DELIVERING FOR VETERANS AND CAREGIVERS: YEAR ONE OF THE DOLE ACT

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS

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C O N T E N T S

WEDNESDAY, MARCH 4, 2026

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SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS' AFFAIRS,
U.S. HOUSE OF REPRESENTATIVES,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:45 p.m., in room 360, Cannon House Office Building, Hon. Jen Kiggans [chairwoman of the subcommittee] presiding.

Present: Representatives Kiggans, Radewagen, Ciscomani, Self, Ramirez, and Kennedy.

OPENING STATEMENT OF JEN KIGGANS, CHAIRWOMAN

Ms. KIGGANS. Good afternoon, everyone. This subcommittee will come to order.

I would like to welcome everyone to this subcommittee hearing to discuss the implementation of the Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act. This landmark bill, led by House Republicans and my friend Representative Ciscomani from Arizona, made a slew of changes at the U.S. Department of Veterans Affairs (VA) to modernize healthcare delivery, especially for aging veterans.

First, I would like to take a pause and ask that everyone joining us that we keep the servicemembers deployed to the Middle East and in harm's way in our thoughts and in our prayers, as well as the families of the six servicemembers who recently gave their lives.

Today's hearing is about oversight, accountability, ensuring that the promises Congress made to veterans, caregivers, and their families are fully realized. While veterans and their caregivers are beginning to feel the benefits of this legislation, VA and Congress' work is not done. Last year Congress passed with bipartisan support the Dole Act with the goal of improving veterans' access to education, healthcare, and programs designed to prevent and reduce veteran homelessness. This was a sweeping, bipartisan, bicameral package negotiated and supported by members in both the House and the Senate, Democrats and Republicans alike, united by a shared commitment to those who served.

The Dole Act represented one of the most comprehensive veterans reform package in recent years and I was proud to support it. This legislation moves the needle to modernize VA healthcare delivery, strengthen support for caregivers, expand access to education and job training, improve long-term care, address rural

health disparities, and reduce veteran homelessness. It was designed to make systemic improvements, not incremental tweaks across the continuum of care for veterans and their families.

The Dole Act included my Caregiver Outreach and Program Enhancement Act, or COPE Act, which intended to establish a grant program to provide mental healthcare to family caregivers supporting their veteran family members. The COPE Act was meant to recognize that when we care for veterans, we must also support those who care for them. Family caregivers are the backbone of our long-term care system, often sacrificing careers, financial stability, and their own health to support their loved ones.

As a veteran, the daughter of a veteran, the wife of a veteran, and the mom to a future veteran and a healthcare provider, I understand the importance of investing in our veteran communities to improve health outcomes. I understand firsthand the sacrifices military families make and the strain that caregiving can place on spouses and loved ones. That perspective makes oversight of this law not just a policy responsibility for me, but a personal one.

To my dismay, it appears the VA has not followed the congressional intent of the COPE Act yet and, to my knowledge, has not followed many other provisions within the Dole Act. Now I am asking the VA to follow congressional intent and fulfill all statutory promises in the Dole Act, and today we will hopefully get a follow-up and hear about the progress that is being made.

Failure to carry out the will of Congress is unacceptable and I hope my colleagues will be united in demanding accountability from the VA. Passing a bill and having it signed into law is only one part of our job, sometimes the easiest part. The most important part of our responsibility is ensuring that the law is faithfully and efficiently implemented in full alignment with congressional intent on behalf of the veterans and families it seeks to benefit. Oversight is not optional. It Is a constitutional obligation. Today's hearing is about making sure this landmark law does not fall short in execution.

Over a year after enactment, 55 out of 72 sections are currently in progress. The VA says it is on track to implement most sections within the timeframes required, but two on track sections are set to expire in less than a year. Section 106, which would increase access to dental care, is set to end January 2027, and it is my understanding that only one phase of the pilot program has been rolled out. Section 143, which covers ambulance costs for veterans in rural areas, is set to sunset in September of this year. The VA has not fully implemented this provision.

These are not minor provisions. These are real benefits affecting real veterans: access to dental care, emergency transportation in rural communities, and essential services that directly impact health outcomes. When implementation lags and sunset dates approach, veterans are the ones who pay the price.

Another eight sections have been marked as at risk or behind schedule. For example, the Veteran Employment Through Technology Education Courses (VET TEC) Pilot Program to improve short-term training and employment opportunities in specialized high-tech fields is behind schedule, putting implementation at risk.

Congress and this committee are delivering on the promises we have made to the veteran community. The VA needs to mobilize and fully implement the Dole Act. This bipartisan, bicameral package was meant to drive sweeping improvements, not sit in prolonged implementation. Veterans, caregivers, and their families upheld their end of the bargain through service and sacrifice. Congress upheld its end by passing comprehensive reform. Now the VA must uphold its end by executing the law with urgency, transparency, and accountability.

Today, we are not here to relitigate the merits of the Dole Act. We are here to ensure that it succeeds because the true measure of this legislation will not be the vote tally that passed it, but whether veterans on the ground feel the difference in their daily lives. I look forward to hearing from our witnesses about concrete timelines, measurable benchmarks, and the specific steps the VA is taking to ensure that every section of this law is implemented as Congress intended.

I now recognize Ranking Member Ramirez for her opening comments.

OPENING STATEMENT OF DELIA RAMIREZ, RANKING MEMBER

Ms. RAMIREZ. Thank you, Chair Kiggans.

It has been 225 days since our last Oversight and Investigations Subcommittee hearing, so it is critical that we are back finally at dais. A lot has happened since our last subcommittee hearing. Secretary Collins has continued to attack, erode, and disrespect the VA workforce. He has tried to strip away veterans' earned benefits through a cruel Interim Final Rule (IFR), only to be swiftly met with so much opposition from veterans in Congress that he was forced to retreat. We witnessed U.S. Department of Homeland Security (DHS) and U.S. Immigration and Customs Enforcement (ICE) terrorize our communities, including our veterans, and execute one of our neighbors, including Alex Pretti, a VA nurse.

Now the President has started an illegal war with Iran to consolidate power, enrich himself and his donors. He is sending servicemembers into harm's way. I am concerned that because of Secretary Collins' leadership, what is left of VA will not be adequate to meet servicemember needs when they return.

Why am I concerned? Let me tell you why, because Secretary Collins' legacy thus far has been dismantling VA and eroding veteran benefits instead of improving the lives of the veterans we are supposed to be serving. That much is clear from the fact that the VA has not made much progress in implementing the bipartisan Dole Act since it was signed into law over 14 months ago. In defiance of Congress' authority, the vast majority of the law has not been, in fact, implemented, leaving the most vulnerable veterans without the resources that Congress approved for them.

Let us start, for example, veteran homelessness. In the Dole Act, we included bills from my Democratic colleagues that gave VA crucial authorities that communities need to address and end veteran homelessness. We actually increased the Grant Per Diem (GPD) rate and authorized the VA to purchase basic necessities for homeless veterans. Having been the executive director of a homeless service agency myself, I understand that oftentimes organizations

have to do more with less. I know that every resource and every dollar matters when you are trying to provide the best service possible with very limited means.

VA worked with committee staff for over a year to refine the homeless sections of the Dole Act before it was signed into law. The VA assured us that providing these increased resources to community providers and to homeless veterans would be simple as a, quote, "turning on a light switch" once the bill would pass. Under the Biden administration, VA was prepared. Yet under Collins' disappointing, dysfunctional, and delinquent leadership, it has taken over a year to implement the most critical parts of the Dole Act.

Homeless service providers are left receiving a paltry $85 a day to provide transitional housing services to veterans instead of the $128 a day we had actually authorized in the law. Community providers are left with the GPD program—community providers have left the GPD Program in droves while they waited for the relief promised by Congress. Those exits create service gaps that are impacting our veterans every single day.

Communities view VA Undersecretary Collins as an unreliable partner in the fight to end veteran homelessness and, frankly, I agree with them. Due to his delays, homeless veterans are also left without access to their basic needs, another critical resource Congress authorized in the Dole Act. We gave VA the authority to use funds to be able to pay for food, for shelter, for clothing, for transportation for homeless veterans to get to and from job interviews or for medical appointments. Every single day that passes, and Doug Collins fails to implement approved provisions of the Dole Act, he is defying congressional authority. Every day that passes that a veteran experiences homelessness on the streets of our country, they are left without the resources that they need to become stably housed. That, to me, is shameful, it is irresponsible, and it is a harmful failure of the Secretary.

Let me talk to you about another shameful note. I want to discuss the staffing provisions of the Dole Act that have yet to be implemented. You see, section 146 required VA to develop and implement staffing models to ensure VA has the workforce it needs to provide care and benefits to the veterans. Staffing models are essential for aligning personal resources so they can be used efficiently, so that the workers with the right skills are in the right place at the right time.

Folks listening may recall that the Veterans Health Administration (VHA) is currently undergoing a massive reorganization, which we discussed at a full committee hearing just last month. One would think that a reorganization of this magnitude of the largest integrated health system in the country would incorporate staffing models. By VA's own admission, they have not complied with the Dole Act and lack staffing models for the vast majority of the medical facilities service lines.

Which begs the question, what is the evidence that the VHA reorganization is, in fact, needed? How can we be sure that the VA is making the correct changes if its leadership does not even know how many staff it needs and where they need them? Even worse, let me ask you this question. Why is VA cutting vacant positions if they do not have staffing models developed?

VA provided data to my staff a couple weeks ago and over 26,000 positions that were cut from the books. The details of those cuts are alarming. For months, VA has told us that these are quote, "old COVID era vacancies for positions that are no longer needed at the agency." Let me tell you that the data, it paints an entirely different picture about the same nature of these cuts. You see over 18,000, not hundred, 18,000 of the positions VA cut had a person in that job in 2025 or even 2026. This included positions for nearly 3,000 nurses, 800 social workers, 300 psychologists, and over a thousand physicians who were on the job in 2025. These VA positions were discarded at the hands of the Secretary's reckless leadership and they are not going to be backfilled.

Chair Kiggans, the medical center that serves your constituents had the most cuts of any VA facility in the country; 733 of the positions VA cut were at the Hampton VA Medical Center. At the facilities that serve my constituents in Chicago, Jesse Brown and Hines, 717 positions were cut. In addition to those 26,000 positions that were wiped from VA's books since Secretary Collins was sworn in the VA, he has showed a net 30,000 employees representing centuries' worth of experiences. Those losses included over 1,100 doctors, 2,300 registered nurses, 700 more social workers, and nearly 300 psychologists.

All of these cuts and losses were made with no staffing models in place as required by the law. Cut after cut after cut, with no analysis of how veteran care and benefits would be affected. It is the definition of negligence.

The Secretary and his political appointees intentionally misled and lied to Congress about the nature of these cuts. Secretary Collins is failing at the most fundamental part of his job, ensuring that veterans have access to world class care at the VA. It is why this hearing is so important. It is why we have to hold them accountable. I look forward to the conversation that we have in this hearing today.

With that, Chair, I yield back.

Ms. KIGGANS. Thank you, Ranking Member Ramirez.

I will now recognize our witnesses on our first panel. Testifying before us today, we have Dr. Thomas O'Toole, acting assistant undersecretary for Health for Clinical Services at the Veterans Health Administration. Dr. Mark Koeniger, acting assistant under secretary for Health and Patient Services of the Veterans Health Administration. Mr. Kenneth Smith, executive director, Education Services at the Veterans Benefit Administration. We also have Ms. Sharon Silas, director of health for the U.S. Government Accountability Office (GAO).

Will the witnesses please stand and raise their right hand?

[Witnesses sworn.]

Ms. KIGGANS. Thank you and you may be seated. Let the record reflect that the witnesses answered in the affirmative.

Dr. O'Toole, you are now recognized for 5 minutes to provide the VA's testimony.

STATEMENT OF THOMAS O'TOOLE

Dr. O'TOOLE. Good afternoon, Chairwoman Kiggans, Ranking Member Ramirez, and distinguished members of the committee.

Joining me today are Dr. Mark Koeniger, acting assistant under secretary for Health and Patient Care Services, and Mr. Ken Smith, executive director of Education Services at Veterans Benefits Administration (VBA). It is an honor to be here to discuss progress implementing the Senator Elizabeth Dole 21st Century Healthcare and Benefits Improvement Act.

First, thank you for this legislation and what it will accomplish. Within VA alone, the Dole Act mandates implementing more than 40 enhancements, new guidelines, or new programs; executing six new pilot programs; conducting outreach and releasing new online tools for veterans, patients, and coroner/medical examiners; and completing 50 new congressional mandated reports. Given the scope and breadth of the legislation, VA moved oversight of Dole Act implementation to the Office of the Secretary, ensuring senior most oversight. As of December 2025, the new Office of Strategic Initiatives is the responsible office.

The lack of funding has been a hurdle, requiring us to change priorities and in some instances use funding from multiple areas to deliver on some of the sections. That said, we have made significant progress implementing this important legislation. Of the 72 sections, VA has fully implemented 25 and we are diligently working on the remaining sections with significant progress being made. I would like to briefly highlight key accomplishments within VHA, VBA, and National Cemetery Administration (NCA), which are leading to transformative changes for veterans and their families.

Section 101 of the Dole Act eliminated an unnecessary layer of approval, allowing veterans to access community care when in their best medical interest.

