The National Association of State Directors of Veterans Affairs

NATIONAL ASSOCIATION OF STATE DIRECTORS OF VETERANS AFFAIRS

Joint Hearing of the House and Senate Veterans Affairs Committees

March 4, 2026

Presented by

Terry Prince

President, National Association of

State Directors of Veterans Affairs (NASDVA)

Director, Illinois Department of Veterans Affairs

INTRODUCTION

Chairman Moran, Chairman Bost, Ranking Member Blumenthal, Ranking Member Takano, and distinguished members of the Committees on Veterans' Affairs, thank you for the opportunity to submit this written testimony on behalf of the **National Association of State Directors of Veterans Affairs (NASDVA)**. I am Director Terry Prince, President of NASDVA, and Director of the Illinois Department of Veterans Affairs.

NASDVA was founded in 1946, following the end of World War II, to unite leaders of Veterans Affairs agencies from all 50 States, the District of Columbia, and the five U.S. Territories: American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands. In the postwar era, Veterans earned both Federal and State benefits, creating a critical need for coordinated efforts to ensure they received their full entitlements.

Directors, as leaders of State and Territorial government agencies, are entrusted by their respective Governors, State Boards, or Commissions to meet the diverse and evolving needs of Veterans, regardless of age, gender, era of service, military branch, or circumstances of service. Although each State and Territory differs in structure, programs, and resources, we share a unified commitment to delivering effective, Veteran-focused services. Equally important, **NASDVA** maintains strong partnerships with the U.S. Department of Veterans Affairs (VA) to advance our shared mission of improving the lives of our nation's Veterans.

VA FUNDING and REORGANIZATION

NASDVA is committed to working with Congress and VA senior leaders to ensure that scarce resources are allocated to priorities that meet our Veterans' most pressing needs in a Veteran-focused manner. **NASDVA** applauds Congress's concerted efforts to improve VA funding accountability, provide adequate funding for health care, claims adjudication, and appeals processing, and address homelessness and suicide prevention. Likewise, continued emphasis is warranted on preparing for the aging Veteran population, the growing cohort of women Veterans, and on support for Caregivers and Survivors.

As the VA continues its transformational journey, **NASDVA** can support the concept and contribute to the VA's proposed significant reorganization of the Veterans Health Administration (VHA), intended to improve patient care, based on recommendations from the OIG (Office of the Inspector General) and the GAO (Government Accountability Office). The major structural change from eighteen (18) Veterans Integrated Service Networks

(VISNs) to five (5), along with shifting staff to high-demand areas and restructuring community care contracts, will affect the entirety of VHA's health care delivery. The stated goals to speed decision-making, ensure consistent policy application across all VA medical facilities, and improve access to VA care supplemented by Community care are desirable. More details are needed to evaluate the overall impact. The reorganization will require careful oversight across the VA to ensure effective and efficient execution and to maintain a continued focus on deploying resources where Veterans are best served. Ultimately, the reorganization needs to enhance VHA's role as the primary health care provider for Veterans.

In addition to organizational changes, VA plans to restart its *Electronic Health Record Modernization (EHRM)* rollout in 2026, targeting 13 new sites, beginning in Michigan in April. Evolutionary upgrades to the VA's Millennium software will enable clinicians to easily access a Veteran's medical history in one location. The system must address medical providers' operational concerns and enhance healthcare delivery for Veterans. Likewise, it is essential to address system deployment challenges and be prepared for future development issues. **NASDVA** supports Congress's efforts to hold the VA's EHRM Integration Office accountable for transitioning to the new system that tracks all aspects of patient care.

VETERANS HEALTHCARE

NASDVA is committed to meeting the healthcare needs of our 16-plus million Veterans through partnership with the Department of Veterans Affairs (VA). A major focus is expanding access to the VA healthcare system for Veterans and eligible family members. This is achieved through strong collaboration among VA and the Departments of Veterans Affairs of the States, five Territories, and the District of Columbia, ensuring streamlined enrollment and expanded care options. Efforts to improve access include expanding Community-Based Outpatient Clinics (CBOCs) and Vet Centers, deploying mobile health clinics, leveraging telehealth, and expanding Community Care. The VA's digital platform stands out for enhancing Veterans' ability to manage their health and benefits, including appointments, communications, prescriptions, vaccine records, and medical updates.

NASDVA applauds the VA's recent initiatives to address mental health and prevent Veteran suicides. Veterans experiencing an acute suicidal crisis can now seek emergency care at any VA or non-VA health care facility at no cost. This includes up to 30 days of inpatient or crisis residential care and up to 90 days of outpatient care. These benefits are available regardless of enrollment in the Veterans Health Administration (VHA). This

expanded access is integral to suicide prevention, providing timely, no-cost care during crises and increasing access for the estimated 9 million Veterans not currently enrolled in VA health care.

