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***STATEMENT OF***
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***LEGISLATIVE HEARING***
***COMMITTEE ON VETERANS' AFFAIRS***
***UNITED STATES HOUSE OF REPRESENTATIVES***
***May 20, 2026***

Chairman Bost, Ranking Member Takano and Members of the Committee:

We appreciate the opportunity for DAV (Disabled American Veterans) to provide testimony at today's hearing on legislation under consideration by the Committee. As you know, DAV is a congressionally chartered and Department of Veterans Affairs (VA)-accredited veterans service organization (VSO) with nearly 1 million members dedicated to ensuring our promise is kept to America's veterans. DAV does this by helping veterans and their families access the full range of benefits available to them, fighting for the interests of America's injured heroes on Capitol Hill, providing employment resources to veterans and their families, offering programs and services to empower them, and educating the public about the great sacrifices and needs of veterans transitioning back to civilian life.

**H.R. 210, the Dental Care for Veterans Act**

DAV strongly supports H.R. 210, the Dental Care for Veterans Act, in accordance with Resolution No. 49, because it advances a fundamental principle of health care: oral health is an essential component of comprehensive medical care and should not be treated as an optional or secondary benefit for veterans, particularly those with service-connected disabilities. Veterans whose disabilities were incurred in service should not be denied medically necessary dental care due to outdated statutory limitations that no longer reflect modern health care standards or the realities of veterans' medical needs.

H.R. 210 would require VA to furnish dental care "*in the same manner as any other medical service*" to all veterans enrolled in the VA health care system. The bill establishes a phased eligibility schedule, expanding access over several years based on VA priority groups. We believe this approach appropriately balances equity in access with the practical considerations of implementation.

Our position is informed by the lived experience of veterans whose service-connected disabilities, prescribed medications, radiation therapy or mental health conditions contribute directly to serious dental conditions. Secondary effects

including periodontal disease, tooth decay, bruxism and temporomandibular joint disorders would remain uncovered under current VA policy, even when they are medically linked to service-connected disabilities or their treatment. Left unaddressed, these conditions can cause irreversible damage, chronic pain and systemic health complications that undermine overall health and quality of life.

According to VA, approximately 9 million veterans are enrolled for health care, but only about 2.4 million are currently eligible for dental care. Because VA's dental resources are already at full capacity in most locations, Congress must ensure adequate resources, workforce growth and community care capacity to protect access for veterans currently receiving dental services. In our FY 2027 Veterans Independent Budget report, co-authored by the Veterans of Foreign Wars (VFW), we proposed making full dental coverage available to all disabled veterans and recommended an additional $675 million for dental care in FY 2027. We propose that VA use that funding to hire additional dental providers and expand dental treatment space in VA facilities, while also supporting expanded community care access as VA increases its internal capacity. We understand this might entail administrative challenges and additional costs to implement the expansion, but that does not justify maintaining inequitable statutory exclusions that deny medically necessary care to veterans, particularly those with service-connected disabilities.

## H.R. 1391, Student Veteran Benefit Restoration Act of 2025

DAV supports H.R. 1391, the Student Veteran Benefit Restoration Act of 2025, in accordance with Resolution No. 179, because veterans who are defrauded by educational institutions should not lose the education benefits they earned through service. When schools engage in fraud, deceptive practices or lose approval to receive VA education benefits, the resulting harm falls squarely on veterans who relied on those institutions in good faith. Restoring lost entitlement is a matter of fairness, accountability and protecting the integrity of veterans' education programs.

H.R. 1391 would require VA to restore education entitlement when veterans are harmed by schools that lack proper approval, engage in fraud or deceptive practices or were closed for legal violations. Under the bill, such payments would not be charged against a veteran's entitlement or counted toward the aggregate period of eligibility for VA education benefits. This legislation also requires educational institutions, as a condition of approval, to repay VA when entitlement is restored due to institutional misconduct.

In testimony, VA stated that the bill would hold institutions financially responsible only for tuition and fee payments made directly to schools, but not for benefits paid directly to veterans, such as housing allowances, book stipends, or subsistence payments, even though entitlement for those benefits would be restored.