Section 120 increased coverage for noninstitutional care alternatives from 65 percent to 100 percent of nursing home costs and the authority to exceed that cap for veterans with Amyotrophic Lateral Sclerosis (ALS), spinal cord injuries, and similar conditions. This enables more veterans to receive care at home, preserving independence and dignity.

Section 402 expanded per diem payments for homeless veterans to 133 percent of the State home domiciliary rate and up to 200 percent for sites identifying—meeting identified criteria. To date, 150 sites have availed of the 133 percent increase and 40 sites have applied for the 200 percent rate.

Section 149 requires an independent assessment of the National Veterans Suicide Prevention Annual Report and development of a public toolkit for coroners and medical examiners to improve reporting accuracy. The independent assessment was completed in January 2026.

VA has experienced some challenges with the implementation of 143 and to a much lesser extent 129, and we welcome the opportunity to work with the subcommittee to ensure that VA can provide the benefits and services intended.

The Dole Act expanded the VA's Native American Direct Loan Program, giving Native American veterans more opportunities to purchase, build, improve, or refinance homes on trust land. VA is also hiring additional coordinators to support these veterans and their families.

Section 212 reestablished the Veterans Technology Education Courses program. VA has scheduled implementation of the managed service claims processing capability for the end of third quarter 2026 and published the student application in the Federal Register in December 2025.

VA has also made progress implementing section 215, linking the GI Bill comparison tool to the Department of Education's College Navigator and is working to incorporate additional data.

Of note, VA's conversion from the benefits delivery network to the Digital GI Bill has impacted full implementation of sections 208, 210, and 212, as well as recent court decisions. We will continue to provide updates to Congress in our calls and briefings.

Section 301 expands burial allowances for veterans who die at home while receiving VA hospice care, ensuring families receive timely support.

Section 302 improves outreach to States and Tribal governments to ensure veterans and their families are aware of burial and memorial benefits they have earned.

Chairwoman Kiggans and Ranking Member Ramirez, this concludes my statement. We appreciate the opportunity to speak before you today and welcome any questions you or other members of the subcommittee may have. Thank you for your continued support of veterans, their families, caregivers, and survivors, and the many VA programs that serve them.

[THE PREPARED STATEMENT OF THOMAS O'TOOLE APPEARS IN THE APPENDIX]

Ms. KIGGANS. Thank you, Dr. O'Toole.

Ms. Silas, you are now recognized for 5 minutes to provide your testimony.

STATEMENT OF SHARON SILAS

Ms. SILAS. Chairwoman Kiggans, Ranking Member Ramirez, and members of the subcommittee, thank you for the opportunity to be here today to discuss VA's progress implementing requirements in the Elizabeth Dole Act.

The Dole Act authorized significant expansions to healthcare programs and support for veterans. Today I would like to highlight GAO's work in two areas that are addressed in the law: the Veterans Community Care Program and the Caregiver Support Program.

First, the Dole Act contains a number of provisions for VA that are intended to improve the agency's healthcare operations, including community care. Relatedly, GAO has a long history of review reviewing the Community Care Program, including some of the more recent changes to how referrals are processed and appointments are scheduled. In a little more than 10 years, the Community Care Program has tripled in size and represents nearly 42 percent of all VA healthcare appointments. With that expansion, the administrative processes at VA facilities have become more complex and continue to be labor intensive.

Through this growth, the Veterans Health Administration has made new, numerous changes to how the program is administered in order to gain efficiencies and ensure that veterans understand their healthcare options. In 2020, we issued a report on VA's imple-

mentation of the Veterans Community Care Program. In that review, we described the timeliness of processing referrals and scheduling appointments. We made three recommendations to VA in that report, two that remain open, including that VHA assess the staffing and resource needed to process community care referrals and schedule appointments. We also recommended the agency set standards for monitoring the appointment scheduling process, including the receipt of care with a community care provider.

We also issued two reports in 2025 addressing two key VHA efforts: the establishment of the VHA's Integrated Veteran Care Office, or IVC; and the Implementation of the Referral Coordination Initiative.

The creation of the IVC was an organizational reform to address VHA's progressively complex processes to manage healthcare delivery at facilities and through the Community Care Program. It consolidated the management of VA healthcare delivered in the facilities and through community care with the intent of improving coordination and ensuring veterans receive seamless access to care.

The Referral Coordination Initiative was created to ensure veterans understood their care options and to also create efficiencies for facilities in processing referrals and scheduling appointments. In both reports, we highlight deficiencies in the implementation of these efforts that ultimately can impact veterans access to care. Recommendations from both of those reviews remain open.

As VHA prepares to go through additional changes, including restructuring and the next generation of community care contracts, it is critical that the agency ensure it has the effective management structures in place to ensure veterans' timely access to care. Addressing GAO's outstanding recommendations and addressing the mandates in the Dole Act will help VA to ensure veterans receive consistent, high-quality healthcare.

The second program that I would like to highlight is VA's Caregiver Support Program. The Caregiver Support Program plays a critical role in supporting caregivers who assist veterans who have suffered serious injuries with essential tasks of everyday living. There are currently about 98,000 caregivers participating in the program. Given the toll that daily caregiving can take on caregivers' mental health, ensuring VHA effectively spreads awareness about the mental health support it offers to caregivers is essential to ensuring that interested caregivers participate in the program and they receive the help that they need. The Dole Act includes a number of provisions to bolster the supports for caregivers caring for veterans, including a mandate for GAO to review mental health support for caregivers.

Our work is ongoing, however, I will preview some preliminary findings. In our report, we describe a variety of services to support caregivers' mental health and well being, such as individual therapy, support groups, respite care, among others. We also identified some challenges caregivers experience in accessing the services, including the limited ability to travel to receive support in person. In our report, we describe some steps VHA has taken to address these challenges, such as creating a virtual psychotherapy program for caregivers.

However, our preliminary findings also show that VHA has not fully implemented performance management practices for ensuring veterans and their caregivers are aware of the program. Effective implementation of performance management practices is not just a bureaucratic exercise. Following the practice of setting program goals with targets and timeframes, collecting data to measure progress toward those goals, and then using that information to assess results and informed decisions on any adjustments to those efforts can help to ensure the program is meeting its intended results: getting caregivers the support they need.

The requirements for VA in the Elizabeth Dole Act align with many of the findings and recommendations from GAO's reviews. VA's adoptions of those recommendations would aid the Department's progress toward implementing the Dole Act's provisions.

That concludes my prepared statement. Thank you.

[THE PREPARED STATEMENT OF SHARON SILAS APPEARS IN THE APPENDIX]

Ms. KIGGANS. Thank you, Ms. Silas.

We will now move to questions and I yield myself 5 minutes.

I want to ask a quick question to Mr. Smith. Can you talk, I know you guys all kind of overviewed some of the work that the VA has done to implement the Dole Act, and can you just briefly describe what the education outreach has been, that has been done to educate veterans, their families, and community care partners, too, just about these new resources that are available to veterans? Are we putting pamphlets in waiting areas or are we sending email? What does that outreach look like?

I know as a primary care provider we often had a large group of veteran patients. It was challenging to understand the resources the VA has out there and we have put so many good things in place and a lot of good changes in motion. I just want to know how we are communicating with veterans and their families that these things are now available.

Mr. SMITH. Thank you for the question. For our education programs, our outreach is predominantly through our website. We have published a number of—information on our website, as well as provide marketing to our students directly through email campaigns. Last, our Veterans Service Organization (VSO) community, they are a great partner in disseminating information.

Ms. KIGGANS. The VSOs are a good source, and I get the VA emails as a veteran, married to a veteran. I do not think I ever visited the VA website before my current job, so I do not do a lot of visit—I do not know how many veterans out there actively—maybe if they are Google searching. I just—that outreach piece, there is a lot of primary caregivers out there, and there is probably a lot of patients sitting in waiting rooms. A poster, I am thinking of even the technology integration we see in waiting rooms, you know, just letting people know. I think that is one of our hardest parts. We have great benefits, but what are those benefits, and communicating that, so.

Keep in mind our primary care, our civilian counterparts as well, we all take care of veterans. I have a large veteran community in Hampton Roads, so it was just always a challenge, you know. I had a great office manager who would do that research and try to con-

nect with the VA. Even as a veteran provider, I did not even know all the resources that were out there, so I think that is half our battle. I am just throwing that out there.

Then going to Dr. O'Toole, the Dole Act has reoriented VA healthcare to put the best medical interests first in each veteran. I applaud the VA for enacting this provision. It saves lives. However, the VA was marked section 122 complete, and that is the operative section of my bill, the COPE Act. It has come to my attention that VA decided not to issue any grants specifically under this program.

Just wondering, Dr. O'Toole, why that law has not been fully acted about the grants? There was 10 million—specifically, there was $10 million appropriated for the program in Fiscal Year 2025 and another 10 million appropriated in Fiscal Year 2026. Just wondering where that money went.

Dr. O'TOOLE. Thank you, Congresswoman. I appreciate that. That is the awards contract for mental healthcare for family caregiver support. My colleague, Dr. Koeniger, I believe, is better situated to comment on that.

Dr. KOENIGER. The caregiver support, particularly in the mental health realm, we have implemented the Virtual Caregiver Support Program. With that program, we have seen, let me see, actually almost 29,000 encounters. That is a virtual—most of those encounters are the virtual program, but caregivers can also be seen face to face as well. Again, those almost 29,000 encounters, there are over 4,300 unique caregivers tied to those encounters.

Ms. KIGGANS. That is good news. Thank you for that.

Let us see, back to Dr. O'Toole. Section 142, it waived the pay cap for highly skilled medical staff. Dr. O'Toole, can you tell us how many waivers the Secretary has made for that? I know that was a complaint we heard frequently, especially with our surgeons, anesthesiologists, we have trouble recruiting, retaining physicians, specialty care physicians who could make so much more on the outside. We need those people at the VA. I am just wondering if you update for that.

Dr. O'TOOLE. Yes, thank you, Congresswoman. First, this is really important legislation for us, as you know, and the wage gap between what these highly trained specialists would make in the private sector versus the VA is only growing.

The challenge and issue for us, quite honestly, is that many, many more specialty groups and specialists among the 25,000 physicians, for instance, that we have in the VA far exceed the 300 people. We run the risk of second and third order consequences if we do not do this right. In particular, if we are picking out certain groups where, you know, one provider is afforded the expansion or the cap extension and others are not, what that may do to the practice.

The other dynamic that we are looking at is how can this be considered from an enterprise perspective? That if a telecare service, such as teleradiology, can be used in a rural community, it is probably going to be a lot more efficient and effective than trying to extend that cap to a radiologist in a rural community.

We are actively moving forward on this. I meet with the under secretary and others to review the parameters for data. We antici-

pate having a criteria put forward within the next 1 to 2 months, I am hopeful for, to be able to start awarding that cap. I do want to pay notice to the fact that, you know, this is critical because it is going to have to extend beyond these 300 individuals that are ultimately selected in this first pass.

Mr. KIGGANS. Keep us posted. I know that is an important part of the program, but thank you.

My time has expired. I will save some for maybe a second round.

I now recognize the ranking member for 5 minutes of questioning.

Ms. RAMIREZ. Thank you, Chairwoman.

Dr. O'Toole, I just want to go ahead and follow up on that. First, thank you for being here. As you know, a few weeks ago the Secretary testified before the full committee and in a back-and-forth with our ranking member, he asked Ranking Member Takano if he would commit to introducing a bill to raise the cap on physician pay so that he can compete in the market to hire more doctors. I want to double down a little bit more on this conversation, because I know you just started a moment ago.

In that committee hearing, the Secretary claimed that he cannot recruit physicians because he does not have the authority to pay physicians more. I am hearing you talk a little bit about the 300, but here is the thing. Section 142 of the Dole Act does authorize the VA to use waivers to increase pay for 300 physicians. The VA does have the authority to pay its physicians more already, which actually contradicts the Secretary's testimony when he said he did not have the resources or the authority to be able to raise those wages.

It sounds like Secretary Collins apparently does not think it is important to learn the laws that govern his agency, much just enact those laws to improve the VA and veteran care. That gets to my next point. I think you have answered this, but I just want to make sure that I put this on the record. How many pay waivers has the VHA requested for physicians under the Dole Act? It sounds like it is zero. The answer is zero. Correct?

Look, in a request for information provided to my staff on February 12, the VHA indicated they had not requested or approved any pay waivers for physicians. I just really need to reiterate what I said to the Secretary at our hearing last month. He cannot come to our committee and state that he cannot hire doctors because he cannot compete in the market when he will not even use the authorities he already has, that we, Congress, have given him to make more competitive offers to attract physicians.

Secretary Collins waited until January 9th of 2026, a year after the Dole Act was signed into law, to publish the implementation plan for the authority to make it easier to hire doctors. It did not seem like there was any real urgency there.

You have to understand why I am concerned here. The Secretary comes before the committee, and he claims that he cannot hire doctors, but he will not even use the tools that we have already given him, authorized them, to make some competitive offers for a number of these physicians. Instead, he lost 1,000 doctors and then he wiped 1,500 more physicians positions from the VA books. It makes no sense, if our goal is to strengthen the services veterans receive,

it makes no sense to continue to claim, as Doug Collins does, that veteran care and benefits are not affected when we are hearing from our constituents on a regular basis, veterans, that they cannot get appointments at the VA. However, his actions make perfect sense if Secretary Collins does not want to hire, let me say this again, does not want to hire doctors because his goal is to ensure that the VA fails so that he can further dismantle and maybe even privatize it.

