STATEMENT OF
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DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
U.S. HOUSE OF REPRESENTATIVES
ON

PENDING LEGISLATION

June 12, 2025

Chairwoman Miller-Meeks, Ranking Member Brownley, and other Members of the Subcommittee, thank you for inviting us here today to present our views on several bills that would affect VA programs and services. Joining me today is Dr. Ilse Wiechers, Deputy Executive Director, Office of Mental Health.

H.R. 785 Representing our Seniors at VA Act

This bill would amend 38 U.S.C. § 7315(a), which generally requires VA to establish a Geriatrics and Gerontology Advisory Committee (the Advisory Committee). The bill would require consultation with the President of the National Association of State Veterans Homes (NASVH) with respect to matters concerning such association. It would further require the Advisory Committee to include one representative of NASVH who holds a professional license in nursing home administration.

VA supports the intent of this bill but cites concerns.

VA fully supports the participation of a NASVH representative on the Advisory Committee, but we do not believe this bill is necessary because, in 2024, VA appointed a member of NASVH to the Advisory Committee. We also believe the bill, as written, creates unnecessary ambiguity regarding who (the Secretary or the Under Secretary for Health) is consulting with the President of NASVH and on what issues (on appointment of members generally, only on matters concerning NASVH, or on the appointment of members concerning NASVH).

We caution that legislating membership of the Advisory Committee could restrain VA's ability to adapt to evolving circumstances in the future. We also have concerns with the language that would apparently subject the appointment of all members of the Advisory Committee, at least with respect to matters concerning NASVH, to the consultation requirements of the NASVH President. While the term consultation is not

defined, this could constrain the Secretary's authority to appoint members and would be inconsistent with other laws regarding Federal Advisory Committees.

VA revised the Advisory Committee's charter in 2024 to permit the Secretary to appoint a representative; the bill would restrict the Secretary's appointment flexibility to a NASVH representative whose skill sets may not provide the best fit for the Committee given its membership composition.

VA does not believe this bill would result in any appreciable costs.

H.R. 1404 CHAMPVA Children's Care Protection Act of 2025

This bill would amend 38 U.S.C. § 1781 to allow a child to be eligible to receive medical care benefits under VA's Civilian Health and Medical Program (CHAMPVA) until the age of 26. VA's CHAMPVA program is primarily for dependent spouses and children of certain Veterans, provided they do not qualify for Department of Defense's (DoD) TRICARE program for dependents. In the absence of a CHAMPVA-specific definition, CHAMPVA relies on the definition of "child" that is codified in 38 U.S.C. § 101 and applicable to other VA benefits available to a child. Generally speaking, a child reaches the age of majority when the child attains 18 years of age. Some exceptions exist, namely for a child who, before attaining the age of majority, became permanently incapable of self-support, or who after reaching the age of majority is pursuing a course of instruction at an approved education institution up until the age of 23 years.

VA does not support this bill.

VA is not subject to the Patient Protection and Affordable Care Act (PPACA), as CHAMPVA is not a health insurance plan. Rather, it is a medical care benefit grounded in statute. No provision of the PPACA amends the title 38 definition of "child" which states that the age of majority is 18. Because CHAMPVA operates like a health insurance plan, there has been a lot of confusion and disputes over who can be covered.

This bill would extend a child's eligibility for CHAMPVA up until the age of 26, thereby aligning the age criterion for CHAMPVA eligibility with that applicable to health insurance dependent care coverage consistent with the PPACA. It would, however, be a greater benefit than found in plans covered by the TRICARE Young Adult Program because this extended eligibility would be regardless of a child's marital status.

CHAMPVA is required by law to provide medical care to CHAMPVA beneficiaries in the same or similar manner as that which is provided to TRICARE dependents, and subject to the same or similar limitations as TRICARE. TRICARE provides premium based (to offset the cost to DoD) extended medical coverage for a young adult up until the age of 26 (provided the child is unmarried and meets certain other requirements such as ineligibility for employer-sponsored health insurance based on the young adult's own employment). Nonetheless, an unmarried child between the ages of 18 and 23 who

is pursuing a course of instruction at an approved educational institution is eligible for CHAMPVA medical benefits only up until the child's 23rd birthday. VA believes this benefit coverage up to age 23 is sufficient for our beneficiary population. VA is also concerned that the bill would require resources that could otherwise be used to support patient care.

The Department does not currently have a cost estimate for this bill; however, by providing coverage to dependents up to the age of 26 under CHAMPVA, this bill would significantly increase costs for VHA.