DAV agrees that accountability must be comprehensive. When institutional misconduct results in the misuse of VA education benefits, responsibility should extend

to the full cost of taxpayer dollars expended, not only those payments routed directly to the institution. Limiting recoupment to tuition and fees risks leaving institutions insulated from the broader financial consequences of their actions while shifting those costs to VA and taxpayers. Any final legislation should ensure that institutions engaging in fraud or deceptive practices are held appropriately accountable, so veterans are fully protected, and program integrity is preserved.

**H.R. 1732, GUARD VA Benefits Act**

We strongly support H.R. 1732, the Governing Unaccredited Representatives Defrauding (GUARD) VA Benefits Act, consistent with DAV Resolution No. 632 and our commitment to protecting veterans and their earned benefits from fraud and scams.

The GUARD VA Benefits Act would reinstate fines for individuals who solicit, contract for, charge or receive unauthorized fees in connection with the preparation, presentation, or prosecution of VA benefits claims. Prior law included penalties for this conduct, but those penalties were repealed. H.R. 1732 restores meaningful enforcement authority to deter predatory practices that exploit veterans and their families.

In recent years, a growing number of entities have emerged claiming to provide "*consulting*," "*coaching*," or other resources related to VA disability claims for a fee. These entities assert that because they do not formally represent veterans before VA, they are not required to be accredited and are therefore not subject to VA oversight. As a result, they charge veterans and their families while operating outside the accreditation framework intended to ensure training, ethical standards, accountability and consumer protections. Their fee agreements are not reviewed by VA, and their activities fall beyond the safeguards designed to protect veterans.

Because these actors are unaccredited, they are not required to complete VA training, follow VA's code of conduct or undergo background checks. DAV is deeply concerned that this business model is deliberately structured to circumvent protections established to safeguard veterans and their families, exposing them to financial harm, misinformation and exploitation.

For many disabled veterans, VA disability compensation is not supplemental income, it is essential to basic financial stability. Improper guidance, excessive fees or delayed claims can have serious consequences, including housing insecurity. That is why DAV has long maintained that veterans seeking assistance with VA benefits must be served by properly accredited individuals and organizations who are trained, vetted and accountable.

Some have claimed that the GUARD VA Benefits Act infringes on veterans' constitutional rights. DAV respectfully disagrees. The bill does not regulate speech or restrict access to information. It regulates professional conduct, specifically, the charging of unauthorized fees in a federally administered benefits system. Courts have

consistently recognized the government's authority to regulate professional conduct to protect the public, particularly vulnerable populations. Restoring penalties for unauthorized, for-fee claims assistance is a lawful and reasonable exercise of that authority.

DAV urges enactment of the GUARD VA Benefits Act to deter predatory practices, reinforce the accredited representation system and protect disabled veterans and their families from exploitation.

**H.R. 2303, the Board of Veterans' Appeals Attorney Retention and Backlog Reduction Act**

H.R. 2303 would allow non-supervisory Board attorneys to be promoted to General Schedule grade GS-15. The stated purpose of the bill is to improve recruitment and retention and to increase decision quality and claims processing speed at the Board. This legislation seeks to address challenges associated with retaining experienced attorneys whose work involves complex statutory interpretation, medical evidence reviews and evolving veterans' benefits law.

While DAV has no resolution specific to this proposal, and takes no position on H.R. 2303, we recognize that staffing stability, institutional expertise and workforce retention affect veterans' experiences in the appellate process. We look forward to continued dialogue with Congress and VA to strengthen the Board so that it has a skilled and stable workforce capable of issuing timely, accurate and consistent decisions.

**H.R. 3183, SAFE STEPS for Veterans Act of 2025**

DAV supports H.R. 3183, the Supporting Access to Falls Education and Prevention and Strengthening Training Efforts and Promoting Safety Initiatives (SAFE STEPS) for Veterans Act of 2025, in accordance with Resolution No. 528, because falls represent a significant and growing risk for aging veterans and veterans with disabilities, often resulting in serious injury, loss of independence and increased health care utilization. Preventing falls is a critical component of veteran safety, quality of life and long-term health outcomes.