I want to follow up on another piece, and this is more specifically to Ms. Silas. Ms. Silas, GAO has recommended that VA assess its community care staffing and resource needs to ensure timely appointment scheduling for veterans seeking care and community. My question to you, Ms. Silas, is why is such a staffing assessment important? How does this recommendation align with the requirement in the Dole Act for VA to implement a staffing model in the IVC, Veterans Integrated Service Networks (VISN), and the local medical facilities?

Ms. SILAS. Thank you for that question. An agency's workforce is really central to an agency transitioning into a high-performance organization. In GAO's high-risk work, we have worked with the Veterans Health Administration to try to get them to be better in terms of clarifying their resource needs. The staffing model and performance metrics that are provisioned in the Dole Act are incredibly important because it helps to align your resources and staff needs with your program needs. It also is important for being able to plan ahead and to manage any risks.

As you all know, each VA facility is unique in terms of the veteran population that they serve and then also in the communities that they reside in. I know that one thing that we have heard consistently for as long as I have been doing this work is that when we meet with staff in these facilities, they say there is not enough staff to process referrals in a timely manner and to do timely appointment scheduling. We always hear about challenges with workload.

In our 2020 report where we recommended that VA assess their staffing resources, they had told us that they have the staffing tool and that they were in the process of updating that, and they have been continually updating that staffing tool as the processes have evolved over the last 5 years. That recommendation, as you know, remains open.

For the staffing model and performance metrics that have been required in the Dole Act, the staffing tool, at the least, can provide information or input into the staffing models they are delivering now.

Ms. RAMIREZ. That makes sense.

Ms. SILAS. It is kind of unclear how these both fit in together. Regardless, GAO does have a mandate in the Dole Act to do a review of the VA's development of the staffing model and performance metrics. Once they complete the effort and issue some reports we will be doing our own review.

Ms. RAMIREZ. Thank you, Ms. Silas. My time is up. If we have a second round, I will do a follow-up. Thank you, Chair.

Ms. KIGGANS. Thank you, Ranking Member.

The chair now recognizes Mrs. Radewagen for 5 minutes.

Ms. RADEWAGEN. Thank you, Chairwoman Kiggans. Talofa lava. I thank the panel for being here today. It is an important hearing today, so thank you to the witnesses as well.

Mr. Smith, what has been the greatest barrier for implementation of section 302 of the legislation?

Mr. SMITH. Thank you for the question, ma'am. Right now, VA is working to publish a rule for that grant program so that we can perform or issue grants to perform the veteran outreach as required by 302.

Ms. RADEWAGEN. How has section 302 helped VA better partner with State and Tribal entities?

Mr. SMITH. I believe that once implemented, we will be able to provide, or at least provide grants, you know, to those organizations so that they can perform outreach on VA's behalf and ensure that they are communicating with their members in a culturally responsive way.

Ms. RADEWAGEN. Ms. Silas, in GAO's review of the Dole Act implementation, what has been your greatest concern?

Ms. SILAS. The GAO has a number of mandates to review implementation of various provisions within the Dole Act. Much of our work that we need to do is either waiting on VA to complete their enactment of their provision so we can oversee that or we are waiting for some reports to be released in order for us to do the review. We have not looked directly at the implementation of any of the specific provisions that VA is responsible for.

We do have ongoing work for our own mandates around the dental services. We are looking at VA's oral health program. We are also looking at the Veterans Community Care Dentistry Program. We are making progress on those reviews. Otherwise, we are waiting for VA to complete their efforts before we look at them.

Ms. RADEWAGEN. Do you believe that VA will be able to implement the act in its entirety in the allotted timeframe?

Ms. SILAS. I do not think I could state for sure. It would be up to VA to tell you what their progress is. Again, I can only speak to the programs that we have oversight of in terms of the mandate and provisions to review those programs. Most of that work is ongoing right now.

Ms. RADEWAGEN. Thank you, Chairwoman. I yield back the balance of my time.

Ms. KIGGANS. Thank you, Ms. Radewagen.

The chair now recognizes Mr. Kennedy for 5 minutes.

Mr. KENNEDY. Thank you. I want to look back at what we were told about the VA staffing cuts versus what has actually happened. In February 2025, Secretary Collins eliminated 2,400 VA jobs after publicly promising that 300,000 mission-critical positions would be protected to ensure uninterrupted services for our Nation's bravest. One month later, a leaked memo showed plans to cut more than 80,000 employees, a number the Secretary confirmed, then denied, then revised to 30,000.

On May 15, Secretary Collins assured our veterans that mission-essential jobs, like doctors, nurses, and claims processors would be protected and that reforms would strengthen, not strain, veterans access to care. That promise was broken. In December, a leaked memo revealed plans to eliminate up to 35,000 healthcare positions

in a single month, the doctors, nurses, and support staff that veterans count on for timely quality care.

When a psychologist is cut, the veteran in crisis has fewer options and longer waits. When a community care scheduler is eliminated, the veteran waiting for a cancer consult or neurosurgery referral waits longer, sometimes dangerously longer. When nurses and physicians are cut, the people who catch conditions early and respond to emergencies are not there when they are needed most. These are not just workforce reductions. There are direct cuts to the care our veterans depend on, sometimes for their lives.

That is why I requested detailed staffing data for the Western New York VA system to understand exactly how many positions were cut and how it is affecting veterans in my district. The VA refused and then days before this hearing, we received incomplete numbers. What we recently uncovered in my own district in Buffalo, New York, is demonstrative of what we are seeing in VA medical centers across the Nation.

On December 14, roughly 100 healthcare positions were eliminated at the Buffalo VA, 23 active critical roles, including 2 psychologists, 2 social workers, 1 recreation assistant, 1 respiratory therapist, 3 physicians, 2 nurses, and 11 Electrocardiogram (EKG) technicians, all cut. These are the people who treat Post-traumatic Stress Disorder (PTSD), diagnose heart conditions, coordinate the care that keeps veterans out of emergencies rooms, and so much more.

We already know what happens when staffing falls short because we have seen it happen at the Buffalo VA. In 2024, an Office of Inspector General (OIG) investigation found that dangerous delays in scheduling community care consults put veterans at serious risk. This investigation identified staffing shortages as a key cause of this degradation of care. Community care schedulers in a follow-up conversation in response to the investigation told us directly that staff shortages led to countless untreated patients and devastating health outcomes, including at least one death.

The Trump administration's response? Eliminate the staff who schedule the consults, the technicians who conduct exams, the personnel who ensure psychiatric care, and the professionals who ensure no veteran is left behind. We know what happens when those positions go unfilled: veterans care suffers and some veterans will die. This is not just mismanagement. It is life and death for the veterans who rely on the VA for timely care.

Secretary Collins stood before this committee and promised that the doctors and nurses should who care for our veterans would not—would be protected. He promised that care for our veterans would not be cut. He was not telling the truth and our veterans are the ones paying the price.

I have a very simple question for those here representing Secretary Collins' VA. When veterans in my district get sick because of a lack of resources, which of you will take responsibility and what are we to tell them?

Dr. O'TOOLE. Well, thank you, Congressman, and I appreciate what you are bringing up and I fully acknowledge the challenges and the issues. If I can, I appreciate—I am hoping for a time exten-

sion to be able to respond to your question, if that is okay, Chairwoman.

The issue of having enough providers for care is a significant one. It is one, however, that we share with the entire American healthcare system. Right now there is an estimated shortage of physicians, nurses, social workers, psychologists, psychiatrists, estimated to be at 90,000 over the next 10 years in the American healthcare system. What we are challenged by in the VA is what all of American healthcare is challenged by. I think that is an important consideration to make. It is why I also, you know, emphasize the importance of section 142 in really trying to help us be to be more competitive in attracting people to come in. It is absolutely important.

I do need to emphasize, though, and clarify. When the Deferred Resignation Program (DRP) process went through, those clinicians who were involved in direct care with providers—with patients were not allowed to pursue the DRP. Those requests for DRP were denied by those direct clinicians. That does not mean that people are not going to retire. That does not mean that people—that positions are going to attrit or that people may leave the VA. We all have workforce challenges in healthcare, and I do not want to minimize that issue or point, nor the importance of Congress in helping us navigate those waters. It is a shared challenge for all of us that extends beyond this.

The positions that were eliminated were vacant positions that had not been filled for quite some time. That does not mean that people were losing their jobs. I do think that is a really important clarifying point to the issues that I think are very valid that you are bringing up.

Ms. KIGGANS. Thank you, Dr. O'Toole.

The chair now recognizes Mr. Self for 5 minutes.

Mr. SELF. Thank you. Thank you, Madam Chair.

Dr. O'Toole, I do not question the President's authority to use impoundment. I just want to clarify. None of what we are hearing is an impoundment under the Dole Act, is it?

Dr. O'TOOLE. I am sorry, Congressman, I am not sure I am following your question. Can you please——

Mr. SELF. Congress authorizes a certain level. The President decides to spend less than that level. Is that—is impoundment involved here? Just to clarify.

Dr. O'TOOLE. Not that I am aware of at all, sir.

Mr. SELF. Very good. I want to go to your written versus your verbal testimony. I think I heard something that is not in your, excuse me, your written testimony. It is in the paragraph, I believe, where you talked about VA using funding from multiple accounts to deliver on some of the sections. Now, in your verbal testimony, you said lack of funding. Can you clarify what you said in that paragraph?

Dr. O'TOOLE. Thank you, Congressman. You know, obviously, you know far better than I, you know, the dynamics of appropriations, and I am not trying to speak to that. Some of the provisions in the Dole Act did not involve appropriated funds. We have tried to implement within the capacities that we have to the best of our abilities or if funds were available through other accounts, use those

and just trying to be fiscally prudent within that context. I want to defer to my colleagues who might be able to speak better to that.

Mr. SMITH. Thank you. For the Digital GI Bill program, we are required to make changes to that environment in order to implement——

Mr. SELF. No, I am not asking for specifics. Thank you. I just wanted to clarify your lack of funding. You did say that, I believe, and I am not sure you clarified it, but thank you.

I want to move to accountability in the 3 minutes I have left because we talk a lot in this committee about inputs. We get VA employees coming and telling us about all the inputs. Who is going to be accountable for this?

This bill was to improve ability to receive care at home. Correct? If you believe that changes in the fee schedule for reimbursement rates related to home health aid and homemaker services were to result in a reduction of up to 43 percent in rural Texas, some of which I represent, do you believe that that improves a veteran's ability to receive home healthcare? How is that balanced?

Dr. KOENIGER. Sir, thank you for the question. I cannot speak directly to veterans in Texas in terms of receiving home healthcare. I can say, though, that the home and community-based services, the VA has done actually a great job at expanding those services. The——

Mr. SELF. Do you think the 43 percent reduction is going to improve their ability to receive home healthcare?

Dr. KOENIGER. So the—again, I——

Mr. SELF. Okay.

Dr. KOENIGER [continuing]. cannot speak specifically to that, but I can say that, again, over—compared to Fiscal Year 2024, over roughly 600,000 veterans have actually benefited from the home——

Mr. SELF. Okay.

Dr. KOENIGER [continuing]. and community-based services.

Mr. SELF. Very good, thank you.

Dr. O'Toole, can you name the specific individuals who, in VA, who are going to be responsible for each of the at-risk sections?

Dr. O'TOOLE. Thank you, Congressman. As I mentioned in my opening statement, we have a centralized office, Office of Strategic Initiatives, that is overseeing this process. All of our senior leadership are fully engaged in this and as the committee staff would know, meet with frequently. I am more than happy to forward to you the org chart that delineates specific——

Mr. SELF. No, I do not need the org chart. I am asking you if you are going to hold someone accountable because you are about one-third of the way through implementation. Is that about right? One-third of the way through in terms of sections?

Dr. O'TOOLE. Sure.

Mr. SELF. What I am really asking is who is going to be held accountable?

Dr. O'TOOLE. Our senior leaders——

Mr. SELF. We always talk about inputs. I want accountability for when you implement this.

Dr. O'TOOLE. Our senior leadership throughout the agency are responsible, sir, including myself.

Mr. SELF. Okay. Very good. What is the critical milestone between now and full—oh, my time is up, Madam Chair. I will yield back. Thank you.

Ms. KIGGANS. Thank you, Mr. Self.

The chair now recognizes Mr. Ciscomani for 5 minutes.

Mr. CISCOMANI. Thank you, Chair Kiggans, for convening this important oversight hearing. Thank you to the witnesses from the Department of Veteran Affairs and Government Accountability Office for being here today with us.

I was proud to help introduce the Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act last Congress and even more proud to see it passed and get into law, be signed into law, because I believe strongly that our veterans and their caregivers deserve a system that truly reflects the sacrifices they have made for our Nation.

Far too often, veterans and their families face barriers when trying to access care, navigate benefits, and receive the superior that they have earned from the VA. This flagship VA legislation was designed to modernize the VA and create a system that works, that works better for veterans and their families and who stand beside them every single day. One year after enactment, it is important that we take a close look at how the Department is implementing these reforms.