H.R. 2068 Veterans Patient Advocacy Act

This bill would amend 38 U.S.C. § 7309A to require VA to ensure that rural Veterans may access the services of patient advocates, including, to the extent practicable, with respect to assigning patient advocates to rural community-based outpatient clinics. VA would have to implement this requirement within two years of enactment. Not later than two years from enactment, the Comptroller General would have to submit a report to Congress evaluating this implementation.

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

Over the last few years, the role of the patient advocate has expanded because of the enactment of the Comprehensive Addiction and Recovery Act of 2016 (P.L. 114-198), the VA MISSION Act of 2018 (P.L. 115-182), the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020 (the Isakson-Roe Act; P.L. 116-315), the Veterans COMPACT Act of 2020 (P.L. 116-214), and the Honoring our PACT Act of 2022 (P.L. 117-168).

VA's goal is to ensure the Patient Advocacy Program is responsive to Veterans' needs based on evidence of what those needs are and strongly recommends continued examination of data analytics from VA facilities to determine how best to proceed in this area. Currently, Veterans can contact a local patient advocate by phone at their local VA medical facility, including in rural areas. Veterans who wish to speak with someone in person can contact the Nursing Supervisor (or designee) to listen to and address their needs. VA also provides Nationwide service through the Ask VA online platform, which allows Veterans to access patient advocacy services at any time; the VA Hotline (855-948-2311) also remains available 24 hours a day, 7 days a week. Hotline staff document concerns and refer them to local patient advocates for review and resolution. VA believes these current options are sufficient to address patients' needs.

While the bill would provide VA 2 years to implement, it would also require the Comptroller General to report within 2 years of enactment on VA's implementation. Given the time it takes to draft and publish a report, the Comptroller General's report could very well reflect information that does not reflect VA's progress by the implementation deadline.

VA does not currently have a cost estimate for this bill.

H.R. 2148 Veteran Caregiver Reeducation, Reemployment, and Retirement Act

Section 2 of the bill would amend 38 U.S.C. § 1781, which authorizes the CHAMPVA program, to allow VA to provide medical care under CHAMPVA to designated primary family caregivers eligible for CHAMPVA during the 180-day period following the removal of such designation unless the individual was dismissed from the program for fraud, abuse, or mistreatment. Notwithstanding any other provision of law, individuals would not be eligible during this 180-day period if they were entitled to hospital insurance benefits under Part A of the Medicare program during that period.

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

Primary family caregivers provide extensive and direct care and support for Veterans with service-connected disabilities; many often face significant constraints that limit their ability to maintain regular employment and, consequently, employer-sponsored health insurance. The 180-day extension of CHAMPVA benefits, as proposed in this bill, would allow these caregivers a necessary transitional period to seek alternative health coverage without facing an abrupt interruption in their medical care.

VA does not have a cost estimate for this section.

Section 3 of the bill would make several amendments to 38 U.S.C. § 1720G, which generally establishes the Program of Comprehensive Assistance of Family Caregivers (PCAFC) under subsection (a). Specifically, section 3(a) of the bill would add a new subsection (e) to § 1720G regarding employment assistance for individuals designated as a primary provider of personal care services under the PCAFC. VA would have to provide to such individuals reimbursement of fees associated with certifications or re-licensure necessary for such employment; no-cost access to VA training modules for purposes of gaining credit for continuing professional education requirements; and, in consultation with DoD and the Department of Labor (DoL), access to employment assistance under DoD's Military OneSource program, DoL's Veterans' Employment and Training Service if they are eligible, and such VA programs as VA determines appropriate. Such individuals would have access to this assistance while participating in PCAFC and during the 180-day period following the date on which the individual is no longer participating in PCAFC, unless the individual was dismissed for fraud, abuse, or mistreatment. The maximum lifetime amount that could be reimbursed for an individual for fees associated with certifications or re-licensure necessary for employment would be $1,000.

Section 3(b) would amend the benefits available to primary family caregivers to allow VA to use agreements (instead of only contracts) for financial planning services (including retirement planning services) and legal services. It also would make such assistance available during the 180-day period following the date on which the primary family caregiver is no longer participating in PCAFC, unless the family caregiver was dismissed for fraud, abuse, or mistreatment, such instruction, preparation, training, and support as VA considers appropriate to assist the caregiver in transitioning away from caregiving.