H.R. 3183 would establish an Office of Falls Prevention within the Veterans Health Administration (VHA). The bill would direct this Office to develop and implement standards of care related to falls prevention; monitor and address deficiencies in falls-related care across VA facilities and community settings; coordinate education and outreach efforts; and promote research and evidence-based interventions aimed at reducing falls among veterans. This legislation also includes provisions to strengthen fall-risk assessments, safe patient handling and evaluation of home-modification programs that may help prevent falls.

Although VA has established a Falls Prevention and Management program, falls prevention requires sustained, system-wide attention and clear accountability. Establishing a dedicated Office of Falls Prevention in statute would help ensure long-term continuity, coordination, and focus across administrations and organizational changes. Veterans with mobility limitations, chronic conditions, and service-connected disabilities face heightened fall risks, and a comprehensive, coordinated approach can reduce preventable injuries while supporting veterans' ability to live safely and independently through a consistent, evidence-based framework.

## H.R. 3869, the Every Veteran Housed Act

DAV supports H.R. 3869, the Every Veteran Housed Act, in accordance with Resolution No. 215, because stable housing is foundational to veterans' health, economic security and successful reintegration into civilian life. Veterans experiencing homelessness often face overlapping challenges, including disabilities, mental health conditions and economic hardship, that cannot be effectively addressed without first ensuring access to safe and stable housing. Reducing barriers to homelessness assistance is essential to meeting the nation's commitment to end veteran homelessness.

Currently, there are multiple eligibility requirements for different federal veterans homeless assistance programs. H.R. 3869 would simplify and expand eligibility for VA homelessness programs by creating a single and more inclusive statutory definition of "eligible veteran" for those programs. Specifically, the bill would include individuals discharged under conditions other than dishonorable, regardless of length of service, duty status, or component, allowing more veterans to access homelessness assistance administered by VA. The bill also makes conforming amendments to ensure that minimum active-duty service requirements do not exclude otherwise eligible individuals from receiving homelessness benefits.

Veterans who served honorably and are experiencing homelessness often face the same risks and challenges regardless of service length or duty status. Expanding eligibility better reflects the realities of veteran homelessness and prioritizes housing stability as a necessary first step toward improved health, employment and long-term self-sufficiency, while underscoring the importance of working with VA to ensure implementation strengthens, rather than strains, the delivery of homelessness services.

## H.R. 4114, the EVEST Act

DAV supports H.R. 4114, the Ensuring Veterans' Smooth Transition (EVEST) Act, in accordance with Resolution No. 384, because timely connection to VA health care during the transition from military service to civilian life is essential and administrative delays can create avoidable gaps in care. Successful execution will ultimately determine whether this policy benefits veterans as intended, making careful attention to implementation essential.

H.R. 4114 would require VA to enroll eligible veterans in the patient enrollment system within 60 days after receiving qualifying information. The bill also requires VA to provide veterans with notice of enrollment, instructions on how to opt out and information on how to enroll at a later date. Notices must be provided by mail and, to the extent practicable, electronically, with consideration given to mass texting. In addition, the bill requires VA to submit an implementation report to Congress and directs GAO to study best practices for providing notice.

DAV has concerns about whether the notice and opt-out framework will function in a manner that is clear, accurate, and protective of veterans' interests. The effectiveness of the bill will depend heavily on the quality and timeliness of communications and the simplicity of the opt-out process. If these elements are confusing or delayed, veterans could encounter administrative friction at precisely the point the legislation is designed to reduce it. The bill's requirement that VA report on both anticipated and unanticipated implementation challenges underscores that these risks are foreseeable and should be addressed proactively.

A key implementation concern identified by VA is how the legislation would affect eligibility for tax credits related to the Affordable Care Act, and whether automatic enrollment in VA health care constitutes minimum essential coverage, which could make some veterans ineligible for marketplace tax credits. VA cautioned that veterans who planned to rely on, or had already received, marketplace tax credits could be adversely affected if they were automatically enrolled in VA health care without clear understanding or timely notice. DAV shares this concern and emphasizes that veterans must receive clear, plain-language information to make informed coverage decisions or opt out when appropriate, without unintended financial consequences for themselves or their families.