While progress has been made in several areas, some provisions remain behind schedule or at risk of not fully being implemented. For veterans and their families these timelines matter. Delays can mean waiting longer for care, missing out on an important support service, or facing unnecessary barriers to benefits they earned through their service. This is why I want to ask a couple of the follow-up questions here, and I will start with Dr. O'Toole.

The Dole Act includes a wide range of reforms touching clinical care, caregiver support, and community-based services. How has the VHA prioritized implementation across these areas to ensure that the most immediate needs of veterans are addressed first?

Dr. O'TOOLE. Thank you, Congressman. I want to defer to my colleague on the community care question, if that is okay.

Dr. KOENIGER. That is a great question. In terms of community care or even caregiver support, I mean, we recognize that taking care of veterans, no matter what their problems are, is very important. In terms of the community-based services, we have four programs that we have rolled out. Those programs have actually seen an increase, as I mentioned earlier, in terms of supporting caregivers as well.

Mr. CISCOMANI. How do you—I am sorry to interrupt because we are going to run out of time, but how do you prioritize? How do you make sure that those that have the most immediate need of veterans get seen first? What is the process like?

Dr. KOENIGER. Again, the veterans that have the highest needs in terms of medical issues, you know, those are the folks that we want to make sure that we take care of.

Mr. CISCOMANI. I agree. How do you get there? How do you identify that?

Dr. KOENIGER. The specific process I would have to get back to you on. I mean, certainly——

Mr. CISCOMANI. I want to make sure that that is actually happening. It is just that, you know, I think you get the sense from the committee here on both sides of the aisle, we are running a little impatient on the implementation of a lot of these programs. This was supposed to be a much more expedited process and seeing the benefits of this. We are not seeing that. This is coming from every angle and every State represented here, we are all seeing this in our district. We need to really zero in on this and we need to start seeing some results.

I am going to move on here. Dr. O'Toole, again, one of Congress' goals in the Dole Act was to improve timely access to care. From your perspective, what measurable changes should veterans expect to see in appointment availability or service delivery as implementation continues?

I keep hearing from our veterans the care they receive at the VA is excellent once they receive it. Receiving it and getting there is the main issue. Again, I am starting to see a trend here of what was passed not being enacted. I want to start seeing some results and so do our veterans. What way are you measuring this?

Dr. O'TOOLE. Thank you, Congressman. This is very important and I think to follow up with your second question as well—or previous question as well.

This is a massive piece of legislation, as you know, you know, 72 provisions that impact across the agency. I cannot—I have been a primary care provider in the VA for 20 years. This is one of the most significant pieces of legislation I have seen having impact across the vast entire agency. First, thank you for that.

As your staff knows and meeting with them and having sat in on several of the calls, this is something where we have to be able to chew gum and walk at the same time and implement multiple efforts concurrently. We are. This has been a difficult year in both securing our most senior leadership, our Senate-confirmed leadership, going through the government shutdown, which created some undue slowdowns in terms of getting things through. We are on the cusp with several of these provisions within the next weeks to a month or two to having them posted in the Federal Register and being implemented.

Very much I feel confident that we will be able to implement all of the provisions in the time allowed. They are priorities for us because they are priorities for our veterans across many different contexts.

Mr. CISCOMANI. I am out of time. I do look forward to seeing results. You know, I think we understand it. We know the significance, the size of the legislation. We worked on it. We passed it. It is big and it is going to take time, we know that. It has been over a year. We need to see some results here. You say weeks, months. I hope it is weeks and I hope we can get a report exactly on numbers and what this matters.

Madam Chair.

Dr. KOENIGER. Madam Chair, I know we are over time. Could I—Congressman, you mentioned access to care and I would just like to say it is a very complicated process. As you know, there are just so many things that have to be taken into account to improve access.

I can tell you that as of May of last year, the Veterans Health Administration stood up the Access Choices in Excellence Group of which I am the executive sponsor and we have been working diligently on all aspects of access to care to, again, objectively measure all of those things and to work on improving access.

As a 36-year veteran of the United States Air Force myself, that sits—that is near and dear to me to make sure that veterans can get in when they need to get in.

Mr. CISCOMANI. Thank you.

Ms. KIGGANS. Thank you. I think we have a few minutes for a second round of questions. I just have two questions for Dr. O'Toole.

As a former geriatric nurse practitioner one of my greatest concerns was ensuring our aging veterans are getting the care that they deserve. Can you provide the committee just with an update on the rollout of the pilot program, section 127, to fortify the assisted living services for veterans and what that looks like?

Dr. O'TOOLE. Thank you, Congresswoman. I think—is that in your scope?

Dr. KOENIGER. Yes. Yes. Thank you for the question. As you know, our population is aging. Again, we have 49 percent of all our veterans are 65 and older. We are working in terms of the two pilots as section 127 states. The VA is—has been working on a purchasing authority and a fee schedule options are under development because we are—we need to get those things in place so we can ramp up those pilots. We are making progress and work in the details of getting the pilots going.

Ms. KIGGANS. Okay. We would love to see some movement in that, too. I think that is important. There are not enough options, especially housing options, for aging Americans. Perhaps the VA should hire more geriatricians, but that is just my two cents.

Then, Dr. O'Toole, our stakeholders have highlighted that the best medical interest standard is coming into conflict with transportation benefits that usually accompany care for disabled veterans. Veterans should not have to sacrifice the best standard of care because the VA will not pay for transportation. How does the VA intend to harmonize this conflict to deliver patient-oriented care?

Dr. O'TOOLE. Thank you. It is a huge issue and obviously providing care that somebody cannot get to sort of misses the mark. We are working specifically and having some challenges specifically on the transportation provision. I think I mentioned that in my opening statement, and it is something that we would like to be able to work with the committee further to be able to go through those provisions to address some of the challenges we are having with that implementation.

Ms. KIGGANS. That would be great. I think that should definitely be a priority for us moving forward.

The chair now recognizes Ranking Member for any remaining questions.

Ms. RAMIREZ. Thank you, Chair. Here you go.

Dr. O'Toole, I just want to follow up on some of the conversations we had at the beginning of the hearing. Specifically I want to talk about my own district. Before the VA cut the 130 nurses at the

Jesse Brown and Hines VA Medical Centers, did the VA have staffing models in place as required by the Dole Act to determine that those 130 nurses were no longer needed at those facilities in Chicago?

Dr. O'TOOLE. Thank you, Congresswoman. It is important to keep in mind, particularly as I know a lot of questions about the staffing model come up in consideration of the Rise Initiative and the reorganization, there has been no change whatsoever in terms of direct care staffing modeling based upon the reorganization efforts under Rise.

Ms. RAMIREZ. Doctor——

Dr. O'TOOLE. The——

Ms. RAMIREZ. Dr. O'Toole.

Dr. O'TOOLE. The staffing models have—we continue to do. They are being refined in the context of the Dole Act.

Ms. RAMIREZ. Did we have staffing models in place there to determine that we did not need those 130 nurses? It is more of a yes or no. Just trying to get clarity.

Dr. O'TOOLE. Ma'am, those positions were not removed. Those were not active positions. Those were positions that had not been filled and not have been filled for quite some time.

Ms. RAMIREZ. I am just looking here at some of the reports we got from all of you here. For example, there are 41 nurses positions filled in 2025 or 2026 that were no longer filled after. These were positions that were—they had bodies in them prior to the cut of these. Of these nurses, yes or no? Did you have people working there? Were there nurses working there?

Dr. O'TOOLE. No.

Ms. RAMIREZ. Okay. Well, the data says a different—the thing is that I am looking at the data that you provided for me for these centers, and so it is inconsistent with what I am getting from you. Let me just wrap up here because I know we only have a few minutes and we want to close this hearing.

Dr. O'TOOLE. We can take that for the record for further clarification.

Ms. RAMIREZ. Yes, I would appreciate that.

I want to just come back to housing real quick. You heard me say I ran a homeless shelter for about 9 years, of which I had the honor and opportunity to serve many veterans who were experiencing homelessness. I just want to wrap up with sections 402 and 403 of the Dole Act, which provided the crucial resources to the VA and community providers who serve homeless veterans. I want to make sure that it is clear that due to the delays in implementing these provisions, homeless veterans and community organizations are having to go without these resources.

During the Biden administration, the homeless program's office staff told me and my team repeatedly that it would be ready to swiftly implement the Dole Act, that it would be like turning on a light switch. It is hard for me to know that we are 14 months in, and it sounds like for Secretary Collins it is going to take over a year to flip a light switch. You know, to me, it is a testament to poor leadership that homeless veterans still do not have the resources they need.

Sadly, I know there is something nefarious going on that led to the delay in implementation of these homeless sections. Specifically, the administration, including Secretary Collins, has wielded attack after attack against veterans experiencing homelessness. They prioritize handcuffs and jail cells over getting these veterans help that they need in place of getting them a home. Look, I believe that the swift—and they are swifting away from interventions that we know have worked address homelessness, programs like Housing First models. This administration's focus on programs that have proven time and time again to actually make homelessness worse are leading the delay that we see here.

You see, I see that Collins is actively pushing a strip down, in effect a for-profit model of homeless service delivery driven by special interest instead of leaving intervention to the experts in homeless program offices. We know that the VA, especially the political leadership, meddled in implementation of the Dole Act is getting in the way of these programs that we actually know work.

Instead of relying on the expertise of an office that has housed over 50,000 homeless veterans last year, these political appointees substituted their poor profit-minded judgment for expertise. The consequence? Fourteen months of veterans not having access to the housing, transportation, clothing, and food that they need. I find that to be unacceptable. Frankly, I find it to be despicable.

These same political appointees are pushing a dangerous proposal to destroy Housing and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH), the most successful permanent supportive housing program in the history of this country and replacing it with a poorly conceived program that we know will fail called Bridging Rental Assistance for Veteran Empowerment (BRAVE).

I want to make sure, on the record, in the last few seconds I have, that I am going to tell you I am going to continue to defend our homeless veterans. They should not be homeless to begin with. We cannot sit here idly watching this administration destroy these programs so that billionaire buddies can get enriched as a result of it

I look forward to getting an update in the immediate future that the VA has fully implemented the homeless sections of the Dole Act and has abandoned the BRAVE proposal because anything less is a disgrace and a disservice to our most vulnerable veterans.

With that Chairwoman, I yield back.

Ms. KIGGANS. Thank you. I just wanted to take a minute to thank the witnesses for coming today. I appreciate the candor in your testimony and your willingness to participate.

Implementing the Dole Act remains a top priority of this committee. I look forward to continuing to ensure the VA remains committed to this goal. Thank you all for being here today.

I ask unanimous consent that all members shall have 5 legislative days in which to revise and extend their remarks. Did you have any concluding remarks, sorry, as well?

Ms. RAMIREZ. I do, Chairwoman, thank you.

As I reflect back on the hearing, our first one in over 200 days, I am struck by some of the answers that were received here. First, Dr. O'Toole, you said that no doctors or nurses were allowed to

take the Deferred Resignation Program. However, data the VA has provided themselves to Mr. Kennedy shows that two nurses from Buffalo were allowed to take the DRP last year.

You also reiterated that the Secretary's talking point that many of these positions eliminated were not filled in a long time. However, again, the data that has been provided by you all says the opposite. Seventy-one percent of these 26,000 positions were filled at some point since January 2025. If these were really COVID era positions, then why were these positions still there? Specifically, I am thinking about the Jesse Brown/Hines positions.

Look, I am glad that we are here. I know that we are going to go ahead and follow up. I think that the work that we do in this committee is incredibly important because we have to implement every facet and every provision of the Dole Act. Twenty-five of the 72 is unacceptable. I look forward to following up with you to make sure that you take the urgency necessary to implement every single section so that our veterans have what they, in fact, need and they deserve.

With that, I yield back.

Ms. KIGGANS. Thank you all again for being here today. I ask unanimous consent that all members shall have 5 legislative days in which to revise and extend their remarks and include any extraneous material. Hearing no objection, so ordered.

The hearing is now adjourned.

[Whereupon, at 3:55 p.m., the subcommittee was adjourned.]

A P P E N D I X

PREPARED STATEMENTS OF WITNESSES

Prepared Statement of Thomas O'Toole

Good afternoon, Chairwoman Kiggans, Ranking Member Ramirez, and distinguished members of the Committee. Joining me today are Dr. Mark Koeniger, Acting Assistant Under Secretary for Health for Patient Care Services, VHA, and Mr. Ken Smith, Executive Director, Education Service, Veterans Benefits Administration (VBA). It is an honor to be here on behalf of VA to discuss our progress on implementing the Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act (the Dole Act; P.L. 118–210).

Enacted on January 2, 2025, the Dole Act is a comprehensive law with more than 70 sections that require action from VA, the Department of Labor, educational institutions that serve Veterans and their families, and the Government Accountability Office. The Dole Act includes requirements for VA to:

- implement more than 40 enhancements, new guidelines, or new programs;
- execute six new pilot programs;
- conduct outreach and release new online tools for Veterans, patients, and coroners/medical examiners; and
- complete 50 new congressionally Mandated Reports.

This variety of new requirements required VA to realign its priorities and establish an enterprise-wide approach to support Dole Act implementation. This approach has been updated several times as new VA leadership was sworn in and VA uses funding from multiple accounts to deliver on some of the sections.