Section 3(c) would further amend the benefits that could be furnished through contracts or agreements to include assistance returning to the workforce upon the discharge or dismissal from PCAFC unless the family caregiver was dismissed for fraud, abuse, or mistreatment.

Section 3(d) would expand the counseling available to family caregivers (not just the primary family caregiver) to include bereavement counseling and support following the death of the eligible Veteran.

Section 3(e) would require VA, in partnership with DoL and no later than 1 year after enactment, to complete a study on the feasibility and advisability of conducting a returnship program for individuals who are or were designated as a primary family caregiver to assist such individuals in returning to the workforce. Not later than 180 days after completing this study, VA would have to submit a report to Congress on the study.

Section 3(f) would require VA, not later than 1 year after enactment, to complete a study on barriers and incentives to hiring individuals who were primary family caregivers at VA facilities to address staffing needs. Within 180 days of completing this study, VA would have to submit a report to Congress on the study.

VA supports this section in general, subject to the availability of appropriations, but cites concerns.

VA appreciates the Committee's interest in expanding support for caregivers of Veterans by offering assistance when they transition out of Caregiver Support Programs and into the workforce or retirement. VA also appreciates the ability to provide bereavement counseling after a Veteran dies, as this loss can be especially difficult for family caregivers who have dedicated their lives to caring for the Veteran.

VA supports some of the requirements under section 3; however, we do have concerns with certain provisions and would appreciate the opportunity to speak with the Committee to address them. We also recommend meeting with DoL as well.

VA does not have a cost estimate for this section.

Section 4 of the bill would require the Comptroller General to submit to Congress a report assessing VA's efforts to support family caregivers under the PCAFC in transitioning away from caregiving, either by assisting those individuals with retirement planning or returning to work.

VA defers to the Comptroller General on this section.

VA does not have a cost estimate for this section.

Section 5 of the bill would require VA, in consultation with the Department of the Treasury and the heads of other relevant entities, to submit to Congress a report on the feasibility and advisability of establishing an individual retirement plan (as defined in section 7701(a)(37) of the Internal Revenue Code of 1986, or similar retirement plans) for family caregivers under the PCAFC or permitting such family caregivers to join an already established pathway to retirement savings.

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

Providing a pathway to retirement savings acknowledges the critical role that family caregivers play in the health and well-being of Veterans. It also demonstrates a commitment to supporting those who make substantial personal and financial sacrifices in the service of their loved ones. We appreciate the intent behind this section, but it would not grant VA any new authority. VA can already work with the Department of the Treasury and other entities to better understand the feasibility of establishing individual retirement plans for family caregivers under PCAFC. We would appreciate the opportunity to talk with the Committee about its intended outcomes to determine if legislation is needed.

VA does not have a cost estimate for this section, but as this would only require a report to Congress, we do not anticipate any appreciable costs.

H.R. 2605 Service Dogs Assisting Veterans Act (SAVES Act)

Section 2(a) of this bill would require VA, not later than 24 months after the date of enactment, to establish a 5-year pilot program under which VA would award grants, on a competitive basis, to nonprofit entities to provide service dogs to eligible Veterans. Section 2(b) would provide that, to be eligible to receive a grant, nonprofit entities would have to submit to VA an application at such time, in such a manner, and containing such commitments and information as VA may require. Applications would have to include a proposal for the provision of service dogs to eligible Veterans, including how the entity would communicate with VA to ensure an increasing number of service dogs are provided to Veterans; applicants would also have to include a description of training

and services provided by the entity, as well as the qualifications of the entity (including documentation that the entity has experience in training dogs as service animals).

Under section 2(c), VA would have to award a grant to each non-profit entity for which VA has approved an application. VA and the entity would have to enter into an agreement containing such terms, conditions, and limitations as VA determines appropriate. The maximum grant amount VA could award to a non-profit entity under this section would be $2 million. VA would have to establish intervals of payment for the administration of each grant awarded under this section.

Under section 2(d), grantees would have to use the grant amounts to plan, develop, implement, or manage (or any combination thereof) one or more programs that provide service dogs to eligible Veterans. VA could establish a maximum amount for each grant awarded under this section to cover administrative expenses. VA also could establish other conditions or limitations on the use of grant amounts.

Under section 2(e), grantees would have to notify each Veteran that receives a service dog through the grant that the dog is being paid for, in whole or in part, by VA, and they would have to inform such Veterans of the benefits and services available from VA for the Veteran and service dog. Grantees could not charge a fee to a Veteran receiving a service dog through the grant.