The VHA must secure sufficient funding to meet the growing complexity of care for over 9 million enrolled Veterans. Adequate resources are essential to recruit and retain qualified doctors, nurses, and other healthcare professionals. In some cases, it is both necessary and appropriate for Veterans to receive treatment from external providers through Community Care, which currently accounts for 40% of all VA healthcare delivery. However, delays in Community Care referrals and appointments have raised concerns among Veterans, underscoring the need for timely, efficient service. Prompt reimbursement for Community Care services is equally important, as slow payments may discourage healthcare providers from participating. **NASDVA** believes the overarching goal is to prioritize Veterans' well-being and choice while maintaining a healthy balance between in-house VA care and community-based options.

Oral health is an important factor in physical, emotional, psychological, and socioeconomic well-being. VA offers comprehensive dental care benefits to only 600,000+ qualifying Veterans, and dental issues must be directly related to military service to be eligible. A Veteran must typically have a service-connected dental disability, be rated 100% disabled due to other service-related conditions, or be a former POW. Veterans who do not meet eligibility criteria must obtain oral health care outside the VA. For many, this is difficult because of out-of-pocket expenses, travel distance, lack of transportation, or a shortage of dentists in their communities. Maintaining good oral health is directly linked to overall physical and mental health. **NASDVA** supports efforts to expand the pool of Veterans eligible for VA dental care services, which may, in turn, reduce other health care challenges.

NASDVA recognizes that the VA's leadership in telehealth is vital to the overall healthcare delivery system, especially in connecting rural and vulnerable Veterans to essential services. Rural Veterans may face barriers to timely mental health care due to travel distances or limited provider availability. Through collaborative outreach, we can help bridge gaps in mental health care access for rural populations, American Indian/Alaska Native communities, and other underserved minority communities.

Women Veterans are the fastest-growing cohort, comprising over 11% of the overall Veteran population and over 900,000 enrolled in VA health care. These numbers underscore the need to continue emphasizing their eligibility for the full range of Federal and State benefits, including robust health care programs. **NASDVA** applauds the placement of Women Veterans Program Managers (**WVPM**s) at medical centers to coordinate a full range

of specialized health care for women Veterans, including primary care, gynecological services, maternity care, and mental health services tailored to their needs. Key services should include Pap smears, mammograms, menopause care, reproductive health, gender-specific prosthetics and sensory aids, and mental health care to address depression and anxiety linked to Military Sexual Trauma (MST).

NASDVA applauds the Memorandum of Understanding (MOU) between the VA and the U.S. Department of Health and Human Services' Indian Health Service (IHS), which aims to increase access and improve the quality of health care and services for eligible American Indians and Alaska Natives. Native American Veterans on their tribal lands are chronically underserved and would prefer care from IHS, with the VA reimbursing IHS. This appears to be a working model and should be continued. This is especially true on large tribal lands and in Alaska, where distances are vast. We are aware that some Veterans are dual users of IHS, VA tribal health, or both. This allows the Veteran to choose the most convenient option for their care. Should there be a government shutdown, IHS should continue, as the VA does with medical care for our Tribal Veterans. Veterans in Island Territories have had significant issues with earned services and support due to their isolation. During natural disasters, such as hurricanes, the VA can often be the only available provider. During any catastrophic event, NASDVA recommends that all Veteran categories be accepted for urgent medical care.

STATE VETERANS HOMES

The ***State Home Construction Grant Program*** is the largest and most cost-effective partnership between the Federal and State governments. There are **175** State Veterans Homes (SVH) that provide more than 50% of total VA long-term care across the 50 States and the Commonwealth of Puerto Rico. These homes provide vital services to elderly and disabled Veterans, with over 30,000 authorized beds for skilled nursing, domiciliary, and adult day health care.

NASDVA and the **NASVH** (National Association of State Veterans Homes) maintain a strong, collaborative relationship. Both support continued funding for VA's grant program, the largest among the Federal and State VAs. The VA provides up to 65% of the cost of construction, rehabilitation, and repair, with States required to provide at least 35% in matching funds. The FY2026 Priority List includes 80 Priority Group 1 projects for which States have already secured matching funds, totaling approximately $1.25B in federal share. However, Congress appropriated $275M, which will cover only the first six of the pending projects. As Veterans' needs for long-term care services continue to rise, funding must increase to catch up and ultimately eliminate the backlog of pending requests.

Congress should appropriate at least **$600 million** in FY 2027 for this program to fund about half of the pending Priority Group 1 requests.

NASDVA also has concerns about behavioral health and the future incidence of PTSD, TBI, and other conditions among the aging Veteran population. While war-related traumas lead to PTSD in younger OEF/OIF Veterans, aging Veterans can be exposed to late-life traumas that can lead to the onset of PTSD or trigger reactivation of pre-existing PTSD. VA has limited care options for Veterans with a propensity for combative or violent behavior, and we have a responsibility to serve this population. NASDVA and NASVH recommend a new Grant Per Diem scale that reflects the staffing intensity required for psychiatric beds and medication management. SVH and VA Community Living Centers are unable to serve intensive-care psychiatric patients, resulting in a lack of step-down capacity in the community. This level of care is critically needed. VA is responsible for specialty care for Veterans in SVH, particularly when the care is in response to a service-connected condition. Often, when coverage requires specialized healthcare services such as psychiatric care, the VA does not cover the cost. Psychiatric services are outside the scope of primary care provided to SVH residents; however, they should be treated as allowed specialty care, similar to cardiology and urology.