VA moved oversight of implementation of the Dole Act to the Office of the Secretary to ensure senior official oversight and involvement in these critical responsibilities. In December 2025, the new Office of Strategic Initiatives became the office responsible for VA-wide oversight, facilitation, and monitoring of implementation efforts, such as those required by the Dole Act.

We are pleased to report that VA has made significant progress toward implementing the Dole Act. Of the 72 sections that required VA implementation efforts, VA has fully implemented 25 sections as of February 9, 2026. We are diligently working on the remaining sections.

While implementation spans the Department, I will begin by highlighting key accomplishments within VHA, which has led to transformative changes in care delivery and support for Veterans and their families under the Dole Act.

VHA

In alignment with section 101 of the Dole Act, effective May 19, 2025, VA eliminated an unnecessary layer of approval in the community care process, allowing Veterans to access care when it is in their best medical interest (BMI). Removing that unnecessary layer has made a real difference. Between June and December 2025, referrals to community care under the BMI criterion increased by over 66 percent compared to the same period in the previous year. Additionally, VA launched a nationwide outreach campaign, including updates to VA.gov and targeted communications through the Solid Start program, reaching over 83,000 newly separated Veterans. These efforts help Veterans understand their options for care from day one, creating a more seamless and responsive health care experience.

The Dole Act also delivered expanded options for Veterans needing long-term and home-based care. Using the authority granted by section 120 of the Dole Act, VA increased coverage for noninstitutional care alternatives from 65 percent to 100 percent of nursing home costs, with authority to exceed that cap for Veterans with amyotrophic lateral sclerosis, spinal cord injuries, and similar conditions. This expansion enables more Veterans to receive care at home, preserving independence and dignity. These changes, combined with new pilot programs for assisted living and enhanced Homemaker and Home Health Aide programs, reflect VA's commit-

ment to meeting Veterans where they are—with care that honors their service and supports their families.

VA has also made critical strides in addressing homelessness and suicide prevention under the Dole Act. Section 402 of the Dole Act expanded per diem payments for homeless Veteran programs, increasing the maximum per diem rate from 115 percent to 133 percent of the State Home domiciliary rate and allows VA to waive the maximum rate for per diem payments to provide payments at a rate that does not exceed 200 percent of the rates authorized for State Homes for domiciliary care under 38 U.S.C. § 1741(a)(1)(A) for no more than 50 percent of all grant recipients and eligible entities for a Fiscal Year (FY), subject to the availability of funding.

Section 403(a) of the Dole Act authorizes VA to provide to covered Veterans, as VA determines necessary, food, shelter, clothing, blankets, and hygiene items required for the safety and survival of the Veteran; transportation required to support the stability and health of the Veteran for appointments with service providers, the conduct of housing and employment searches, and the obtainment of food and supplies; and tablets, smartphones, disposable phones, and other technology and related service plans required to support the stability and health of the Veteran through the maintenance of contact with service providers, prospective landlords, and family members. Section 403(b) authorized VA to collaborate with one or more organizations to manage the use of VA land for homeless Veterans for living and sleeping.

Section 404 created a new 38 U.S.C. § 2069, which requires VA, to the extent practicable, to ensure that Veterans participating in or receiving services from a program under chapter 20 have access to telehealth services to which the Veterans are eligible under the laws administered by VA.

These changes, from implementing sections 402, 403 and 404, strengthen the safety net for Veterans at risk of homelessness and improve access to care. VA published a Federal Register Notice on February 6, 2026, notifying the public of subregulatory guidance to implement section 402 of the Dole Act, and we expect to publish very soon a Federal Register Notice to inform the public about VA's implementation of section 403 of the Dole Act.

In addition, section 149 of the Dole Act strengthened accountability by requiring an independent assessment of the National Veteran Suicide Prevention Annual Report and development of a public toolkit for coroners and medical examiners to improve reporting accuracy. The independent assessment was completed in January 2026. VA's most recent Annual Suicide Prevention Report, published February 5, 2026, shows 6,398 Veteran suicides in 2023—down from 6,442 in 2022—with the average daily rate falling slightly to 17.5. However, suicide rates remain elevated among younger Veterans and those facing risk factors such as homelessness, health challenges, and chronic pain. To address these risks, VA has expanded outreach and care access. Since January 2026, VA has conducted a new outreach campaign that has led more than 33,000 unenrolled Veterans to sign up for VA care, and partnerships with civilian health systems have helped identify and contact 140,000 at-risk Veterans. VA has made good progress on the remaining requirements and anticipates meeting the statutory timelines.

VHA has experienced some challenges with implementation of certain sections of the Dole Act, particularly section 143 (regarding reimbursement for transporting certain Veterans by ambulance from rural locations for care) and, to a lesser degree, section 129 (regarding recognition of organizations and individuals to assist Veterans, family members, and caregivers in navigating VHA programs and services). VA would greatly welcome the opportunity to work with the Subcommittee to modify these provisions to ensure VA can provide the benefits and services intended by these sections.

VBA

These efforts within VHA demonstrate our commitment to improving health care access and support for Veterans and caregivers. Equally important are the provisions under the Dole Act that strengthen Veterans' benefits and streamline claims processing.

Native Americans have historically served in the U.S. military at a higher per capita rate than any other group. However, they face unique challenges in obtaining home loans on Federal trust land. To help VA address this challenge, the Dole Act expanded VA's Native American Direct Loan (NADL) program, thereby strengthening VA's authority to make, evaluate, and secure loans on trust land and giving Native American Veterans more opportunities to purchase, build, improve, or refinance homes on trust land. VA is also hiring additional NADL coordinators and collaborating with other Federal agencies to develop effective policies that support Native American Veterans and their families and developing new policies to support a Native Community Development Financial Institution relending program.

VA continues to prioritize systems enhancements to support implementation of sections 208, 210, and 212 of the Dole Act. In 2025, after years of planning and coordination, VA had scheduled and committed to the decommissioning of the Benefits Delivery Network (BDN) system. The Fiscal Year 2025 decommissioning date could not be moved due to the ending of the BDN support contract in October 2025, and a requirement to close out Fiscal Year 2025 books in BDN.

The largest provision of the Dole Act to be implemented by VBA is section 212, which reestablished the Veterans Technology Education Courses (VET TEC) program, or VET TEC 2.0. VA will implement the VET TEC 2.0 claims processing capability in Fiscal Year 2026 and has made other significant progress toward implementation. For example, on December 16, 2025, VA published the Student Application in the Federal Register, starting the 60-day public comment period. VA also successfully completed updates to the payment management systems that will enable Education Service to implement a claims adjudication and process capability by the end of the third quarter of Fiscal Year 2026. Finally, VA completed several other tasks to ensure a smooth rollout of VET TEC 2.0 as soon as the information technology solution is available. For example, VA completed:

- the Training Provider application,
- a draft Communications plan to notify the Training Providers and begin soliciting and accepting new Training Provider applications,
- a Training Provider and Expert Credentials checklist, and
- a training plan for the Training Providers and Education Liaison Representatives.

VA has made progress toward implementing section 215 of the Dole Act. For example, VA has linked the GI Bill Comparison Tool to the Department of Education's (ED) College Navigator and recently met with ED to identify the appropriate points of contact to incorporate additional data.

VA will also schedule and adopt additional updates following two recent court decisions – Rudisill v. McDonough and Perkins v. Collins. Specifically, by 2027, VA will aim to achieve 1-day completion of education claims and reinstitute VET TEC 2.0.

VA has not yet scheduled:

- DGIB updates necessary to support the integration of the new monthly housing allowance requirements under section 208; and
- integration of electronic certificates of eligibility and award letter requirements under section 210.

VA anticipates it will schedule these updates in 2026. To mitigate challenges until they are scheduled, VA conducts quarterly reviews of DGIB enhancements and continues to prioritize enhancements. VA will continue to provide updates to Congress in our calls about DGIB progress about sections 208 and 210.

In addition to benefits focused on the Native American community and education services, the Dole Act strengthens memorial benefits administered by the National Cemetery Administration. For example, section 301 of the Dole Act expanded burial allowances for Veterans who die at home while receiving VA hospice care, ensuring families receive timely support during a difficult time.

National Cemetery Administration

VA is working under section 302 of the Dole Act to improve outreach to States and tribal governments, helping ensure that Veterans and their families are aware of burial and memorial benefits they have earned. These provisions reflect VA's commitment to honoring Veterans not only throughout their lives but also at life's end, with dignity and respect.

Conclusion

Chairwoman Kiggans and Ranking Member Ramirez, this concludes my statement. We appreciate the opportunity to speak before you today and welcome any questions you or other Members of the Subcommittee may have. Thank you for your continued support of Veterans, their families, caregivers, and survivors as well as the many VA programs to support them.

Prepared Statement of Sharon Silas

United States Government Accountability Office

Testimony

Before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

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VA HEALTH CARE

Recommendations and Observations to Improve Community Care and Support for Caregivers Related to Dole Act

Statement of Sharon M. Silas, Director, Health Care

GAO-26-108943

GAO Highlights

VA Health Care

Recommendations and Observations to Improve Community Care and Support for Caregivers Related to the Dole Act

GAO-26-108943 March 4, 2026

A testimony before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

For more information, contact: Sharon M. Silas at silass@gao.gov.

What GAO Found

The Department of Veterans Affairs (VA) allows eligible veterans to receive health care from community providers through the Veterans Community Care Program. Since 2020, GAO has made several recommendations to improve access to the Veterans Community Care Program in areas also highlighted by the 2025 Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act (Dole Act). As of February 2026, VA has not fully implemented GAO's recommendations. For example:

- **Timely appointment scheduling.** In 2020, GAO found that most Veterans Health Administration (VHA) facilities from the region included in its review did not have the recommended number of staff needed to manage community care referrals, creating potential risks to timely scheduling. GAO recommended that VHA assess community care staffing needs to identify and address any risks. VHA agreed with this recommendation and is working to enable its staffing tool to identify and report such risks, according to officials. GAO also recommended that VHA establish a wait time measure for community care appointments and align its performance metrics. VHA disagreed with this recommendation but has defined time frames for some steps. VHA has not fully implemented these recommendations. The Dole Act requires VA to take action on its staffing model and performance metrics to ensure timely care for veterans.
- **Referral coordination and communication.** In 2025, GAO reported that VHA facilities had mixed results in implementing the Referral Coordination Initiative, which aimed to improve referral coordination and streamline appointment scheduling. VHA had not documented key elements of the initiative in policy, which may contribute to inconsistences in implementation and limit staff and veterans' understanding of community care options. GAO recommended that VHA include this initiative in its national policy. VHA concurred in principle with the recommendation, but has not yet implemented it. GAO also reported in 2025 that the Office of Integrated Veteran Care, which VHA created to improve coordination of community care, did not always clearly communicate information to its facilities. GAO recommended that VHA ensure this information is clearly communicated. VHA concurred with this recommendation but has not yet implemented it. The Dole Act also requires VA to review facilities' processes for making such referrals.

GAO also has ongoing work on VHA's Caregiver Support Program. Preliminary results show that VHA responded to challenges caregivers reported with accessing in-person support by implementing a virtual therapy program. VHA also established goals to assess the effectiveness of its outreach efforts. These include a goal to increase program enrollment by 15 percent each fiscal year, which it met in fiscal year 2025. However, VHA has not set quantitative targets and time frames for its other goals. Doing so would better position VHA to assess its efforts and make any needed adjustments. The Dole Act also includes provisions addressing caregivers' access to and awareness of VHA's Caregiver Support Program.

Why GAO Did This Study

The Dole Act authorized significant expansions of health care programs for veterans and support for their caregivers. These programs are administered by VHA.

An increasing number of veterans receive their care from providers outside of VHA facilities through the Veterans Community Care Program; in 2024, about 3.1 million veterans received such care. VHA also provides services and support to nearly 100,000 caregivers of veterans who suffered serious injuries in the line of duty through its Caregiver Support Program. Concerns have been raised about the mental health of veterans' caregivers who often provide around the clock care that enables veterans to live at home and help with their recovery.

GAO has a large body of work related to aspects of the community care and caregiver programs, both of which were addressed in the Dole Act. This statement summarizes recommendations and related work on the Community Care program. It is based on three GAO reports issued from 2020 through 2025 (GAO-20-643, GAO-25-106678, and GAO-25-107212). This statement also includes preliminary results from GAO's ongoing work examining VA's efforts to provide mental health support to caregivers. To do this work, GAO reviewed VHA documents on its caregiver program and interviewed VHA officials, program staff, and participating caregivers at four selected VHA facilities.

Chairwoman Kiggans, Ranking Member Ramirez, and Members of the Subcommittee:

I appreciate the opportunity to be here today to discuss key programs where the Department of Veterans Affairs (VA) is charged with implementing mandates from the Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act (Dole Act).[1] The Dole Act authorized significant expansions of health care programs for our nation's veterans and support for their caregivers, among other things. This act is one of several steps Congress has taken in the last decade to improve veterans' access to care, such as increasing veterans' ability to receive care from providers in their communities.[2] GAO has a large body of work related to several of the mandates for VA included in the Dole Act. This statement will highlight certain reviews we have conducted of the Veterans Community Care Program and the Caregiver Support Program—two programs where the Dole Act explicitly requires VA action.