Under section 2(f), VA would have to provide to each Veteran who receives a service dog through a grant a commercially available veterinary insurance policy for the service dog, and, if VA provides such a veterinary insurance policy to a Veteran, VA would have to continue to provide the policy without regard to the continuation or termination of the pilot program.

Under section 2(g), VA could provide training and technical assistance to recipients of grants under this section.

Under section 2(h), VA would have to establish oversight and monitoring requirements as appropriate to ensure grants are used appropriately, and VA could take actions as necessary to address any issues identified through the enforcement of such requirements. VA could require each grantee to provide reports or written answers to specific questions, surveys, or questionnaires as VA determines necessary.

Section 2(i) would define terms for purposes of this Act. The term “eligible veteran” would be defined to mean Veterans who have a covered condition. The term “covered condition” would mean any of the following: blindness or visual impairment; loss of use of a limb, paralysis, or other significant mobility issue, including mental health mobility; loss of hearing; posttraumatic stress disorder (PTSD); traumatic brain injury (TBI); and any other disability, condition, or diagnosis VA determines, based on medical judgment, that it is optimal for the Veteran to manage the disability, condition, or diagnosis and live independently through the assistance of a service dog. The term “service dog” would mean any dog that is individually trained to do work or perform

tasks that are for the benefit of a Veteran with a disability, condition, or diagnosis described above and directly related to the disability, condition, or diagnosis of the Veteran.

Section 2(j) would authorize to be appropriated $10 million for each of the 5 consecutive fiscal years following the fiscal year in which the pilot program is established.

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

VA provides benefits for service dogs for eligible Veterans who have been diagnosed with a visual, hearing, or substantial mobility impairment (including mental health mobility) when the VA clinical team treating the Veteran for such impairment determines, based upon medical judgment, that it is optimal for the Veteran to manage the impairment and live independently through the assistance of a trained service dog. See 38 C.F.R. § 17.148(b). VA provides a commercially available veterinary insurance policy for service dogs, as well as payments for travel expenses associated with obtaining a dog if the Veteran is eligible for beneficiary travel under 38 U.S.C. § 111 and 38 C.F.R. part 70 and if pre-approved for such benefits.

While not involving the provision of service dogs, since February 2022, VA has been implementing the Puppies Assisting Wounded Servicemembers for Veterans Therapy Act (P.L. 117-37), which requires VA to conduct a pilot program to provide canine training to eligible Veterans diagnosed with PTSD as an element of a complementary and integrative health program for such Veterans. Service dogs provide essential support for many Veterans.

We appreciate that the bill generally focuses on creating a more direct connection in the legislation between grant funds and the provision of service dogs to eligible Veterans, but we believe this could be clearer. Specifically, in section 2(d), the bill would require grantees to use funds "to plan, develop, implement, or manage (or any combination thereof) one or more" programs that provide service dogs to eligible Veterans. Allowing the use of funds to plan a program that provides service dogs, but which ultimately does not provide service dogs, is not an ideal use of funds. We recommend the bill simply state that grantees would use funds to provide service dogs to eligible Veterans. In VA's experience, Veterans can wait between 1 and 3 years between when a dog has been recommended by VA and when a Veteran has been fully paired with a service dog that has graduated training. VA believes the grants provided under this authority could help increase the supply of service dogs to reduce this delay. In any grant program, but particularly in the case of service dog training, it is essential to ensure that funds are properly used.

Several provisions in the bill raise concerns. First, VA recommends clearly aligning the definition of service dog under this section with VA's existing definition in regulations. Second, VA is concerned about the list of disabilities that was presented in

the bill. Specifically, the inclusion of TBI, for which a Veteran may already otherwise qualify based on having a significant mobility issue, and PTSD, as there is no substantial evidence to date that service dogs provide improvements in functioning and quality of life for Veterans with PTSD as compared to emotional support dogs. VA recommends striking these provisions. We note, similar to the discussion above regarding Veterans with TBI qualifying for a service dog when they have a significant mobility issue, Veterans with PTSD can receive a service dog on the same basis. Further, VA recommends including additional language that would ensure clear authority for the administration of a grant program. Finally, we note that the current bill expands eligibility to all Veterans (presumably those who meet the requirements of 38 U.S.C. § 101), not just Veterans enrolled in VA health care. This would complicate administration of this program.

We also note that this proposal would likely require dedicated staff in a new office to administer this program.

VA does not have a cost estimate for this bill.