The nationwide shortage of direct-care providers, including doctors, RNs, LPNs, and CNAs (Certified Nursing Assistants), is well documented. Fewer health care professionals are being recruited, and providers are leaving the workforce or retiring in large numbers. The national competition among providers is creating an untenable situation, worsened by burnout among nursing professionals due to the rigors of care and by the salaries offered by large, well-financed hospital groups. Maintaining the resident census at SVH is difficult amid chronic staff shortages that are projected to continue, resulting in fewer Veterans being served and providers unable to cope with financial losses from lower reimbursement rates tied to a lower census. Thus, vulnerable Veterans in need of care are being denied access because of insufficient staff and the inability to meet demand.

NASDVA and **NASVH** appreciate VA's ***Nurse Recruitment and Retention Grant Program,*** which promotes the hiring and retention of nurses. However, it applies only to RNs, LPNs, Licensed Vocational Nurses, and CNAs. Expanding the program to cover other critical staffing vacancies, such as physicians, physical and occupational therapists, dietitians, and social workers, could help SVH compete with private-sector employers that offer higher salaries and benefits. Expanding the program to additional clinical roles would increase the number and quality of providers needed to care for aging veterans. Congress should expand the Nurse Recruitment & Retention Grant Program to allow SVHs to use

these grants to address other hard-to-fill hiring and retention challenges, including dietitians, recreation therapists, and other support functions that impact activities of daily living (ADL).

VA is authorized to cover up to 50% of care costs through a per diem rate for residents receiving care at SVH. However, current basic rates cover less than a third of costs. Factors such as labor costs in a competitive environment, higher pharmaceutical costs, rising food costs, unfunded mandates, and overall medical inflation have diminished the value of per diem. Honorably discharged Veterans are eligible for a daily VA per diem payment. The FY2025 rates are as follows: Nursing Care $148.71 per veteran per day; Adult Day Healthcare $118.48 per veteran per visit; and Domiciliary Care $64.19 per veteran per day. Both NASDVA and NASVH recommend a new Grant Per Diem scale; the rates need to be increased. Veterans with a service-connected disability rating of 70% or higher are eligible for no-cost nursing care at the SVH. However, VA does not pay for high-cost medications for this cohort. Certain medications, such as chemotherapy, can cost thousands per month. Community contract nursing homes with the VA are reimbursed when these costs exceed a certain percentage (typically 8.5%) of the per diem rate. Bipartisan legislation, the ***Providing Veterans Essential Medications Act (H.R. 1970)***, has been introduced to require VA to reimburse State Veterans Homes for high-cost medications, similar to the arrangement many private contract nursing homes currently have with VA, to ensure that seriously disabled Veterans have the choice to spend their final years in an SVH with VA paying for their high-cost medications.

VA's ***Geriatrics and Gerontology Advisory Committee*** was established to advise the VA Secretary on all matters related to geriatrics and gerontology, including long-term care programs and policies that affect SVHs. The committee can also provide recommendations on the procedures and policies that govern SVHs. It would be beneficial for the committee to include a *"voting"* member who is a licensed nursing home administrator currently serving as an SVH Administrator or in a supervisory role over SVHs. Legislation has been introduced, and Congress should pass the ***Representing Our Seniors at VA Act of 2025 (H.R. 785)***, which requires that at least one member of the committee represent NASVH's perspective.

NASDVA and **NASVH** recommend that the SVH conduct a single annual VA survey acceptable to CMS. SVHs undergo an annual VA inspection survey that reviews clinical practices and life-safety protocols, as well as a financial audit. Many SVHs are also CMS-certified and undergo a separate CMS inspection survey to qualify for CMS reimbursement. The CMS inspection survey is nearly identical to the clinical and life-safety sections of the VA survey. The VA inspection survey also covers domiciliary and adult day health care

programs at SVH. Legislation would ensure that VA and CMS retain their oversight, enforcement, and compliance tools, enabling veterans to continue receiving safe, high-quality care while residing in SVH. The ***State Veterans Homes Inspection Simplification Act*** (***S. 3532)*** would allow homes to undergo a single annual inspection survey conducted by VA that is acceptable to CMS. Bottom line, this bipartisan legislation benefits SVHs and taxpayers without diminishing care for Veteran residents.