In recent years, an increasing number of veterans have received care from providers outside of VA facilities through the Veterans Community Care Program, which is administered by the Veterans Health Administration (VHA). According to VHA, the number of veterans who received services through community care increased from about 1.1 million in 2014 to about 3.1 million in 2024. VHA is responsible for helping veterans access community care, and its efforts to do so have been the subject of many GAO evaluations both before and after the Dole Act was enacted in 2025.

In addition, many veterans have suffered serious injuries in the line of duty and receive care from family members or others to help them with everyday tasks. Concerns have been raised about the mental health of caregivers of veterans, who often provide around the clock care that enables veterans to live at home and help with their recovery. VHA administers the Caregiver Support Program to assist these caregivers with caring for veterans enrolled in VHA by providing resources and support, such as respite care to provide breaks from caregiving, and

[1]Pub. L. No. 118-210, 138 Stat. 2706 (2025).

[2]The VA MISSION Act of 2018 (VA MISSION Act) broadened veterans' eligibility to receive care outside of the VA health care system under the Veterans Community Care Program. Pub. L. No. 115-182, tit. I, § 101, 132 Stat. 1393, 1395. The Veterans Community Care Program replaced the prior temporary program that had been in place since 2014—the Veterans Choice Program—and consolidated it with other existing community care programs.

mental health services. In fiscal year 2025, about 98,000 caregivers of veterans participated in the Caregiver Support Program, nearly double the number who participated in fiscal year 2021. Recent legislation, including the Dole Act, expanded caregivers' access to the program and the mental health support it offers.[3]

The Dole Act's mandates highlight how central community care is to VHA delivering on its mission to ensure every veteran can access high quality health care, as well as the importance of VHA's support for veterans' caregivers. My statement summarizes GAO's recent work on the Veterans Community Care Program and the status of related recommendations. It also provides preliminary results from our review of the caregiver program in response to a Dole Act provision. This statement is based on three GAO reports that were issued between 2020 and 2025, as well as ongoing work.[4]

Detailed information on the scope and methodology of our prior work can be found within the specific reports on which this statement is based. These reports are listed in the related products page at the end of this statement. To do the work upon which our preliminary results are based, we reviewed VHA data and documentation on the Caregiver Support Program. We also interviewed VHA officials and program staff and 50 caregivers at four selected VHA medical facilities through site visits.[5]

[3]For example, the VA MISSION Act expanded eligibility for veterans and caregivers to participate in the comprehensive component of the program, which provides additional benefits like a monthly stipend, but has stricter eligibility criteria. Pub. L. No. 115-182, tit. I, § 161, 132 Stat. at 1438. Caregivers of veterans who served after September 11, 2001, have been eligible for the comprehensive component since it was established in 2011. Veterans who served before May 7, 1975, became eligible as of October 1, 2020, and veterans who served between May 7, 1975, and September 11, 2001, became eligible as of October 1, 2022. 38 C.F.R. § 71.20 (2025).

[4]See GAO, *Veterans Community Care Program: Improvements Needed to Help Ensure Timely Access to Care*, GAO-20-643 (Washington, D.C.: Sept. 28, 2020); *Veterans Health Care: Referral Coordination Initiative for Specialty Care Needs Improved Program Direction and Guidance*, GAO-25-106678 (Washington, D.C.: Jan. 21, 2025); and *Veterans Health Care: Better Communication Needed to Integrate Management of Medical Facility and Community-Based Care*, GAO-25-107212 (Washington, D.C.: Sept. 2, 2025). Appendix I provides an update on the status of recommendations GAO made in those reports.

[5]The four selected VHA facilities are located in Long Beach, California; Hines, Illinois; Manchester, New Hampshire; and Lexington, Kentucky. We selected these VA medical centers to obtain variation in geography, rurality, and the number of caregivers participating in the Caregiver Support Program.

We conducted the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

VHA operates one of the largest health care delivery systems in the nation, serving over 6 million veterans. VHA's system is organized into 18 regional networks known as Veterans Integrated Service Networks (VISN) that manage VHA's medical facilities, including outpatient facilities.[6] VHA headquarters, its regional network of VISNs, and VHA medical facilities all play a role in managing referrals and scheduling veterans' appointments for care in a timely manner at VHA medical facilities and in the community, through the Veterans Community Care Program.

VHA medical facilities are also the key point of contact in VHA's administration of its Caregiver Support Program, through which VHA offers various resources and services to support eligible caregivers' mental health and wellbeing. For example, VHA facilities host support groups and facility staff help caregivers access respite care.

Veterans Community Care Program

Eligibility and Scheduling for Community Care

Through the Veterans Community Care Program, which VHA implemented on June 6, 2019, in response to the VA MISSION Act, eligible veterans may choose to obtain health care services from community providers rather than from VHA providers in some circumstances. There are six criteria that can qualify a veteran to receive care under the Veterans Community Care Program. For example, veterans may qualify for community care when the needed services are not available at their VHA facility or if VHA cannot provide care within its designated access standards. VHA's designated access standards specify that a veteran may be eligible for community care if

[6]VHA operates 173 medical centers and more than 1,200 outpatient facilities, which we refer to collectively as "VHA medical facilities." In addition, in December 2025, VA announced that it intends to reorganize the management structure of VHA, including potentially reorganizing the 18 VISNs into 5 VISNs.

- the average drive time to a VHA provider is more than 30 minutes for primary care or more than 60 minutes for specialty care, or
- the next available appointment with a VHA provider is not available within 20 days for primary care or 28 days for specialty care based on the date of the request for care unless a later date has been agreed upon.

VHA is responsible for overseeing the scheduling processes for appointments at VHA medical facilities and through community care and establishing requirements for staff involved in the scheduling process. [7] The process for scheduling a veteran's appointment under the Veterans Community Care Program generally begins when a VHA provider creates a referral for a veteran to receive care from another provider, such as for specialty care.[8] The VHA provider sends the referral to a team of clinical and administrative VHA facility staff that determines the veteran's eligibility for community care. If the veteran is eligible for community care, the team discusses options with the veteran and collects any preferences, such as if the veteran prefers a specific provider. If the veteran opts to receive care in the community, the team sends the referral to the VHA facility's community care staff who review the referral. Community care staff contact community providers to schedule the appointment, send documentation to the community provider, and communicate the appointment information to the veteran.

VHA's Referral Coordination Initiative

In 2019, VHA began implementing the Referral Coordination Initiative to streamline scheduling for specialty care appointments at its medical facilities across the country, as well as to leverage its facility resources and staff more efficiently. The implementation of the initiative marked a significant change to the process previously followed by VHA medical facility staff for management of specialty care referrals. According to VHA guidance, the initiative is intended to

- create dedicated referral coordination teams that are focused on sharing with veterans their health care options,

[7]See, for example, Department of Veterans Affairs, *Outpatient Scheduling Management*, VHA Directive 1230 (Washington, D.C.: June 1, 2022) and *Consult Processes and Procedures*, VHA Directive 1232(5) (Washington, D.C.: Aug. 24, 2016, amended Dec. 5, 2022).

[8]Under the Veterans Community Care Program, eligible veterans can also self-schedule their community care appointments or use VA's online scheduling capabilities to request an appointment for primary care and select specialty care with community providers, which may involve different steps by VHA facility staff.

- empower veterans to make the health care choice that is right for them, and
- improve scheduling timeliness.

The Referral Coordination Initiative process is handled by facility referral coordination teams that include designated clinical and administrative staff who assist with scheduling and are trained to discuss veterans' options for care at the time of scheduling. The process is intended to ensure that referral documentation is complete and includes all pertinent clinical information before the coordination teams discuss care options with veterans and schedule appointments in VHA medical facilities or with community providers. In implementing the initiative, VHA provided facilities with guidance describing the different ways to structure their referral coordination teams but gave facilities flexibility to determine what worked best for their circumstances.

VHA's Office of Integrated Veteran Care

In 2020, VHA performed an assessment to further improve how VHA manages veterans' access to care and to reduce inadvertent overlap and duplication of clinical, administrative, and financial operations in its organizational structure. Based on one of several recommendations from this assessment, VHA created the Office of Integrated Veteran Care (IVC) in 2022 and began to implement changes to improve coordination of access to both VHA medical facility-based and community care. The IVC is responsible for establishing policy and conducting oversight of appointment scheduling processes. In March 2025, the Secretary of Veterans Affairs announced a department-wide review to consider future reorganization and workforce reduction efforts, which may affect the future organization and work of IVC.

Caregiver Support Program

The Caregiver Support Program consists of two components—the Program of General Caregiver Support Services (general component) and the Program of Comprehensive Assistance for Family Caregivers (comprehensive component). These components vary in their eligibility criteria and services offered. For the general component, caregivers of any veteran enrolled in the VHA health care system, and who are age 18 or older, can join. In contrast, the comprehensive component has additional criteria, including that the caregiver must be a family member

or live with the veteran, and the veteran must meet a certain level of need for at least 6 continuous months.[9]

VHA provides a variety of support to caregivers in both components of the program. This includes resources to help caregivers care for the veteran, such as education and training, peer mentoring, and telephone support. The program also offers services to support caregivers' mental health and wellbeing, such as support groups, respite care, and emotional support from program staff. VHA provides additional benefits to caregivers participating in the comprehensive component, such as a monthly stipend, travel benefits, legal and financial planning services, and mental health treatment like psychotherapy for their individual needs.

Dole Act

The Dole Act addresses a number of VA programs, benefits, and services available to veterans and their families, including the Veterans Community Care Program and the Caregiver Support Program. It directs VA to make changes related to program administration, outreach to veterans and their caregivers, and care and information standards, among other things, aimed to improve veterans' access to quality care and support for their caregivers. The Dole Act also includes provisions directing GAO and VA to report on these changes.

VHA Has Not Fully Implemented GAO Recommendations to Improve Access to Community Care

We have examined VHA's management of the Veterans Community Care Program since its inception in 2019, including its efforts to ensure veterans' timely access to community care and actions it has taken to ensure veterans are aware of their options for community care. Through this work we have also made recommendations to VHA to improve its community care staffing models and wait-time metrics, develop clear policy for the Referral Coordination Initiative, and enhance communication regarding the Office of Integrated Veterans Care. As of February 2026, VHA has not implemented these recommendations. These are all areas where Congress, through the Dole Act, has mandated that VA take action to make improvements to enhance veterans' access to and experience with their care in the community.

[9]For purposes of the Caregiver Support Program, VA considers a veteran to have this level of need if the veteran is unable to perform an activity of daily living, needs supervision or protection based on symptoms or residuals of neurological or other impairment or injury, or needs regular or extensive instruction or supervision without which the ability of the veteran to function in daily life would be seriously impaired, according to Caregiver Support Program guidance. Veterans must also have at least a 70 percent service-connected disability rating for their caregiver to be eligible.

Improvements to Staffing Models and Metrics Are Needed for Scheduling Timely Care

The 2025 Dole Act includes a provision requiring VA to develop and implement action on its staffing model and performance metrics for employees with responsibility for ensuring timely care for veterans.[10] This provision relates directly to work we did in 2020, in which we examined those aspects of the Veterans Community Care Program.[11] We found that improvements were needed to ensure veterans have timely access to care. Specifically, we reported that VHA developed a tool in 2017 to help VHA facilities determine their staffing needs to manage community care referrals and appointments. However, at that time, most of the VHA facilities in Community Care Network Region 1 did not have the recommended number of staff to manage the increasing volume of referrals.[12] As a result, staff from two VHA facilities described their workload at that time as "unsustainable," and some staff reported feeling frustrated that they were unable to keep up with the referral workload.

In that report, we recommended that leadership assess their community care staffing and resource needs and develop a plan to address any identified risks to their ability to schedule appointments in a timely manner, including strategies to adjust staff levels and address recruitment and retention challenges as needed. VHA concurred with this recommendation and has taken some steps to address it. Officials stated in September 2025 that they were collaborating with a contract team to incorporate a mechanism within the staffing tool that would enable VHA facilities to identify any risks associated with timely appointment scheduling. According to VHA officials, facilities will be required to develop an action plan to address any identified risks, which will be tracked by VISNs. As of February 2026, VHA has not implemented this recommendation.

Additionally, we have identified improving timely access to the Veterans Community Care Program as a priority area warranting VHA's timely and focused attention. In this same report in 2020, we made a recommendation that VHA align its monitoring metrics with the time frames it established for scheduling community care appointments to

[10]Pub. L. No. 118-210, § 146, 138 Stat. at 2752.

[11]GAO-20-643.

[12]The Veterans Community Care Program allows VHA to purchase community care through regional contracts called Community Care Networks, which are developed and administered by contracted, third party administrators. VHA implemented these networks by region on a rolling basis starting in December 2018. See GAO-20-643 for more information.

effectively monitor the extent to which veterans receive care within such specified time frames; we classified this as a priority recommendation. VHA did not agree with our recommendation at the time of our report but has since taken some steps to address it. Specifically, VHA has defined some steps in the scheduling process, but has yet to establish a timeliness standard for when a veteran's appointment should occur. As of February 2026 VA has not fully implemented the recommendation. We reiterate the importance of implementing our recommendation. Correcting deficiencies in VHA's alignment of its monitoring metrics and establishing a performance metric to measure wait times for the receipt of community care will permit VHA to more effectively monitor the timeliness of veterans receiving care regardless of whether the care is received at a VHA facility or in the community.