H.R. 3400 Territorial Response and Access to Veterans' Essential Lifecare Act (TRAVEL Act of 2025)

Section 2(a) would add a new 38 U.S.C. § 7415, regarding traveling physicians. Proposed section 7415(a) would authorize VA to assign a physician appointed under 38 U.S.C. § 7401(1) to serve as a traveling physician for a maximum of 1 year. Such traveling physician(s) would provide health care to Veterans residing in the territories or possessions of the United States at Department facilities in such territories or possessions (including American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, and any other U.S. territory or possession).

Proposed section 7415(b) would require the traveling physicians to coordinate with non-Department medical providers to the extent necessary to ensure high quality and coordinated care for Veterans receiving hospital care and medical services.

Proposed section 7415(c) would require VA to provide to the traveling physicians, in addition to pay under 38 U.S.C. § 7431 (which generally governs VHA physician pay), a relocation or retention bonus that is substantially similar to one offered under sections 5753 and 5754 of title 5, U.S.C., as the Secretary considers appropriate.

Section 2(b) would make a clerical amendment.

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

VA supports section 2 if amended to modify the current text to reference VA's bonus authority under title 38 and remove the reference to retention bonuses offered under 5 U.S.C. § 5754.

VHA physicians are eligible to receive recruitment or relocation bonuses and retention allowances under 38 U.S.C. § 7410(a), which requires payment of these incentives in a manner consistent with the authorities described in 5 U.S.C. §§ 5753 and 5754. By aligning the incentive authority under 38 U.S.C. § 7410(a), these payments would be excluded from the total compensation limit in 38 U.S.C. § 7431(e)(4). A retention bonus may not be an appropriate incentive mechanism due to the statutory requirement for the agency to determine that an employee is likely to leave Federal service (or to take a different Federal position in limited cases).

Current VA policy in VA Handbook 5007, Pay Administration, allows for the authorization of relocation incentives for temporary workplace changes of 120 days or more, not to include when an employee remains in temporary duty travel status. In accordance with VA Handbook 5007, an employee must also have a rating of record of at least "Fully Successful" for the position held immediately before the temporary workplace change and physically relocate to a different geographic area to receive a relocation incentive. Edits to VA policy may be required to ensure traveling physicians would be eligible for relocation incentives. Service agreements would generally be required in accordance with policy and the proposed legislation as drafted.

VA welcomes the opportunity to work with the Committee on technical assistance to clarify such bonus eligibility and required coordination of care, as well as a technical amendment to clarify the traveling physician would not necessarily provide care in each and every possession or territory.

VA does not have a cost estimate for this bill.

H.R. 3643 VA Data Transparency and Trust Act

Section 2(a) of this bill would amend 38 U.S.C. § 7330B, which required VA to submit a report to Congress, between 2018 and 2022, including three defined elements. These reports were, on average approximately 40-50 pages in length. The proposed amendments would re-establish, for a period of 5 years, and significantly expand these reporting requirements by requiring VA to report on 24 distinct elements, many of which would contain a number of sub-elements. The bill would also require VA to develop and carry out a data sharing system to grant access to researchers who meet certain criteria regarding data security and protection established by VA in regulations. Data access by these researchers would be limited to aggregated, anonymized data for Veterans and individuals receiving health care furnished by VA. VA would have to consider the Centers for Medicare & Medicaid Services Qualified Entity Program (also known as the Medicare Data Sharing for Performance Measurement Program) in developing the new data sharing system. VA would have to ensure that data available through such data sharing system includes each type of data available under the Medicare Data Sharing

for Performance Measurement Program, data on enrolled Veterans, data on health care visits at VA facilities, and data on insurance claims submitted to VA for care furnished at non-VA facilities.

Section 2(b) would create a new section 7735 in title 38, U.S.C., that would require reporting of data in the Annual Benefits Report of the Veterans Benefits Administration (VBA) on 15 elements for similarly detailed data as required by subsection (a) for VHA. Proposed § 7735(b) would establish a similar data sharing system requirement as described above.

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

While VA agrees with the transparency this bill would require, the level of necessary detail would make implementation very complex and resource intensive. Given the nuances of VA operations and data systems, VA recommends the bill focus on the desired topic areas for inclusion in the reports in lieu of mandating specific metrics that may not meet the drafter's intent.