## H.R. 5203, to direct the Secretary of Veterans Affairs to update directives of the Department of Veterans Affairs regarding the management of acute sexual assault

Sexual assault is among the most devastating traumas a person can experience, particularly for veterans who have already sacrificed in service to this nation. Failing to receive timely, competent and compassionate care in the immediate aftermath of such an assault compounds that harm immeasurably. Military sexual trauma affects veterans across all service branches, genders and eras, and its consequences extend far beyond the initial assault, contributing to lasting mental health conditions, physical health complications and diminished quality of life.

Despite the known prevalence of military sexual trauma among veterans, oversight reviews by the VA Office of Inspector General and the Government Accountability Office show that VA facilities have not consistently maintained the personnel, supplies or care coordination needed to respond effectively to survivors seeking emergency care. The current patchwork of facility-level policies has left too many veterans without access to a Sexual Assault Nurse Examiner or other certified

Sexual Assault Forensic Examination provider, without timely offers of prophylactic treatment and without clear pathways to mental health support in the critical hours following an assault. These gaps are not merely administrative shortcomings; they represent a profound failure of the care system veterans have earned and deserve, underscoring the urgent need for standardized, enforceable and consistently implemented departmental directives.

H.R. 5203 would address these systemic deficiencies by requiring VA to update directives related to military sexual trauma within 18 months of enactment and ensure that every VA medical facility either employs certified forensic examination personnel, coordinates community referrals under existing authorities or establishes alternate plans of care. The bill mandates that facilities maintain unexpired rape kits, offer clinically indicated prophylaxes for sexually transmitted diseases and pregnancy and provide survivors with access to mental health services or coordinated referrals. It also requires clear guidance for VA police on documenting and reporting acute sexual assaults in a manner that balances survivor confidentiality with applicable federal, state and local reporting requirements.

The bill requires annual training for both VHA employees and VA police officers, grounded in trauma-informed curricula, tailored to facility-specific resources and delivered through guided instruction rather than passive materials. This would create meaningful accountability and help ensure that staff are prepared to respond appropriately and compassionately. The oversight role assigned to Veterans Integrated Service Network (VISN) directors strengthens accountability by requiring monitoring, analysis and remediation of compliance gaps, rather than allowing deficiencies to persist unaddressed.

DAV supports H.R. 5203, in accordance with Resolution No. 309, as a necessary and overdue step toward ensuring that veterans who experience sexual assault receive consistent, trauma-informed and clinically appropriate care at every VA facility, while advancing congressional action to correct systemic failures and reaffirm a strong commitment to protecting the dignity, health and well-being of veterans.

## H.R. 6580, the VA National Formulary Act of 2025

H.R. 6580 would codify a uniform national formulary for the VA and significantly restrict the use of local formularies at VISN and individual medical centers. While the bill preserves access to non-formulary medications through a centralized request and appeals process, it would limit local flexibility by prohibiting facilities from maintaining medications outside the national formulary except through waivers approved at the national level. The bill also establishes new governance structures, reporting requirements and timelines for formulary decisions, as well as tiered copayment structures intended to incentivize formulary and generic drug use.

DAV has no resolution specific to this legislation, and takes no position on H.R. 6580; however, we do have questions about how this proposal could affect veterans'

clinical care, continuity of treatment and individualized medical decision-making. We believe that formulary policy should remain sufficiently flexible to ensure that clinical judgment, not administrative structure, remains the primary driver of treatment decisions. Prescription medications are a cornerstone of care for veterans managing chronic, complex or service-connected conditions. If the Committee intends to move forward with this legislation, we urge you to ensure that any reforms to formulary governance promote transparency and consistency without undermining clinical discretion, individualized care or timely access to medically necessary therapies. We want to ensure that new, innovative, and novel medications, treatments and therapies are not stifled or delayed through reforms seeking standardization, efficiency or cost savings. Veterans have earned the right to the latest, safest and best medical care available, including pharmaceuticals.