Clearer Policy Is Needed for VHA's Referral Coordination Initiative

Provisions within the Dole Act require VA to report on referrals made within VHA medical facilities for veterans to receive care from non-VA providers, as well as to review the processes within VHA facilities for making referrals.[13] In January 2025 we examined VHA's Referral Coordination Initiative, which was announced in 2019 and marked a significant change to the process previously followed for specialty care referrals.[14] We issued a report in 2025, in which we described the status of the initiative's implementation and potential benefits, such as reducing appointment scheduling time. However, we also found that facilities experienced mixed results implementing the Referral Coordination Initiative.

Furthermore, as described in our 2025 report, in May 2024, VHA began efforts to improve consistency of Referral Coordination Initiative implementation by increasing regional networks' leadership and oversight of VHA medical facilities' implementation of the initiative. However, we found that VHA had not documented in policy key elements needed to guide the initiative's implementation. Specifically, we found that VHA lacked national policy that defines program direction and had not provided quality guidance that aligns with policy. As a result, VHA networks and medical facilities may continue to experience inconsistencies in the initiative's implementation and the Referral Coordination Initiative may not fully achieve its goals of providing veterans with a full understanding of

[13]For example, the Dole Act requires VA to provide quarterly reports on referrals to non-VA health care and to review workflows associated with referral processing. Pub. L. No. 118-210, §§ 140, 152, 138 Stat. at 2743, 2761.

[14]GAO-25-106678.

their available care options. In our 2025 report, we recommended, among other things, that VHA include Referral Coordination Initiative program direction as part of its national policy. VHA concurred in principle with our recommendation, and said it is in the process of evaluating the strategic direction of the initiative. As of February 2026 it had not implemented our recommendations.

Enhanced Communication Is Needed for IVC to Better Coordinate Care

Provisions within the Dole Act require VA to review and take action on aspects of its community care program. The increased use of community care for veterans is a major change for VA and requires that relatively new VHA entities play key roles in coordinating veterans' care between VA providers and those in the community. For example, VHA's IVC was created to integrate management of both VHA medical facility-based and community care into one entity within VHA's national level central office.[15] According to agency officials, the intent behind this integration is to improve coordination and provide seamless access to care for veterans. In 2025, our evaluation of IVC identified challenges related to VA's communication with field staff about changes within IVC, which oversees the Veterans Community Care Program and other access-to-care-related issues.[16]

Specifically, we reported that as IVC has evolved, VHA has not always clearly communicated with relevant parties, including officials in VISNs and medical facilities and other stakeholders such as Congress, as these changes are being developed and implemented. In our September 2025 report we identified some examples suggesting a lack of clear understanding of IVC's organizational structure among employees in the selected VISNs and VHA medical facilities in our review. For example, officials from one VISN said they did not understand who to contact with questions about training.

In our report we recommended that as VHA continues to evolve IVC and other aspects of its headquarters' structure, it should ensure there is a strategy for clear and continuous two-way communication with relevant employees—including those at the VISN and medical facility-level. Better communication will help IVC to successfully implement its priorities and initiatives to meet its mission to ensure every veteran can access high-

[15]IVC was established in the spring of 2022 when portions of two prior offices within VHA— the Office of Veterans Access to Care and the Office of Community Care—were merged.

[16]GAO-25-107212.

value care where they need it, when they need it. VHA concurred with our recommendation and as of February 2026 it has not implemented it.

Preliminary Results Show VHA Has Responded to Challenges Caregivers Reported but Has Not Fully Assessed Its Efforts

The Dole Act includes a provision for us to review VHA's efforts to provide mental health support for caregivers of veterans.[17] Preliminary results from our ongoing work in this area indicate that VHA responded to challenges caregivers reported in accessing mental health support. However, VHA has not fully implemented performance management practices we identified in our prior work, such as setting goals with quantitative targets and time frames, that would allow it to fully assess the effectiveness of its outreach efforts.[18]

VHA Has Taken Steps to Address Caregiver-Reported Challenges Accessing Program Services

The Dole Act includes provisions to improve support for veterans' caregivers through the Caregiver Support Program and increase their access to mental health treatment.[19] Preliminary results from our ongoing review of the Caregiver Support Program show that VHA offers a variety of services to support caregivers' mental health and wellbeing, such as individual therapy, support groups, self-care education and resources, and respite care. Caregivers we interviewed at four selected VHA facilities said they appreciated the mental health support that the Caregiver Support Program offers. However, the caregivers also reported experiencing some challenges obtaining support. For example, some caregivers said they cannot travel to a VHA facility for in-person services because they live far away or because they cannot leave their veteran alone. Caregivers also expressed concerns about limited staffing and availability of desired services at these facilities.

[17]Pub. L. No. 118-210, § 131, 138 Stat. at 2741.

[18]In our prior work, we define performance management as a three-step process by which agencies (1) set goals with quantitative targets and time frames to identify the results they seek to achieve, (2) collect performance information to measure progress towards meeting its goals, and (3) use that information to assess results and inform decisions to ensure further progress towards achieving its goals. See GAO, *Evidence-Based Policymaking: Practices to Help Manage and Assess the Results of Federal Efforts,* GAO-23-105460 (Washington, D.C.: July 12, 2023).

[19]For example, the Dole Act provides authority for the Secretary of VA to award grants and contracts to improve the provision of mental health services for caregivers in the comprehensive component and includes a provision to improve coordination of assistance and services for caregivers. Pub. L. No. 118-210, §§ 122, 124 138 Stat. at 2724, 2730.

Our preliminary results suggest that VHA has taken some steps to respond to these challenges. For example, starting in fiscal year 2023, VHA implemented a virtual psychotherapy program to provide mental health treatment to caregivers in the comprehensive component through telehealth. Program officials told us that they developed this virtual psychotherapy program to address challenges caregivers faced traveling to VHA facilities for in-person treatment and limited capacity among mental health providers at VHA facilities.

The Dole Act also addresses caregivers' access to respite care, which provides them with breaks from their caregiving duties.[20] Caregivers we interviewed at selected VHA facilities reported using respite care. However, some caregivers identified challenges accessing respite care, including limited availability, concerns about the quality, or limited awareness of the Caregiver Support Program's respite care offerings. Our preliminary review of VHA documentation suggests that VHA has taken some steps to address these concerns by monitoring how many caregivers are using respite care at each VHA facility and requiring those facilities with low utilization to have a plan to educate caregivers about respite offerings.

VHA Developed Goals for Program Awareness but Has Not Fully Assessed Progress

The Dole Act includes provisions related to VA's communication with caregivers about their eligibility and available services.[21] Our ongoing work found that VHA advertises the Caregiver Support Program through various methods such as email updates, brochures at VA medical centers, and partnering with veterans service organizations to share information with veterans and their caregivers. Some caregivers we interviewed had learned about the program through these methods. However, some caregivers told us they wished they had learned about the program sooner and noted that others may not be aware of the support available to them.

To assess whether its outreach efforts are effective at increasing caregivers' awareness of the program, VHA established four goals, according to its communications strategic plan One goal is to increase the number of caregivers enrolled in the general component by 15 percent

[20]For example, the Dole Act provides not less than 30 days annually of respite care for eligible caregivers. Pub. L. No. 118-210, §§ 123, 124(b), 138 Stat. at 2726, 2731.

[21]For example, the Dole Act includes provisions for VA to develop a centralized website for program information and that VA provide outreach to caregivers in the comprehensive component regarding mental health services. Pub. L. No. 118-210, §§ 122, 132, 138 Stat. at 2726, 2742.

each fiscal year. In fiscal year 2025, enrollment in the general component increased to about 28,500 from about 24,800 in fiscal year 2024 (15 percent), thus meeting this goal, according to VHA data.

However, preliminary results from our ongoing work also show that the other three goals, such as increasing subscribers to its email updates, do not have quantitative targets and time frames against which VHA could measure its progress.[22] Setting targets and time frames for these goals would better position VHA to more effectively assess its efforts to raise awareness of the program among caregivers who are not enrolled. If needed, VHA could make adjustments to its outreach to ensure caregivers are aware of and can access support, which would help them to better support the veterans for whom they provide care.

VHA's mission is to provide high quality health care for veterans and to support those who care for them. We have reported for many years on VHA's challenges providing timely access to health care for veterans, including through the Veterans Community Care Program. Our work has identified a number of actions that VHA can take to overcome these challenges. Fully implementing our recommendations would aid VA's progress toward implementing the Dole Act's provisions.

Chairwoman Kiggans, Ranking Member Ramirez, and Members of the Subcommittee, this completes my prepared statement. I would be pleased to respond to any questions that you may have at this time.

GAO Contact and Staff Acknowledgments

If you or your staff have any questions about this testimony, please contact Sharon M. Silas, Director, Health Care, at silass@gao.gov. Contact points for our Offices of Congressional Relations and media relations may be found on the last page of this statement.

GAO staff who made key contributions to this testimony are Jill Center (Assistant Director), Erika Huber (Analyst in Charge), Ann Marie Cortez, Kelly Turner, and Cathleen Whitmore.

[22]According to its communications strategic plan, VHA's other two goals are to increase program inquiries and increase caregivers' use of services.

Appendix I: Selected Open GAO Recommendations Related to the Veterans Community Care Program

Table 1: Status of Open Recommendations Related to the Department of Veterans Affairs' Veterans Community Care Program for GAO Reports Included in This Statement, as of February 2026

GAO recommendation (GAO Report, Date)	Implementation status
The Under Secretary for Health should ensure the Office of Integrated Veteran Care develops and implements a strategy for conducting clear, direct, and continuous two-way communication with relevant employees—including those at regional networks and medical facilities—and stakeholders as the office continues to evolve and makes changes to its central office organizational structure. (GAO-25-107212, September 2025)	Open – not addressed. Veterans Health Administration (VHA) concurred with our recommendation. When we confirm what actions the agency has taken in response to this recommendation, we will provide updated information.
The Under Secretary for Health should ensure that the Office of Integrated Veteran Care defines Referral Coordination Initiative program direction—strategic goals, roles and responsibilities, standards for consistent implementation, and oversight and accountability—in appropriate VHA national policy. (GAO-25-106678, January 2025)	Open – not addressed. VHA concurred in principle with our recommendation. In response to our draft report, VHA acknowledged the importance of clear program direction and stated that should not be interpreted as a stand-alone process but rather one piece of the overall referral management process. We maintain that the Referral Coordination Initiative marks a significant change from how referrals have historically been managed within VHA, and as such, our recommendation that program direction be fully defined in national policy would increase accountability mechanisms and help ensure veterans receive timely and effective care. VHA said it is in the process of evaluating the Referral Coordination Initiative and plans to update its Standard Operating Procedures after a strategic direction has been established. As of February 2026, VHA estimated that its actions would be completed by May 2026.
The Under Secretary for Health, upon inclusion of the Referral Coordination Initiative in the appropriate VHA national policy, should ensure that the Office of Integrated Veteran Care aligns Referral Coordination Initiative guidance with VHA national policy and updates it as needed to reflect available evidence, such as findings from studies, best practices, and other elements that promote consistent implementation. (GAO-25-106678, January 2025)	Open – not addressed. VHA concurred with our recommendation. In response to our draft report, VHA described actions the Office of Integrated Veteran Care would take to promote consistent implementation, such as a future update to Referral Coordination Initiative guidance. For example, VHA stated that the Office of Integrated Veteran Care will update Referral Coordination Initiative guidance to include a Veterans Integrated Service Network-led model that is based on evidence-based studies and identified best practices. As of February 2026, VHA estimated that its actions would be completed by May 2026.
The Under Secretary for Health, following initial alignment of Referral Coordination Initiative guidance and national policy, should ensure that the Office of Integrated Veteran Care establishes a process to ensure that any guidance remains current and accurate when the Office of Integrated Veteran Care makes changes to Referral Coordination Initiative policy or program requirements. (GAO-25-106678, January 2025)	Open – not addressed. VHA concurred with our recommendation. In response to our draft report, VHA stated that the Office of Integrated Veteran Care will establish a process for recurring reviews and revisions of Referral Coordination Initiative guidance and other resources. As of February 2026, VHA estimated that its actions would be completed by May 2026.