VA also has concerns with a number of the specific reporting requirements in the bill. To satisfy some of these, VA would need additional and regular updates regarding income, education level, and military service for Veterans. Some of the provisions refer to VA as a health insurance plan or as receiving health insurance claims, which are not accurate. VA also recommends clarifying the requirement to provide data on the average amount of compensation paid to Veterans for non-service-connected disabilities; we believe this is intended to refer specifically to benefits under 38 U.S.C. § 1151, which authorizes VA to award compensation for a qualifying disability (as if the disability were service-connected) resulting from hospital care, medical or surgical treatment, or examination furnished by VA; VA may also award compensation if the disability was proximately caused by the provision of training and rehabilitation services provided by VA as part of an approved vocational rehabilitation training, or in compensated work therapy.

Further, VA is concerned about the availability of information technology (IT) systems necessary to facilitate the data exchanges required to satisfy all of the requirements of this bill, specifically with agencies whereby a data sharing exchange platform is not already established with VA. This could require additional time and resources before VA could implement. VA also recommends amending the requirement for data on re-evaluations of disability ratings to begin from the date on which the data are first available. Limitations in existing systems could present challenges in providing requested information more than 25 years old.

As written, this bill would mandate the release of granular data on Veterans' health and benefits to Congress and establish a system allowing eligible researchers to access anonymized individual-level data. While this initiative can hold great promise for fostering innovation and improving the quality of care and benefits for our Veterans, it

also presents significant privacy challenges. While the bill intends to ensure data released would be anonymized, providing the detail required at an individual level makes robust anonymization very difficult. VA recommends the requirement for individual level data be removed, permitting the use of aggregated data that would provide detail without impacting Veterans' privacy. Retaining the individual-level data requirement would necessitate robust access restrictions to prevent users from deanonymizing the underlying data.

VA additionally requests that the bill include wording to acknowledge the expanded data sharing from other Federal agencies that would be required for this level of reporting, including details on income and dependents that would require expansion of data provided by the Department of Treasury.

VA has other technical amendments and comments on this bill.

VA believes this bill would result in significant additional costs, although VA does not have a cost estimate at this time. The resources needed to collect and report these data would divert from health care and benefits delivery.

H.R. XXXX Fisher House Availability Act of 2025

This bill would amend 38 U.S.C. § 1708, which allows VA to furnish certain persons with temporary lodging in a Fisher house or another appropriate facility. Specifically, it would amend § 1708(a) to remove the condition that temporary lodging be in connection with the examination, treatment, or care of a Veteran under chapter 17 or in connection with benefits administered by VA. It would also amend § 1708(b), which defines which persons can receive lodging under subsection (a). It would add two new cohorts, both on a space-available basis: covered beneficiaries that must travel a significant distance to receive care or services at a non-VA facility, and members of the family of a covered beneficiary that provide the equivalent of familial support for such beneficiary. The bill would amend what is currently § 1708(e) (but would be redesignated as subsection (d)) to require that VA's regulations would have to include provisions establishing criteria for persons considered to be accompanying a Veteran or covered beneficiary, and to establish criteria for providing access to temporary lodging facilities on a space-available basis to the two new cohorts of eligible individuals under § 1708(b), as revised. Finally, the bill would define the term "covered beneficiary" to mean a beneficiary under chapter 55 of title 10, U.S.C., other than beneficiaries under 10 U.S.C. § 1074(a), which refers to certain members of the uniformed services (based on the definition of that term in 10 U.S.C. § 1072(5) and 10 U.S.C. § 1074(a)); it would also amend the definition of "Fisher house" to include a reference to the Fisher House Foundation, Inc., as well.

VA supports this bill, subject to amendments.

VA supports allowing Fisher Houses to provide lodging, on a space available basis, to Service members who receive care at VA facilities and their families. VA has

adopted this posture through VHA Directive 1107, Department of Veterans Affairs Fisher Houses and Other Temporary Lodging (October 19, 2023), but current law is ambiguous in this respect, and the bill's proposed changes would not clearly include all Service members who may receive care at a VA facility. We are concerned that if Congress amended current law to include certain individuals, but not all Service members, this could create an adverse inference that providing lodging to other Service members is prohibited by law. We also recommend amendments to ensure the eligibility for lodging for dependents of both Veterans and Service members is the same or comparable.

We also note that the bill has technical issues that need to be addressed, particularly concerning the proposed amendments to section 1708(a), where the bill would refer to removing a phrase that appears in two different places without clearly stating which phase would be amended.