MEMORIAL AFFAIRS

NASDVA applauds the Veterans Cemetery Grant Program (VCGP) of the National Cemetery Administration (NCA), a collaborative partnership with States, Territories, and Tribal governments. It is the second-largest VA grant program for States. The **124 VCGP**-funded cemeteries complement NCA's 158 national VA-managed cemeteries for Veterans and their families, expanding access to memorial benefits that meet "*shrine*" standards. Importantly, the program supports NCA's goal of increasing access to burial options for more than 94% of all Veterans within a 75-mile radius of their home county. In FY2025, grant-funded cemeteries accounted for more than 43,705 of the total 174,705 NCA and VCGP interments, representing **25%**.

Since the program's establishment in 1978, VA has awarded more than $1.1 billion in grants to establish, expand, improve, operate, and maintain 124 Veterans cemeteries in 47 States, 14 Tribal trust lands, and 3 Territories (Puerto Rico, Guam, and Saipan). The latest grant, $16.7 million, will establish the Interior Alaska Veterans Cemetery in Fairbanks. The cemetery will serve more than 12,000 Veterans and their eligible family members. This will be Alaska's first state Veterans cemetery. The recently published FY2026 Priority List of program pre-applications is as follows:

- Priority Group 1 - Expansion or Improvement, 14 pre-applications totaling more than $45.7 million, needed to avoid disruption of burial services within 4 years of the pre-application date and to benefit 1,979,509 veterans in the area served by the cemeteries.
- Priority Group 2 - Establishment of New Cemeteries, 18 pre-applications totaling more than $175.1 million, benefiting an additional 121,182 veterans in new cemeteries.
- Priority Group 3 - Expansion or Improvement for Projects with more than 4 years of depletion, 7 pre-applications totaling more than $34.4 million, and benefiting 630,665 veterans in the area served by the cemeteries.

- Priority Group 4 – Operations and Maintenance or Other Improvements, with 11 pre-applications totaling over $27.1 million.

The total **VCGP** need is **$282.3 million**; however, the FY2026 budget proposal is **$150 million**. This amount is sufficient to address Priority Group 1 (Expansion and Improvement) pre-application projects, but will not cover the full need for Priority Group 2 to establish new veterans cemeteries. It is difficult for States to budget for land acquisition and set aside funds for a new cemetery only to remain in Priority Group 2 year after year, while existing, aging Group 1 cemeteries need expansion or improvement. There are insufficient funds available for the remainder of Priority Group 2 and for all of Priority Groups 3 and 4; thus, **NASDVA** recommends that FY2027 remain at the **$150 million** level.

NASDVA also recommends that the FY2026 budget fund the plot allowance at $1,002 and authorize it for eligible family members. The President's budget submission proposes expanding this benefit: "Expand plot allowance for certain individuals eligible for interment in a national cemetery: The proposal would amend 38 U.S.C. § 2303 to provide plot or interment allowances to VA grant-funded State and Tribal Veterans' cemeteries for interments of certain individuals eligible for interment in national cemeteries. This proposal aligns eligibility for the plot allowance in grant-funded cemeteries with eligibility criteria for interment in national cemeteries."

Extending plot allowance funds to Veterans' spouses and eligible family members would help offset higher operational costs across all VCGP cemeteries. It would also allow States to avoid charging for burial services, thereby maintaining parity with National Cemeteries, where family members are not charged. Currently, States cover operational costs by charging either the equivalent plot allowance or a flat fee. This would address the inequity between the federal and state systems.

The ***Burial Equity for Guards and Reserves Act*** was incorporated as Division CC of Public Law 117-103 (The Consolidated Appropriations Act for FY2022). The VA Office of General Counsel determined that the law allows VCGP-funded cemeteries to inter certain "non-veteran" individuals; however, it does not compel such interments. Those who elect to do so must bear the costs of the headstone and outer burial container or niche cover. Because there will be no plot allowance to help cover the interment costs, the state VCGP cemeteries will need to appropriate additional funds. This creates an inequitable situation between Veterans and Non-Veterans who receive full memorial benefits and are interred in the same cemetery. Although the number of those without federal active-duty service who qualify as "Veterans" is small, it is desirable for States and Tribal governments to provide interment. Local appreciation and respect for Guard/Reserve members who respond to

natural disasters in the community are strong. The average citizen is unaware of differences in eligibility and simply views military members as worthy of the same memorial honors.

In summary, **NASDVA** strongly supports the FY2026 VCGP budget proposal of **$150 million** and urges that the FY2027 budget remain at that level. The budget also codifies the **$1,002** Plot Allowance for Veterans and, importantly, authorizes the **Plot Allowance** for Spouses and Eligible Family Members.

VETERANS BENEFITS SERVICES

NASDVA applauds VBA's record-breaking FY2025 performance, processing more than 3 million disability and compensation claims, surpassing the previous high of 2.49 million set in FY2024. As a result, Veterans and their dependents received more than $195 billion in disability C&P benefits. VBA has been transparent in its up-to-date reporting on claims inventory, backlog, accuracy, and fully developed claims. Claims processing accuracy improved to 93.5%, and the backlog was reduced by more than 57%.