## H.R. 6583, the Research Reform Act of 2025

H.R. 6583, the Research Reform Act of 2025*,* would comprehensively restructure the entire VA research enterprise which has operated successfully as a partnership bringing together the VA health care system, academic affiliates, nonprofit research corporations and other public and private research entities. For more than 50 years, VA research programs have produced major medical breakthroughs that improved care for both veterans and the broader public, including pioneering work on the first implantable cardiac pacemaker, development of the nicotine patch, advances in prosthetics, PTSD treatment and innovations in electronic health records. VA research has led to Nobel Prize–winning discoveries and improved treatments for numerous conditions, including spinal cord injury, traumatic brain injury and PTSD. While the intention of this legislation may be to make VA research more efficient and effective, DAV cannot support the legislation as currently drafted.

DAV is a member of Friends of VA Medical Care and Health Research (FOVA), a national coalition of more than 150 academic, medical, scientific, patient advocacy and veterans organizations dedicated to strengthening VA's health care and medical research enterprise. FOVA has thoroughly reviewed the legislation and concluded that VA research *"…does not require wholesale restructuring, but rather an investment towards modernization that enhances what already works."* DAV shares FOVA's concerns.

H.R. 6583 would establish the "VA Centralized Research Data System", requiring detailed information for each research project, identifying department and non-department funding, the name and affiliation of principal investigators and collaborators and the status and dates of approvals such as IRB approvals or exemptions. DAV agrees with FOVA that this type of centralized reporting would require detailed disclosure of all research activities, including funding sources and collaborations, without sufficient safeguards. FOVA warned that this could expose sensitive information and discourage the external investment and partnerships on which VA research depends. We share this concern and believe any modernization effort must protect the confidentiality and contractual frameworks that sustain VA research partnerships.

The bill would also impose a tiered review system with standardized national timelines applied uniformly across VA facilities, and it provides Office of Research and Development (ORD) override authority if review timelines are not met. FOVA warned that granting ORD the authority to intervene in or override local review processes "…*directly weakens local institutional review boards…*," which are essential to ethical oversight and regulatory compliance, and noted that delays in study activation stem from resource constraints and bureaucratic complexity rather than from a lack of centralized authority. We agree that improving timeliness is a legitimate goal, but reforms should focus on capacity and process improvements, not weakening the local oversight structures that protect veteran research participants.

H.R. 6583 would further direct VA to develop and implement research performance metrics used to benchmark facilities and identify highest performers and facilities lagging behind, and it would establish regional research hubs within VHA under ORD. FOVA argued that public benchmarking across facilities, without accounting for differences in size, geography or patient populations, risks distorting priorities and incentivizing volume over meaningful scientific and clinical impact, and that creating new hub structures risks duplication, not improvement by layering bureaucracy over existing partnership-based capabilities. We share the concern that additional administrative layers, without new resources, could slow research activity, complicate roles and responsibilities and divert attention from patient-focused investigation.

DAV opposes H.R. 6583 as drafted because it would restructure and centralize VA's research enterprise in ways that, as FOVA warned, could threaten the partnership-based ecosystem, weaken local ethical oversight capacity, and introduce new reporting, benchmarking, and governance mandates without adequate safeguards or resources. We urge the Committee to pursue reforms that strengthen what works, reduce unnecessary administrative burden and invest in workforce and infrastructure, rather than impose structural changes that could destabilize a proven research system that benefits veterans and all Americans.

## H.R. 6599, the Leasing and Infrastructure Act of 2025

H.R. 6599 would provide the VA with independent authority to enter into leases for major medical facilities, subject to congressional prospectus approval, and would establish a Veterans Leasing Fund to centralize leasing obligations. The bill also includes new cost-estimation and reporting requirements, including market-based cost estimates and standardized life-cycle cost methodologies for major medical facility leases, as well as periodic updates to VA design guides. DAV has no resolution for these specific proposals and takes no position on the legislation.

