver world-class health care to veterans consistently across the country.

SUBTITLE B – Reviews and Reports.

Sec. 321. Review of resilience of facilities, land, and other relevant capital assets of Department of Veterans Affairs.

- Directs VA to conduct a comprehensive review of the resilience of its facilities, land, and other relevant capital assets as it relates to extreme weather events and provide an action plan in response to the findings and submit those findings to Congress.

Background: VA has a large infrastructure footprint across the country, and, in some of those locations, facilities are susceptible to damage from flooding, rising sea levels, wildfire, tornadoes, hurricanes, or other storms or extreme weather events. In addition to serving veterans, VA also has a statutory mission to serve as the nation's emergency backup health system. For these reasons, it is important for VA to study the resilience of its facilities, further develop policies and plans for the strategic placement of future facilities, and develop recommendations to ensure VA facilities are prepared to safely deliver care and services to veterans.

Sec. 322. Reports on key capital asset investments, activities, and performance of Department of Veterans Affairs.

- Modifies an existing Congressionally Mandated Report VA provides to Congress by requiring VA to report on infrastructure spending, activities, and performance –including a list of completed and planned key capital asset investments/expenditures, with meaningful metrics to show progress toward meeting relevant capital asset management goals.

Background: Under current law, VA is only required to provide a minimal amount of infrastructure performance information to VA's authorizing Committees, such as a quarterly reports on "super construction projects" that cost more than $100 million and to notification to Congress when certain leases are awarded. Beyond that information and material included in VA's yearly budget submission, there is very little regularly required reporting on performance, schedules, and execution of funds. This lack of regular information inhibits Congressional oversight, including the ability to monitor VA's progress in improving its management and delivery of infrastructure projects.

Sec. 323. Report on long-term care physical infrastructure needs of Department of Veterans Affairs.

- Directs VA to report to Congress, within one year of enactment, on the infrastructure required by VA, disaggregated by VAMC, to allow the provision of long-term care for veterans including women veterans, veterans with spinal cord injuries and diseases, veterans with traumatic brain injury, veterans with unique behavioral health needs, veterans with memory loss, and other population groups with unique needs.

Background: VA, Congress, and VSOs have all identified a need for additional capacity for VA to provide long-term care services for veterans, including for more diverse patient populations. National health care experts have identified the need for health care providers to plan for the long-term care needs of the "baby boomer" generation. VA has not developed a specific consolidated and national plan that includes the individual veteran long-term care needs in each state and cost estimates to address them through relevant construction projects.

Sec. 324. Report on women veterans retrofit initiative.

- Amends Section 5102 of the Deborah Sampson Act of 2020 (Title V of Public Law 116-315) to direct VA to report, within one year of enactment, on the status of prioritized infrastructure projects for women veterans and how many of those remain to be completed.

Background: Section 5102 of the Deborah Sampson Act included a requirement for a one-time VA report on infrastructure projects needed to ensure all medical facilities of the Department are retrofitted or renovated to support the delivery of women veterans' health care. Women are now the fastest growing cohort within the veteran community. The percent of women veterans is projected to increase to about eighteen percent of the total veteran population in 2040, up from six percent in 2000. This section would modify the existing requirement under law and make VA report once a year for 10 years – or less if the list of projects is completed

– on its progress toward addressing all women veterans facility retrofit projects, to include a list of those projects that are identified but not yet funded. The goal of this report is to allow Congress to monitor the progress towards completing all relevant renovations to existing facilities to make them accessible and welcoming to women veterans.

Sec. 325. Report on capital asset and information technology needs of the research and development program of Department of Veterans Affairs.

- Directs VA to report, within two years of enactment, on the physical and IT infrastructure needs of the Department's research and development programs.

Background: VA's research program is a national treasure and asset, benefiting veterans and all Americans. However, over decades, its physical and IT infrastructure has not been consistently modernized. This section would require VA to provide an updated report on VA's research infrastructure needs as well as IT needs to support research activities, including data storage, cloud computing, and other requirements. This information would again help Congress plan for how to make these investments a reality over a specific timeframe.

Sec. 326. Review and report on provisions of law relating to Department of Veterans Affairs capital asset management and oversight.

- This section directs VA to report, within two years of enactment, on the physical and IT infrastructure needs of the Department's research and development programs.

Background: VA's research and development (R&D) program is a national treasure and asset, benefiting veterans and all Americans. However, over decades, its physical and IT infrastructure has not been consistently modernized. After a request from Congress, in 2012 VA issued a 625-page report on VA's R&D infrastructure needs. This section would require VA to provide an updated report on VA's R&D infrastructure needs as well as IT needs to support research activities, including data storage, cloud computing, and other requirements. This information would again help Congress plan for how to make these investments a reality over a specific timeframe.

Sec. 327. Improving prevention, detection, and reporting of waste, fraud, and abuse in Department of Veterans Affairs capital asset projects and activities.

- Directs VA to submit a report to Congress on actions it is currently taking or plans to take to enhance the ability of the Department to prevent, detect, and report waste, fraud, and abuse occurring in capital asset projects of the Department, whether by employees, contractors, or other relevant persons or entities.

Background: If VA's construction budgets grow over the next several years to meet the demands of modernizing its infrastructure, it is important for its oversight functions – including preventing, detecting, and reporting waste, fraud, and abuse – to also grow. This report is intended to ensure VA is strengthening its fraud prevention, including through further collaboration with OIG and GAO, as well as enhanced training.

Sec. 328. Comptroller General report on continued need for non-Department of Veterans Affairs project management for super construction projects.

- Directs GAO to conduct a review of VA's major construction program, specifically its "super construction" projects – construction projects valued above $100 million.
- In particular, GAO would be tasked with reviewing and providing options for how Congress should evaluate whether VA has achieved enough operational and management capabilities that it should no longer be required, as in current law, to use the U.S. Army Corps of Engineers (USACE) or other non-Department federal entities to manage its super construction projects.
- Requires GAO to research and describe the current cost structures or fees VA pays to the USACE to manage large construction projects on VA's behalf.

Background: For a variety of reasons, VA mismanaged several large construction projects over the period of 2010-2018, with the most attention focused on the Aurora, CO facility, whose budget and schedule/timeline increased significantly, requiring various congressional supplemental funds. As a result of these challenges, VA launched several internal reforms and Congress instituted several reforms in statute. Among those were a requirement for a non-VA federal entity (i.e., the USACE) to take over the Aurora project and for VA to use a non-Department federal entity to manage all future VA projects with an expected cost greater than $100 million. These changes have been in place since 2015. This section directs GAO to review whether VA has matured enough in its management of construction projects to no longer be required to use a non-Department federal entity. GAO would also examine the fees VA pays USACE and what savings VA might generate if it were to no longer use USACE to manage construction projects. To be clear, under either scenario, VA would and does contract with a private construction firm to manage and carry out the construction. The policy question which this report would assist Congress with is whether VA should still be required to use a federal third party as its "agent" in super construction projects.