NASDVA is concerned about the lengthy backlog of appeals before the Board of Veterans' Appeals (BVA). This backlog comprises approximately 200,000 pending cases, while the BVA can reasonably adjudicate only about 120,000 cases annually. Veterans now routinely wait three or four years for a BVA decision. The bipartisan ***Veterans Appeals Efficiency Act of 2025 (H.R. 3835/S.1992)*** proposes several amendments to the process, including expanding the jurisdiction of the United States Court of Appeals for Veterans Claims (CAVC) and allowing the BVA to aggregate Veterans' appeals involving common questions of law or fact. **NASDVA** urges passage and enactment of the full slate of fundamental improvements in this bipartisan legislation during the 119th session.

To further reduce the appellate backlog, **NASDVA** encourages VBA to restore a crucial feature of its prior collaborations with State and Territorial Veterans Service Officers (VSO): a 48-hour pre-decisional review period before issuing a decision, during which the Veteran's representative could examine the proposed decision and identify any errors of law or fact. This pre-decisional review period was a hallmark of VBA's collaborative relationship with VSO, helping prevent errors before the decision letter reached the Veteran and avoiding lengthy, time-consuming, and costly appeals sparked by simple errors that VBA could address and correct. **NASDVA** would like to see this collaborative process return, as it will benefit both the nation's Veterans and the VA by reducing errors, increasing satisfaction, lowering costs, and improving efficiency.

NASDVA recognizes and appreciates that VBA has implemented a "Claim Accuracy Request" (CAR) pilot program in lieu of the 48-hour review period. However, the CAR pilot falls far short of the value the 48-hour review period once provided. For instance, the CAR pilot categorically excludes several types of claims, including *Nehmer* claims for Vietnam War Veterans exposed to Agent Orange. The previous 48-hour pre-decisional review process imposed no such exclusions. VBA also rejects CARs when a VA decision assigns a rating percentage lower than the schedule of ratings supports. This means an advocate cannot use a CAR to point out that the evidence of record meets the criteria for a higher rating. The advocate is therefore forced to resort to the longer, slower appellate processes to get such matters reviewed, leaving the Veteran frustrated. Again, none of these restrictions existed under the previous 48-hour pre-decisional review process. **NASDVA** encourages VBA to restore the 48-hour pre-decisional review period to improve the accuracy of claims decisions, reduce the BVA backlog, avoid unnecessary duress for Veteran claimants, enhance the efficiency of VBA's procedures, and maintain collaboration between VBA and VSOs across all States and Territories.

NASDVA notes that the most common errors in initial VBA rating decisions often stem from flawed Compensation and Pension (C&P) examinations. Title 38 of the United States Code requires VBA to grant disability compensation if a Veteran proves that a medical condition is "at least as likely as not" caused or worsened by military service. Far too often, VBA receives sufficient medical evidence from a Veteran claimant to meet this standard of proof yet still demands that the Veteran undergo a C&P exam. Furthermore, **NASDVA** observes that too many C&P exams are conducted by medical professionals who are not specialists in the field relevant to the Veteran's condition, leading to incorrect findings and inaccurate decisions that, in turn, contribute to the BVA backlog described above. For example, a C&P exam for PTSD conducted by urologists, a C&P exam for Parkinson's disease conducted by general practitioners without any neurological specialty, and a C&P exam for orthopedic conditions conducted by endocrinologists. **NASDVA** urges VBA to conduct a comprehensive review of its C&P exam process and, based on the review's results, revise its procedures to improve efficiency and effectiveness. In the interest of full procedural transparency and accountability, **NASDVA** also urges VBA to publish its contracts with all private-sector companies that conduct C&P examinations, ensuring that all Veterans and their advocates fully understand the expectations and standards to which C&P examiners are held, as well as the payment scales and payment processes for these companies.

NASDVA applauds VBA's tremendous efforts in adjudicating the historically large number of claims filed by Veterans and Military Families following the enactment of the

Honoring Our PACT Act of 2022. This life-changing legislation opened the door for an unprecedented number of Veterans to receive long-overdue medical and financial benefits for illnesses related to toxic exposures incurred during military service. **NASDVA** notes, however, that this vital mission of justice for Veterans suffering from toxic exposures related to their military service is not yet complete. For example, VBA has acknowledged that Veterans who served at Fort McClellan in Alabama, the longtime training ground of the U.S. Army's Chemical Corps and the Chemical/Biological/Radiological Agency, may have been exposed during their service at this base to radioactive compounds, chemical warfare agents, and airborne polychlorinated biphenyls (PCBs). Nevertheless, VBA repeatedly declines to recognize a presumption linking service at Fort McClellan to the medical conditions commonly associated with the exposures that VBA itself acknowledges occurred there.