DAV recognizes the urgent need to modernize VA's aging infrastructure to meet rising demand for care and ensure veterans have timely access to safe, high-quality medical facilities. Any reforms to leasing authority and funding mechanisms should support VA's role as the primary provider and coordinator of veterans' health care. More

importantly, VA and Congress must begin to seriously invest in VA's hospitals, clinics and other health care infrastructure in order to sustain the VA health care system. For decades, VA has requested, and Congress has appropriated, significantly less for VA's health care infrastructure than is required.

In the latest *Veterans Independent Budget (VIB)*, co-authored by DAV and the VFW, we pointed out that VA's Strategic Capital Investment Planning (SCIP) last year estimated it would require an investment of $85 billion in Major and Minor Construction to maintain VA's health care system capacity. Meeting that target would require an average appropriation of approximately $8.5 billion each year. Yet, over the past three years, VA has requested, and Congress has approved, an average of less than $2.3 billion, contributing to the lack of safe treatment space and reduced capacity to meet rising demand for care. To begin correcting this infrastructure gap, the VIB recommends an increase to $3.6 billion for Major and $5.1 billion for Minor Construction in FY 2027. We also note that in its latest budget proposal for FY 2027, VA dramatically slashed its 10-year SCIP estimate from $85 billion to approximately $28 billion without any explanation. A reduction of this magnitude in VA's health care infrastructure could have catastrophic consequences. We call on the Committee to significantly increase funding to properly maintain, repair, rehabilitate and replace VA hospitals and clinics that are the foundation of the entire VA health care system.

**H.R. 6733, the VISN Reform Act of 2025**

H.R. 6733 would significantly alter the management structure of VHA by reducing the number of geographically defined regional networks from the current 18 to just 8 VISNs. The legislation would also limit each VISN headquarters to no more than 50 full-time employees, with limited waivers, and would require all VHA employees working at any facility within a VISN to report directly to the VISN director.

While DAV has no resolution specific to the number and organization of VISNs, and takes no position on the legislation, we have concerns about the impact of this legislation based on recent efforts to significantly shrink the VA health care system, including workforce reductions in 2025, the latest VA budget proposal, a huge new community care contract proposal and VA's plan to reorganize and streamline VHA.

According to VA, its workforce was reduced by approximately 30,000 employees last year through attrition, resignations and a federal hiring freeze, the largest reduction in the history of the department. This workforce reduction took place even though VA continues to report that there are over 40,000 vacancies across its health care system and the demand for direct care is rising.

VA's new FY 2027 and FY 2028 budget proposal includes a dramatic shift in funding away from VA-provided direct care to private sector community care. Specifically, the two-year total resource request for direct care in FY 2028 represents just a 1.4% increase over FY 2026, which doesn't come close to accounting for medical inflation or rising enrollment and usage. In fact, the budget request states that, *"…VHA*

*is assuming that staffing levels will decrease, which is expected to reduce VHA capacity to provide for the growing demand for VA direct care services.*" By contrast, VA's total resource request for private sector community care would increase by 54% from FY 2026 to FY 2028, significantly shifting care delivery from VA to the private sector.

Further evidence of this shift is the enormous reduction in VA's projected infrastructure investment over the next decade. VA's Strategic Capital Investment Planning (SCIP) process, which estimates how much funding will be required to maintain VA's physical infrastructure – primarily its hospitals and clinics – was cut by more than 60% in the budget proposal. Further, VA last year announced an historic increase in spending on private sector care through a new 10-year, $1 trillion community care contract. Taken together, these proposals reflect a future VA health care system that is significantly smaller, with fewer hospitals and clinics, requiring fewer managers and administrators, and serving fewer veterans. In this context, reorganization proposals that reduce the number and staffing of VISNs appear to align with a shrinking VA health care system.

DAV believes that maintaining a comprehensive, nationwide, integrated, full continuum of care VA health care system is essential for America's veterans, particularly disabled veterans. VA must remain the primary provider and coordinator of care for enrolled veterans. We know that VA cannot provide care to all enrolled veterans at all times and in all locations, so we have consistently backed a robust community care program that works seamlessly with VA to ensure that no veterans are forced to wait too long or travel too far to receive the care they have earned through their service.