Additionally, we recommend the bill be amended to expressly authorize VA to provide lodging at Fisher Houses to Service members who receive care at VA facilities and their families. VA has adopted this posture through VHA Directive 1107, Department of Veterans Affairs Fisher Houses and Other Temporary Lodging (October 19, 2023), but we are concerned that if Congress amended current law to include other individuals, but not Service members, this could create an adverse inference that providing lodging to Service members is prohibited by law. VA would welcome the opportunity to provide technical assistance to address these concerns.

VA does not have a cost estimate for this bill.

H.R. XXXX Prohibiting Smoking in Facilities of the Veterans Health Administration

This bill would repeal section 526 of P.L. 102-585 and amend 38 U.S.C. § 1715 to prohibit any person (including Veterans, patients, residents, employees, contractors, or visitors) from smoking on the premises of any VHA facility. The bill would prohibit the use of cigarettes, cigars, pipes, and any other combustion or heating of tobacco, as well as the use of any electronic nicotine delivery system, including electronic or e-cigarettes, vape pens, and e-cigars. The prohibition would apply to any land or building that is under VA's jurisdiction, under the control of VHA, and not under the control of the General Services Administration.

VA strongly supports this bill.

Legislation to prohibit smoking on the premises of any VHA facility will ensure that VA can provide a smoke-free health care environment. Currently, there are more than 4,000 local or State, territorial, or commonwealth hospitals, health care systems and clinics, and at least four national health care systems (Kaiser Permanente, Mayo Clinic, SSM Health Care, and CIGNA Corporation) in the United States that have adopted 100% smoke-free policies that extend to all their facilities, grounds, and office

buildings. Absent this legislation, VHA patients, health care providers and visitors may not have the same level of enduring protection from the hazardous effects of secondhand smoke exposure as do patients and employees in these other systems. Currently, approximately 12.7% of Veterans enrolled in VA health care are smokers. Many of the non-smokers are also older Veterans who may be at higher risk for cardiac or other conditions that may make them even more vulnerable to the cardiovascular events associated with secondhand smoke.

As with other health care systems, VA believes its Veteran patients and employees have a right to be protected from secondhand smoke exposure when seeking health care or working at a VA facility. For Veteran smokers who are inpatients, nicotine replacement therapy is available. VA also offers tobacco cessation programs and resources for Veterans and employees. VA notes that it would support an exception for ceremonial uses of tobacco within limited parameters set by the Secretary in coordination with federally recognized tribes, consistent with Indian Health Service tobacco policy. VA recommends including an effective date to facilitate implementation.

VA estimates that this bill would not result in any costs because it is consistent with current policy.

H.R. XXXX Study on RNA Sequencing to Diagnose PTSD in Veterans

This bill would require VA, acting through the Center for Innovation for Care and Payment (CICP) and within 120 days of enactment, to conduct a study to determine whether ribonucleic acid (RNA) sequencing could be used to effectively diagnose Veterans with inflammation or cellular stress, symptoms of PTSD. VA would have to carry out the study in medical facilities in five Veterans Integrated Service Networks (VISN). The study would have to terminate on September 30, 2027. Not later than September 30, 2028, VA would have to submit a report to Congress containing the results of the study.

VA supports the intent of this bill, subject to the availability of appropriations, but cites concerns.

VA supports efforts to expand work in this critical research area. However, VA cites concerns with this proposed legislation because, at the current time, such a study would be premature given the state of the science. There is not sufficient scientific evidence to indicate that clinically useful information would result from such a study. Additionally, we have concerns with codifying research approaches or methodologies, as this bill would do, and we note this research could be conducted with current authority. We also note the timeline for this bill would be too short to produce scientifically valid results. Further, the CICP would not be the appropriate entity to carry out this study. We would appreciate the opportunity to discuss current research efforts in this area and how legislation might support these.

VA does not have a cost estimate for this bill.

H.R. XXXX Providing for a Time Frame for Employment in VA of Participants in the Health Professionals Scholarship Program (HPSP)

This bill would amend 38 U.S.C. § 7616 by adding a subsection (d) to require VA to appoint Health Professional Scholarship Program (HPSP) participants in a full-time clinical position at a VA facility within 90 days of course completion.

VA does not support this bill.

VA agrees with the intent to expedite the employment process for health care professionals. However, VA does not support the bill because it would not allow VA to consider the various hiring considerations inherent in health care occupations or current operational constraints.

The proposed 90-day timeframe does not accommodate the various requirements across health care professions. For instance, certain health care professions necessitate the completion of licensure, certifications, internships, or residencies before the health care professional can be appointed to their respective position. A one-size-fits-all approach does not reflect the variability in preparation and does not align with VA qualification standards across the various health care occupations.

