STATEMENT OF
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BEFORE THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

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Chairman Bost, Ranking Member Takano, and other Members of the Committee, thank you for inviting us here today to present our views on several bills that would affect Department of Veterans Affairs (VA) programs and services. Joining me today is Ms. Tracy Therit, Chief Human Capital Officer and Dr. Sachin Yende, Chief Medical Officer for Integrated Veterans Care with the Veterans Health Administration.

H.R. 1391 "Student Veteran Benefit Restoration Act of 2025"

This bill would add a new 38 U.S.C. § 3699C that would require VA to restore entitlement to VA educational assistance for individuals pursuing an approved course or program of education in certain circumstances. The new section would also prohibit VA, in those same circumstances, from counting payment of VA educational assistance towards the 48-month limit on the aggregate period for receiving assistance under 2 or more educational assistance programs. The circumstances under which these requirements would apply are as follows:

- For any period during which an educational institution was not properly approved to receive VA benefits on behalf of students, including when an educational institution's approval was revoked;
- For any period during which VA determines that an educational institution engaged in prohibited activities relating to advertising, sales, and enrollment practices;
- For any period during which a court finds the educational institution guilty of, or liable for, fraud;
- For any period during which the Department of Justice closed the educational institution on the basis of fraud or for a violation of Federal or state law; and
- For any period during which the educational institution engaged in fraud, after which it closed.

In addition, new section 3699C would, as a condition of approval of a course or program, require that an educational institution agree that, if VA restores a portion of a student's entitlement to VA educational assistance, the educational institution will repay VA the portion of educational assistance it received for the student. Furthermore, if a court finds an educational institution guilty of or liable for fraud and orders the educational institution to pay financial relief to the Federal Government, VA may file a claim with the Department of the Treasury for recoupment of all amounts of VA

educational assistance the institution obtained through fraud. Finally, new section 3699C would require VA to establish an appeal process for an educational institution to request review of a VA finding that the institution has to repay educational assistance.

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

This bill would protect the Nation's Veterans who are using their VA education benefits to attend educational institutions that engage in deceptive practices by restoring entitlement used for periods an institution engaged in such practices. The bill would also help to safeguard taxpayers' dollars when violations are found.

However, when an educational institution engages in deceptive practices, proposed section 3699C(c)(1) would hold it financially responsible for only the tuition and fee payments VA made directly to it, but not for payments of benefits that VA pays directly to a beneficiary, such as monthly housing payments and book and supply stipends under the Post-9/11 GI Bill, and monthly benefit payments under the Survivors and Dependents Educational Assistance Program (chapter 35, DEA), the Montgomery GI Bill (chapter 30, MGIB), and the Montgomery GI Bill – Selected Reserve (chapter 1606, MGIB-SR), as well as Veterans Readiness and Employment benefits, including tuition, fees, supplies and monthly subsistence allowance. On the other hand, when an educational institution engages in deceptive practices, proposed section 3699C(a) and (e) would require VA to restore entitlement to all educational assistance, including entitlement to educational assistance paid to a beneficiary. We believe that section 3699C(c)(1) should require an educational institution to be responsible for repayment of the total amount of educational assistance paid (that is, payments made to both the educational institution and the beneficiary) because of the institution's engagement in deceptive practices. Otherwise, the beneficiary would be responsible for repaying any overpayments of benefits paid directly to the beneficiary instead of to the educational institution.

A cost estimate is not available at this time, but VA anticipates that this bill will have mandatory costs.

H.R. 496 Veterans Second Amendment Restoration Act

This bill would require VA to notify the Attorney General that the basis for transmitting a beneficiary's personally identifiable information, solely on the basis of a determination under 38 U.S.C § 5502 for the purpose of assigning a fiduciary to a VA beneficiary who is incapable of managing their own affairs, to the Department of Justice (DOJ), for use by the National Instant Criminal Background Check System (NICS) established under section 103 of the Brady Handgun Violence Prevention Act, as amended (Brady Act), does not apply, or no longer applies.

This bill would also require VA not to treat a person as having been adjudicated as a mental defective solely on the basis of determining that the individual is mentally incompetent under 38 U.S.C. § 3.353 or requires a fiduciary under 38 U.S.C. § 5502.

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

VA has concerns because the definition of "adjudicated as a mental defective" is implemented by DOJ under 27 C.F.R. § 478.11(a)(2). This definition includes a person who "lacks the mental capacity to contract or manage his own affairs," which is identical to the language VA uses in its regulations implementing the fiduciary statute. Furthermore, DOJ's definition is utilized when carrying out the Gun Control Act of 1968, as amended, which prohibits nine classes of persons to ship, transport, possess, or receive firearms and ammunition. Under 18 U.S.C. § 922(g)(4), this includes any person who has "been adjudicated as a mental defective or who has been committed to a mental institution." The Act does not propose amending 18 U.S.C. 922 to address a change as to how the prohibitions of 18 U.S.C. § 922(g)(4) are implemented.

VA notes this definition will still be problematic because a determination that a Veteran is mentally incompetent under 38 C.F.R. § 3.353 or requires a fiduciary under 38 U.S.C. § 5502 will not amend the definition of a mental defective in 18 U.S.C. § 922(g)(4) or its clarifying DOJ definition in 27 C.F.R. § 478.11. 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(g)(4) on the basis of VA's determination. Without this clarification, Veterans and other beneficiaries who need a fiduciary for VA purposes may face possible criminal liability if they purchase firearms, because this bill would only address VA reporting. Additionally, if retroactively applied, the Act would cause these records to be removed from the NICS Indices and unless the definition in 27 CFR § 478.11 is amended or superseded, this would create a separate standard for prohibiting veterans versus other persons who have been adjudicated by other lawful authorities as lacking the mental capacity to contract or manage their own affairs "as a result of marked subnormal intelligence, or mental illness, incompetency, condition, or disease." This approach may create a litigation risk for the Department of Justice based on the lack of uniform treatment.

H.R. 1041 "Veterans 2nd Amendment Protection Act"

This bill would add a new section, 38 U.S.C. § 5501B that 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 DOJ for use by 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 the 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 proposed legislation will amend the United States Code to codify the prohibitions for NICS reporting, which were instituted under the "Consolidated Appropriations Act of 2024."

Section 413 Division A of the Consolidated Appropriations Act, 2024, prohibits 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 policy within section 413 of Division A of the Consolidated Appropriations Act, 2024, 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(a), 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, as with **H.R. XXXX, [Unnamed Second Amendment Bill],** VA notes that VA's enforcement of the Brady Act is a requirement stipulated by DOJ, and any alteration to that process should include updates to DOJ's regulations or be clarified in this bill. The Brady Act prohibits nine classes of persons to ship, transport, possess, or receive firearms and ammunition. Under 18 U.S.C. § 922(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(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 purchase firearms. DOJ concurrence 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 on the NICS database and, thus, could violate that regulation by improperly operating a firearm.

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. VA reads the bill as currently drafted to require that an order or finding noting that a beneficiary is a danger to themselves or others at any point following a VA determination of incompetency would require VA to report that information to NICS.

H.R. 740 Veterans' 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. 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 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 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 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 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 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 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 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(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 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 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(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.

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(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.

H.R. 472 Restore VA Accountability Act of 2025

Position: VA supports, if amended.

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 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 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) 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 draft bill.

Cost estimates are not available at this time.

Conclusion

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