Appendix I: Selected Open GAO Recommendations Related to the Veterans Community Care Program

GAO recommendation (GAO Report, Date)	Implementation status
The Under Secretary for Health should ensure that the Office of Integrated Veteran Care reviews the Referral Coordination Initiative performance metrics, and updates them as needed, to ensure that the metrics align with and assess progress toward all aspects of Referral Coordination Initiative's strategic goals. (GAO-25-106678, January 2025)	Open – not addressed. VHA concurred with our recommendation. In response to our draft report, VHA stated that the Office of Integrated Veteran Care is in the process of reviewing, revising, and developing key performance indicators to assess its progress against Referral Coordination Initiative's strategic goals. As of February 2026, VHA estimated that its actions would be completed by May 2026.
The Under Secretary for Health should ensure that the Office of Integrated Veteran Care communicates with Veterans Integrated Service Networks and VHA facilities regarding how to use its metrics to measure performance toward the Referral Coordination Initiative goals. (GAO-25-106678, January 2025)	Open – not addressed. VHA concurred with our recommendation. In response to our draft report, VHA described actions the Office of Integrated Veteran Care will take, including publishing information on the key performance indicators it develops on the internal Referral Coordination Initiative SharePoint. Further, the Office of Integrated Veteran Care plans to use community of practice calls and site visits to communicate informational updates. VHA noted that, through these efforts, the Office of Integrated Veteran Care will also be able to incorporate feedback from Veterans Integrated Service Networks and facilities into the development of its program documentation. As of February 2026, VHA estimated that its actions would be completed by May 2026.
The Undersecretary of Health should align its monitoring metrics with the time frames established in the Veterans Community Care Program scheduling process.[a] (GAO-20-643, September 2020)	Open – partially addressed. VHA initially did not agree with our recommendation but since February 2022 has started to address it. In a directive and standard operating procedure, VHA defined some time frames for VHA facilities to follow when scheduling appointments under the Veterans Community Care Program. The Consolidated Appropriations Act, 2023, enacted on December 29, 2022, requires VHA to establish a specific wait-time measure (the number of days from the date of request for the appointment to the first next available appointment) for veterans eligible for care under the Veterans Community Care Program and requires program third-party administrators to furnish care within this standard. Pub. L. No. 117-328, div. U, tit. I, § 121, 136 Stat. 4459, 5415 (2022). In September 2023, VHA officials stated that they continue to evaluate the technical, logistical, and financial implications of operationalizing these legislative requirements. However, as of February 2026, VHA has not yet defined a timeliness standard for when a veteran's appointment should occur. Once established, VA can take steps to ensure they align their monitoring metric for receipt of care to that timeliness standard

GAO recommendation (GAO Report, Date)	Implementation status
The Under Secretary of Health should direct VA medical center leadership to assess their community care staffing and resource needs, and develop a plan to address any identified risks to their ability to schedule appointments in a timely manner, including strategies to adjust staff levels and address recruitment and retention challenges as needed. (GAO-20-643, September 2020)	Open. VHA agreed with our recommendation and in January 2023, stated that it last updated its staffing tool in March 2022 to enable each VHA medical facility to quantify resource needs and identify the recommended number of administrative and clinical staff based on current workload data, systems, and processes. VHA also stated that VHA medical facilities are to make quarterly updates to the staffing tool, which is then used by the facility community care offices to support position requests and for discussions with leadership regarding community care staffing levels. In addition, VHA submits staffing tool results to Congress every 180 days. Under the Referral Coordination Initiative, VHA transitioned responsibilities for community care appointments from multiple clinical employees to designated referral coordination teams at each VHA medical facility. In January 2023, VHA stated that community care staffing needs are expected to evolve further over the next year as VHA medical facilities continue to recruit staff and implement new business processes, like the use of referral coordination teams and enhanced technological tools to expedite referral management and appointment scheduling. In September 2025, officials stated that they are collaborating with a staffing tool contract team to incorporate a mechanism within the staffing tool that enables Veterans Integrated Service Networks to report any risks associated with timely appointment scheduling. According to VHA officials, this self-assessment feature will allow VHA medical facilities to evaluate if staffing deficiencies are affecting their scheduling capabilities. If a facility identifies any scheduling risks, they are required to develop an action plan, which will be tracked by the networks and reported to the VHA program office for monitoring and further action. VHA officials estimate providing an update on its actions in March 2026.

Source: GAO-25-107212, GAO-25-106678, and GAO-20-643, and GAO analysis of Veterans Health Administration (VHA) information. | GAO-26-108943

[a]GAO identifies priority open recommendations each year. These are GAO recommendations that have not been implemented and warrant priority attention from heads of key departments or agencies because their implementation could help the federal government save large amounts of money or significantly improve government operations. In the 2025 update, this was a priority open recommendation for VA. See GAO, *Priority Open Recommendations: Department of Veterans Affairs*, *GAO-25-108071* (Washington, D.C.: May 5, 2025).

Related GAO Products

Veterans Health Care: Better Communication Needed to Integrate Management of Medical Facility and Community-Based Care. GAO-25-107212. Washington, D.C.: Sept. 2, 2025.

Veterans Health Care: Referral Coordination Initiative for Specialty Care Needs Improved Program Direction and Guidance. GAO-25-106678. Washington, D.C.: Jan. 21, 2025.

Veterans Community Care Program: VA Needs to Strengthen Contract Oversight. GAO-24-106390. Washington, D.C.: Aug. 21, 2024.

Veterans Health Care: Opportunities Exist to Improve Assessment of Network Adequacy for Mental Health. GAO-24-106410. Washington, D.C.: June 3, 2024.

Veterans Health Care: VA Actions Needed to Ensure Timely Scheduling of Specialty Care Appointments. GAO-23-105617. Washington, D.C.: Jan. 4, 2023.

Veterans Community Care Program: VA Needs to Strengthen Its Oversight and Improve Data on Its Community Care Network Providers. GAO-23-105290. Washington, D.C.: Nov. 10, 2022.

Veterans Community Care Program: Improvements Needed to Help Ensure Timely Access to Care. GAO-20-643. Washington, D.C.: Sept. 28, 2020.

STATEMENTS FOR THE RECORD

Prepared Statement of Elizabeth Dole Foundation

Chairwoman Kiggans, Ranking Member Ramirez, and members of the subcommittee, the Elizabeth Dole Foundation would like to thank you for the opportunity to submit our views on the status of implementation of the *Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act*.

The passage of this legislation during the 118th Congress marked one of the most significant Federal policy advancements secured on behalf of veterans, caregivers, and survivors in recent years, and Senator Dole remains both proud and humbled to have had it named in her honor.

The Foundation worked tirelessly with caregivers and our veteran service organization partners to secure its passage not only because of the impact on family caregivers, but also because of the broad array of issues covered in the bill that impact veterans and families. While as an organization we focus on issues of direct impact to caregivers, we also address issues of significant interest to that population. Clearly, the quality of the care and services available to veterans is at the top of that list.

Daily we hear from caregivers asking about the long-delayed finalization of the rule governing the Department of Veterans Affairs Program of Comprehensive Assistance for Family Caregivers (PCAFC). We are now entering year 4 of waiting for a new rule to expand eligibility and improve the program. Even more often, however, we hear from caregivers about their struggles navigating VA's programs and services including Veteran Directed Care, CHAMPVA, respite, home health, skilled care, benefits, home and vehicle modifications, etc.—all programs intended for the veteran but with real life impacts for the whole family.

While there is still work to be done, the Dole Act was intended to address many of these challenges for the benefit of the entire veteran community. We are especially pleased that Section 120, which drastically increased the expenditure cap for non-institutional care, was implemented in September 2025. The enactment of this provision helps our most vulnerable veterans and their caregivers by removing a long-standing barrier to keeping loved ones at home. We encourage VA and the Office of Geriatric and Extended Care (GEC) to continue training clinical providers and social workers both inside and outside GEC on this opportunity to ensure those in need are aware of available services.

However, the Elizabeth Dole Foundation has questions and concerns regarding multiple remaining provisions and their current status.

Section 101:

Section 101, also known as the "Medical Best Interest" provision, allows veterans to access care in the community if it is determined by the clinician that it is in the veteran's medical best interest to do so. We supported this provision because we recognize both the need to ensure VA is able to offer robust, high-quality care as well as provide access to necessary care in a timely manner, sometimes found in the community. We are familiar with cases where this provision was especially helpful in getting a veteran to appropriate specialty care. However, VA's regulations that govern necessary travel often associated with care in the community have not yet caught up to the intent of section 101.

Under the current rules, VA can only authorize travel reimbursement to the closest medical facility that can provide the necessary care. Since the relevant provision does not comment on the facility's capability—only on the veteran's medical best interest—we are seeing travel authorizations denied even though the care itself is authorized. We encourage VA to reconcile this language to ensure that veterans and their family members are not unnecessarily and unintentionally caught in a bureaucratic trap that leads to either increased out-of-pocket expenses or an inability to access care.

Section 122:

Based on the Chairwoman's COPE Act, this provision authorizes the VA Secretary to award grants to community-based organizations to provide mental health services to family caregivers participating in PCAFC. According to a 2024 RAND study commissioned by the Elizabeth Dole Foundation, caregiving often places significant strain on caregivers and increases their risk for developing physical and mental health conditions, including depression and suicidal ideation. Relatedly, caregivers' mental well-being directly affects the quality of care provided, impacting outcomes for both caregivers and those they support. By prioritizing the mental health of caregivers, the overall effectiveness of care can be enhanced.

Recognizing both the value and risks associated with caregiving, VA established a program through which PCAFC caregivers can receive mental health care from VA providers, with options available through both telehealth and in person. With approximately 29,000 encounters among 4,374 patients in Fiscal Year 2025, the program is certainly beneficial and a significant step in the right direction. However, caregivers enrolled in PCAFC are often hesitant to seek mental health services directly from VA for fear their participation will impact their eligibility for the caregiver support program. In addition, they are hesitant to use another VA program, as it is perceived as an additional care coordination burden.

While VA has not yet issued grants in accordance with section 122, as it was discretionary and not mandatory, the Elizabeth Dole Foundation strongly supports the establishment and issuance of these grants to increase opportunities for access to necessary mental health care for family caregivers. In addition, the Elizabeth Dole Foundation supports increasing the pool of eligible participants to those enrolled in the VA's Program of General Caregiver Support Services (PGCSS), rather than just PCAFC, to improve the health and well-being of a larger pool of caregivers as well as that of the veterans for whom they care.

Section 123:

Derived from the original *Elizabeth Dole Home Care Act* introduced by Representatives Brownley and Bergman, Section 123 codifies the Home and Community Based Services (HCBS) programs to ensure their long-term viability. Under this provision, the Veteran Directed Care (VDC) program, provided in partnership with the Administration on Community Living (ACL), is required to be provided at each VA medical center. VDC provides a flexible, monthly budget, allowing veterans to hire their own caregivers—— including family or friends—and purchase services to manage their care. This system offers more control and ownership of that care to the veteran and caregiver and, where utilized, has proven very effective.

VA has stated that VDC is now technically available in all VA medical centers, but we have learned that access remains difficult due to a limited number of contracts in place, staffing VDC as a collateral duty, and a general lack of knowledge of program availability. In order to learn what steps may have been made to address some of these challenges, the Elizabeth Dole Foundation requests VA brief all interested veteran service organizations regarding the current status of VDC implementation including enrollment numbers and locations, current contract availability, and staffing models. This briefing will help VA identify ongoing challenges as they seek the full implementation of this valuable program.

Sections 123 and 124:

The Elizabeth Dole Foundation was pleased to participate in a recent roundtable hosted by the Senate Veterans Affairs Committee to discuss many of the improvements to PCAFC required under sections 123 and 124. These include the enhanced use of automation to facilitate information gathering and eligibility determination processes as well as improvements to decision letters to better inform applicants. The Elizabeth Dole Foundation was also pleased to learn that steps are being taken to improve the coordination of care between the PCAFC program and services available to individuals under GEC.

While we appreciate these positive steps, the Elizabeth Dole Foundation is gravely concerned that the final rule governing the PCAFC program has not been issued. As mentioned above, recognizing significant challenges and an excessive number of caregiver removals in March 2022, the VA suspended discharges from the program in an effort to pause, review, and discuss needed changes. Eventually, VA entered into a new rulemaking process and issued a proposed rule in December 2024. Garnering over 800 comments, this proposed rule appears to be stalled; we are now well over a year after its issuance, leaving this highly vulnerable population of family caregivers in limbo as they wait to learn their fate. Worse, the very rule that was recognized as insufficient in 2022 and that resulted in the pause, is still being used today to determine eligibility for new applicants, leaving many out of the program whom Congress intended to cover. The Elizabeth Dole Foundation strongly urges

Congress to use its oversight authority to impress upon VA the urgency of finalizing a rule quickly that supports family caregivers and aligns with congressional intent.

Section 129:

Commonly referred to the "Pathway to Advocacy" this provision requires the VA Secretary to establish a process by which organizations can become trained, certified and recognized to help a veteran, caregiver, or survivor to navigate the services of the Veterans Health Administration. Too often, this committee learns of situations where vulnerable individual veterans or their family members are unaware of or unable to access the programs intended to help them, even though VA has the services necessary to support them. Given the potential positive impacts of this initiative on connecting veterans, caregivers, and survivors with needed resources, the Elizabeth Dole Foundation again recommends that VA brief interested organizations on the status of this provision's enactment and solicit feedback to ensure any recommendations align with congressional intent.

Section 130:

Given veteran preference for care in the home, GEC provides an invaluable set of tools to both accommodate the veteran's wishes and support the family caregivers who are often thrust into this role. Among other things, section 130 requires that VA undergo an extensive review of these services to ensure consistency in program management, appropriate staffing levels, proper care coordination, and eliminate service gaps. While this provision was enacted prior to the current reorganization efforts underway at the agency, the Elizabeth Dole Foundation encourages VA to enact the provisions in the spirit in which they were intended to ensure that these vital programs are staffed appropriately to better serve veterans and caregivers.

Conclusion:

The passage of the *Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act* provided an opportunity for VA to implement bipartisan legislation that was carefully crafted with the support of many in the veteran community. As VA continues its work on the implementation of this law, we encourage the agency to update and solicit regular feedback of relevant veteran service and non-profit organizations to achieve our mutual goal of serving veterans, caregivers, and survivors.

The Elizabeth Dole Foundation would once again like to thank the subcommittee for the opportunity to present our views today. We look forward to continuing to work with you on the full and prompt implementation of this law and would be happy to answer any questions.