NASDVA has observed this pattern in other locations and with other toxins. Panama, for instance, is not included in the ***PACT Act***, yet our members have worked with many Veterans who served in the Panama Canal Zone during the 1980s and were exposed to the remnants of toxic herbicides, including Agent Orange, as well as toxic pesticides mixed with diesel and sprayed from trucks. Numerous reports and testimonies confirm the presence and storage of Agent Orange in Okinawa during and after the Vietnam War, especially on and around military installations such as Kadena Air Force Base and Marine Corps Air Station Futenma. Yet VBA still declines to recognize a presumption of toxic exposure for Veterans who served during the Vietnam War in these areas of operation. Abundant reports verify the presence of Agent Orange along the Korean Demilitarized Zone (DMZ) during the Vietnam War, but VBA recognizes a presumption of Agent Orange exposure only for Veterans who served at the DMZ between the limited timeframe of September 1, 1967, and August 31, 1971. In Cambodia, where the United States Armed Forces sprayed Agent Orange and other tactical herbicides throughout the Vietnam War to disrupt enemy supply lines, VBA's presumption of Agent Orange exposure is even more inexplicably limited, confined solely to April 1969. The ***PACT Act*** accurately recognizes jet fuel (e.g., JP-8, JP-5) as a toxic substance and requires VBA to examine the impacts of jet fuel exposure more closely, yet VBA refuses to find any illness presumptuously linked to this toxic exposure.

NASDVA witnessed this pattern play out over many years as VBA denied any correlation between Agent Orange exposure and the medical conditions linked to it. Later, this history repeated itself with Veterans exposed to toxic water at Camp Lejeune, who were denied benefits for decades until VBA finally recognized the connections between this toxic exposure and medical conditions ranging from adult leukemia to bladder cancer. Even more recently, **NASDVA** advocated for many years on behalf of Veterans exposed to toxic fumes

from burn pits in the Middle East, highlighting medical connections that VBA neglected until the *PACT Act* finally forced these presumptions into existence. This history need not repeat itself. **NASDVA** encourages VBA to study toxic exposures not specifically covered in the *PACT Act* or any other legislation but that have been raised for many years by Veterans' advocates, including, but not limited to, toxic exposures and associated medical conditions related to Fort McClellan, the Panama Canal Zone, Okinawa, the Korean DMZ, Cambodia, and Veterans in all theaters whose service brought them within close proximity to jet fuel. **NASDVA** asks that VBA publish its findings in these areas to ensure full transparency on these important topics, and, most importantly, that VBA move quickly to establish a presumption of toxic exposure and to recognize the medical conditions that such exposure causes in all areas where the research findings warrant such a presumption.

NASDVA applauds VBA for its rapid adoption of the ***VA Home Loan Program Reform Act*** (**HLPRA**) (*Public Law 119-31*) following the termination of the Veterans Affairs Serving Purchase Program (VASP). While HLPRA still does not provide the protections VASP previously offered, the partial claim structure it established offers a useful option for some Veteran borrowers facing financial distress. However, **NASDVA** is concerned about VBA's lack of progress in rulemaking and implementing the HLPRA's terms. VBA has not yet promulgated the regulations necessary to implement these measures. Consequently, the process remains opaque to Veteran borrowers seeking to apply for and use HLPRA's partial claim structure. In helping Veterans navigate the HLPRA system, roadblocks arise from processes that are not yet fully in place. **NASDVA** encourages VBA to complete its implementation of this important program rapidly to bring the provisions described in the HLPRA into full effect.

The ***Major Richard Star Act (H.R. 2102/S. 1032)*** is bipartisan legislation that has garnered substantial support, with over 70% of Congress backing its passage. It clearly warrants enactment. It directly affects over 52,000 combat-injured Veterans who were medically retired with less than 20 years of service. These Veterans are subject to an offset, with their retirement pay reduced "*dollar-for-dollar*" by the VA disability compensation they receive, unlike disabled Veterans who serve more than 20 years. Retired pay is for completed years of service paid by the DoD, while disability compensation is for lifelong injury paid by the VA. These are two distinct payments for two distinct purposes, and reducing retirement pay because of a disability is unjust and, in essence, a "wounded Veterans tax." **NASDVA** strongly recommends that this critical legislation be passed by the 119th Congress for those most deserving disabled Veterans.

NASDVA urges renewed focus on preventing the unscrupulous actions of individuals and groups (Claims Sharks) that violate Title 38 of the United States Code regarding the representation of claimants. This includes, but is not limited to, individuals and groups that claim the ability to represent Veterans before VBA despite lacking accreditation, and individuals and groups that breach federal law by charging fees for the initial preparation, presentation, and prosecution of VBA claims. The reach of these bad actors and the adverse impacts they cause have increased steadily in recent years, leading many Veterans and their families to pay exorbitant fees for minimal services and, as a result, lose significant portions of the benefits they rightfully earned. **NASDVA** recommends greater oversight of this process and stricter enforcement of applicable federal laws. It is not intended to restrain trade or limit the options available to Veterans. **NASDVA** does not advocate eliminating all for-profit actors in this space; it only advocates eliminating those that fail to comply with governing law. **NASDVA** seeks full enforcement of the provisions of Title 38 that Congress passed to protect Veterans from harm these bad actors can perpetrate. For-profit entities must follow the law governing their practices, just as the States, Territories, and VSOs must.