There are many instances in which the hiring of individuals within 90 days of completing HPSP is not possible. For example, VHA Qualification Standards for Physicians require graduates to complete a residency training, approved by the Accreditation Council for Graduate Medical Education, American Osteopathic Association, or other residencies which the local Medical Staff Executive Committee deems appropriate. Once residency training is complete, individuals must pass the United States Medical Licensing Examination or Comprehensive Osteopathic Medical Licensing Examination. Upon receiving licensure, in some cases, VA requires an additional physician board certification for those overseeing medical students or physician residents (including fellows), or faculty status with an affiliated medical school. For registered nurses, VHA Qualification Standards require graduates to pass the National Council Licensure Examination and maintain an active, current, full and unrestricted license. Additionally, VHA Directive 1077, VHA Registered Nurse Transition-to-Practice Residency Program, requires those with one year of professional experience serve in a residency program for one year before they can operate in a full-time clinical capacity position. In each of these examples, VA would be unable to comply with the proposed 90-day hiring requirement due to critical mandatory steps to obtain requisite licensure, certification, and experience.

VA does not have a cost estimate for this bill.

H.R. XXXX VA Mental Health Outreach and Engagement Act

This bill would amend 38 U.S.C. § 1167 related to mental health consultations to clarify that the current subsection (a) would refer only to initial mental health consultations. This statute requires VA, not later than 30 days after the date on which a Veteran submits to VA a claim for compensation under chapter 11 for a service-connected disability relating to a mental health diagnosis, to offer the Veteran a mental health consultation to assess the mental health needs of, and care options for, the Veteran. VA is required to offer such a consultation without regard to any previous denial or approval of a claim for a service-connected disability relating to a mental health diagnosis for the Veteran and to ensure the Veteran offered a mental health consultation can elect to receive such consultation during the 1-year period beginning on the date on which the consultation is offered (although VA can provide a longer time period if appropriate).

This bill would insert a new subsection (b) that would require VA, not less frequently than annually, with regard to a Veteran who is receiving compensation under chapter 11 for a service-connected disability relating to a mental health diagnosis, to offer a mental health consultation to assess the mental health needs of, and discuss other mental health care options for, the Veteran. VA would also have to conduct annual outreach to each such Veteran regarding the availability of mental health consultations and other mental health services from VA. Current subsections (b) and (c) would be redesignated as subsections (c) and (d), respectively.

This bill also would make technical corrections to 38 U.S.C. § 1167 related to mental health consultations to instead be codified at 38 U.S.C. § 1169. It would also make amendments to the table of contents to reflect this change.

Finally, the bill would require the Comptroller General to submit to Congress a report on the effect of the amendments made by this section. This report would need to include the number of Veterans who received mental health consultations under the newly-designated § 1169(b)(1) and outreach under § 1169(b)(2). It would also need to include whether Veterans reported barriers to seeking consultations and such barriers, if any.

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

In particular, VA supports the technical corrections as this would provide clarity to the U.S. Code. However, VA only partially supports the substantive amendments this bill would make, subject to amendments and the availability of appropriations. VA currently offers an annual screening to enrolled Veterans for commonly occurring mental health conditions. Veterans who screen positive receive further evaluation and treatment, if they are willing to engage in care. In the first quarter of FY 2025, 73% of Veterans receiving compensation under chapter 11 for a service-connected disability

relating to a mental health diagnosis were enrolled in VA health care and receive the annual mental health screenings described above.

Instead of requiring annual offers of mental health consultations to those Veterans receiving compensation as described above, VA believes it would be more appropriate only to conduct annual outreach to such Veterans advising them of VA mental health services and how to access them. Veterans who elect to enroll, or to seek care without enrolling (if eligible), would receive a mental health assessment as part of an initial appointment. If mental health needs are identified, the Veteran would also receive information about treatment goals and options. This would connect Veterans directly to existing mental health services, and every VA health care facility must screen Veterans requesting mental health services for urgent needs and immediately address them.

VA would appreciate the opportunity to discuss other technical issues with the Committee regarding current 38 U.S.C. § 1167 (regarding mental health consultations) and section 2068 (regarding mental health consultations for Veterans entering Homeless Programs Office programs). VA has been working to implement these authorities since their enactment, but we believe Congress could facilitate this implementation with additional revisions to these statutes.

VA does not have a cost estimate for this bill.

Conclusion

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