Many standardized forms that VBA requires a claimant to complete and file to receive earned benefits are lengthy and complex. While VBA updates many of these forms frequently, these updates rarely reduce the overall complexity of the paperwork required for a Veteran to file a successful claim. This is especially true for the standardized forms required to prepare, present, and prosecute a claim for non-service-connected pension, a process that sometimes requires a Veteran to complete more than twenty-five pages of paperwork to file the claim. Congress designed VBA's pension system to aid Veterans with low incomes, limited assets, and permanent and total disabilities. As boots-on-the-ground advocates across all States and Territories, **NASDVA** members can provide valuable feedback and ideas to VBA's leadership as they draft the latest editions of their standardized forms, which accomplish the due diligence of a proper claims review while eliminating redundancies and improving ease of access. This will improve the overall efficiency of VBA's processes and enable deserving Veterans to receive the benefits they earned more quickly and accurately.

NASDVA agrees with Secretary Collins' decision to stay the "effective immediately" of the Interim Final Rule (RIN 2900-aAS49) and to continue the comment period through April 20, 2026. The VA stated that the rule was necessary to clarify long-standing interpretations and correct judicial interpretations, specifically citing *Ingram v. Collins*. We are concerned that the VA is amending 38 CFR 4.10 to require that disability evaluations reflect a veteran's "actual functional impairment while on medication or treatment," rather than determining severity without it. Earlier precedent in *Jones v. Shinseki* holds that ratings must not take the ameliorative effects of

medication into account unless VA's schedule of ratings for that specific condition states that the adjudicator may do so. **NASDVA** cannot support any Interim Final Rule that reduces earned benefits simply because a Veteran follows prescribed treatment. Further, **NASDVA** supports efforts to ensure consistency in disability evaluations.

VETERANS HOMELESSNESS

NASDVA appreciates VA's ongoing commitment to ending Veteran homelessness. States remain dedicated to creating and supporting outreach programs that help VA achieve this important goal, particularly by improving the identification of homeless Veterans and bolstering efforts to prevent homelessness. Working with VA at the community level, we are addressing the factors that lead to Veteran homelessness, including medical and mental health challenges, legal concerns, job skills and work history, and affordable housing.

NASDVA urges continued support for specialized homeless programs, including the *Homeless Providers Grant and Per Diem (GPD), Health Care for Homeless Veterans (HCHV), Domiciliary Care for Homeless Veterans (DCHV), Supportive Services for Veteran Families (SSVF), and Compensated Work Therapy (CWT).* Continued collaboration between VA and community groups is essential to provide Veterans with transitional and permanent housing. Factors contributing to Veteran homelessness can be addressed through treatment programs, job training, and case management. Adequate staffing and consistent funding for these initiatives are necessary.

NASDVA commends VA and HUD for their collaboration in increasing the number of Veterans Affairs Supportive Housing (HUD-VASH) vouchers. In high-cost areas, voucher values may be insufficient to secure adequate housing for Veterans, warranting a cost-of-living adjustment tied to the local market to ensure VASH vouchers can cover the cost of affordable housing. Additional attention is needed for older homeless veterans, particularly Vietnam Veterans with disabling injuries or diseases, or who can no longer care for themselves. These Veterans are highly vulnerable and may require long-term care but may not have filed for service-connected disabilities or be able to navigate the system. **NASDVA** recommends that Congress review policy changes to allow these Veterans to use HUD-VASH vouchers for Residential Housing with services. Such a change could broaden access and clarify the distinction between assisted living facilities and skilled nursing facilities.

NASDVA recommends reestablishing a nationwide verification process through which Communities and States may receive federal recognition for their success in ending veteran homelessness. VA joined with HUD community continuums of care (COCs), which

coordinate community-wide services, resources, and expenses to end homelessness. The national Mayoral Challenge to End Veteran Homelessness added municipal efforts, as well as veteran-specific housing operators and advocates. For over a decade, the U.S. Interagency Council on Homelessness (USICH) provided an independent, interagency verification process to confirm that communities met the federal benchmarks. These confirmations were conducted jointly by VA and HUD, creating incentives for local governments, philanthropy, and public systems to sustain coordinated efforts toward "functional zero" or "effectively ending veteran homelessness." In March 2025, a White House directive titled "*Continuing the Reduction of the Federal Bureaucracy"* halted several non-statutory functions across agencies, including USICH's federal verification role. As a result, there is no federal entity validating communities that have met the criteria and benchmarks. **NASDVA** requests and will support legislation to amend Title 38, United States Code, to require the Department of Veterans Affairs to create a federal verification process for States and Communities that have effectively ended veteran homelessness.

SUICIDE PREVENTION

NASDVA and **VA** continue to place strong emphasis on Veteran suicide prevention, yet it remains a crisis, with roughly 17.5 Veteran deaths per day. The entire Veterans community must take on this critical task. The recently released VA "*annual suicide prevention report"* is informative and helpful. It states that the Veteran suicide rate remains twice that of the non-Veteran population. Even with a declining Veteran population, the 2023 suicide rate among non-Veterans was 16.9 per 100,000, while the rate among Veterans was 35.2 per 100,000, more than twice as high.

NASDVA's role is important in engaging community coalitions through the Governor's Challenge and the Mayor's Challenge on Veterans' Suicide Prevention, which can support the VA's efforts. The Governor's Challenge advances a public health approach by bringing together key state leaders to develop strategic action plans focused on preventing Veteran suicide. Teams receive support from the VA and SAMHSA, including technical assistance, consultation with subject-matter experts, and sharing best practices and innovations with other teams nationwide. These VA community-based interventions reach Veterans through multiple touchpoints, cross-agency collaborations, and community partnerships. As the annual report noted, there are Veteran populations that the VA and the Veterans community should consider targeting for prevention.

VA providers should be alert for suicidal warning signs among VA patients, particularly those with cancer, those being treated for mental health conditions or

substance abuse, those with TBI, and women Veterans who have experienced military sexual trauma. Everyone should be attentive to Veterans who are unemployed, have poor job histories, have limited income, are involved with the justice system, and are homeless. Veterans engaging with other Veterans through *"buddy checks"* can make a difference. Importantly, data indicate that 70% of Veterans who take their own lives do not engage with the VA. While access to VA health care has improved, outreach to inform Veterans about their benefits needs constant emphasis. Engaging Veterans in VA health care saves lives. As the annual report stated, VA officials said, "the findings indicate a need to ensure that suicide prevention resources are integrated throughout VA and in Communities," and "the importance of a public health approach to preventing suicide among Veterans cannot be overstated." **NASDVA** members can lead at the community level in the States and Territories through an "all hands-on deck" approach to outreach and help fight this complex problem.

TRANSITION ASSISTANCE PROGRAM (TAP)

The Department of Defense reports that approximately 200,000 Service Members (SM) leave the military each year and transition to civilian life. They face challenges in employment, education, finances, housing, health, and new relationships. **NASDVA** strongly encourages transition programs to support success during this stressful period. These programs are important for emotional well-being and for making a strong start on the next phase of a productive life.

SM are required to attend the multi-day Transition Assistance Program (TAP) at their military installation before separation or retirement. Spouses are also encouraged to attend as appropriate. TAP is a mandated, standardized workshop across all services and components, primarily delivered by the Department of Defense and VA. It focuses on earned benefits, employment opportunities, and education. Depending on the SM's plans, the TAP process may be inadequate to meet individual needs, and the volume of information can be challenging to absorb. As a result, many view TAP as something they need to get through to leave the service rather than a helpful resource. Regardless, **NASDVA** recommends increased emphasis on mandatory TAP participation.

It is often challenging for Transitioning Service Members (TSM) to connect with available earned State services, benefits, and support. Likewise, it is difficult for States to inform service members about these benefits and services, especially in their new communities. This lack of connectivity between TSM and the States creates significant barriers to employment and increases the mental stress associated with their transition. NASDVA applauds the recent change that allows pre-discharge documents to provide for

"opt-out" (instead of "opt-in") for the sharing of email addresses and contact information with the States. States are uniquely positioned to provide critical information that helps TSM access earned Federal and State services, benefits, and support. Post-service contact information on the electronic DD Form 214 discharge remains important for engaging and informing those retiring or separating service members with the States and community-based organizations.

NASDVA applauds the VBA's coordination and efforts to include a 45-minute instructional block in its 8-hour curriculum, enabling representatives from the States and VSOs to participate. We believe this important initiative by the VBA Under Secretary allows SDVA and VSOs to provide information on additional services and benefits available to those staying in their current location or relocating, further enabling TSM to make the best decision about their post-service careers. Ultimately, an effective TAP, across all partners at the federal, state, and local levels, makes a significant difference in helping the Veteran and their family experience a smooth transition.

CONCLUSION

NASDVA respects the important work Congress has done and continues to do to improve the well-being of our nation's Veterans. As stated, we are "government-to-government" partners (Federal-to-State) and are second only to the federal VA in delivering earned benefits and services to those who have served our great country, particularly through State Veterans Nursing Homes and State Veterans Cemeteries. State VA agencies serve as a vital link to Veterans where they live. We are an integral part of the "whole of government" in serving our nation's Veterans, their families, Caregivers, and Survivors. With your continued support, we can ensure that the needs of our Veterans remain a national priority. In doing so, we fulfill the promise to take care of those who "have borne the battle" and demonstrate a commitment to the nation's future Veterans.