For these reasons, we urge the Committee to carefully review VA's reorganization plans and this legislation to ensure they do not endanger the long-term viability of the VA health care system. Further, we call for serious and sustained investment in VA's hospitals and clinics as well as sufficient funding its medical care programs to meet veterans' rising demand for care and assure the long-term continuation of the irreplaceable VA health care system.

**H.R. 6764, the Veterans Affairs Advisory Committee Oversight Act of 2025**

H.R. 6764 would significantly restructure the VA's statutory advisory committee framework by eliminating numerous long-standing, specialized advisory committees and replacing them with a small number of newly created committees with overly broad and expansive portfolios. While DAV appreciates the Committee's interest in improving efficiency and oversight within VA's advisory system, we believe the approach taken in this legislation would ultimately weaken veteran representation, dilute subject-matter expertise and reduce the effectiveness of stakeholder input into VA policy and program decisions.

The bill would establish four new advisory committees covering veterans' health, economic opportunity and transition, special populations and compensation and memorial affairs, while sunsetting or terminating more than a dozen existing advisory

bodies that currently focus on discrete veteran populations and policy areas. Many of these existing committees, such as those addressing women veterans, disability compensation, minority and tribal veterans, education, geriatrics, environmental hazards and memorial affairs, were created by Congress because those issues require sustained, specialized attention informed by lived experience and technical expertise.

We are concerned that consolidating these distinct responsibilities into a limited number of broadly tasked committees would overburden committee members and make it unrealistic to expect meaningful, timely and well-informed recommendations across such a wide range of complex issues. Rather than improving oversight, this consolidation risks producing more generalized advice that lacks the depth necessary to address the unique challenges faced by different veteran communities.

Equally troubling is the loss of institutional knowledge and continuity that would result from terminating long-standing advisory committees that have developed deep expertise and established trust with veteran communities over many years. Advisory committees function best when members can build experience, institutional memory, and sustained engagement, qualities that are undermined by wholesale elimination and restructuring.

We support transparency, accountability and effective oversight at VA. However, we believe those goals are best achieved by strengthening and modernizing existing advisory committees, not by dismantling them and replacing them with fewer, overextended bodies. Veterans are not a monolithic population, and VA benefits and health care programs are too complex to be adequately advised through a one-size-fits-all committee structure.

For these reasons, DAV opposes H.R. 6764 and urges Congress to reconsider this approach. We stand ready to work with the Committee to identify reforms that enhance advisory committee effectiveness while preserving the focused expertise and veteran voices that are essential to sound policymaking.

## H.R. 6843, Veterans Economic Opportunity and Transition Administration Act of 2025

DAV supports H.R. 6843, in accordance with Resolution No. 358, which would establish a Veterans Economic Opportunity and Transition Administration within VA to oversee and administer programs related to veterans' economic opportunity. The bill would create a new Under Secretary for Veterans Economic Opportunity and Transition to lead the Administration and be directly accountable to the Secretary for its operations.

The bill would assign the new Administration responsibility for administering vocational rehabilitation and employment programs, educational assistance programs, veterans' housing loan and related programs, the Transition Assistance Program, and other VA programs as determined appropriate by the Secretary. The legislation would

also require VA to include information on these programs in its annual report to Congress.

The proposal seeks to improve coordination, accountability and leadership across VA's education, employment and transition programs. Veterans navigating the transition from military service to civilian life often interact with multiple VA education, training, rehabilitation, employment, housing and entrepreneurship programs, and fragmentation among the programs can create confusion, inefficiency and barriers to timely assistance. A unified organizational structure has the potential to improve strategic planning, policy alignment and service delivery for veterans pursuing education, employment and long-term economic stability.

VA has cited concerns related to implementation, resources and transition planning. DAV emphasizes that any reorganization must be carefully implemented, adequately resourced and phased in a manner that avoids disruption of benefits or services currently relied upon by veterans. Clear oversight and sustained congressional engagement will be essential to ensure veterans' experience improves, rather than diminishing, access to economic opportunity programs during and after the transition.

## **H.R. 6904, Veterans Readiness and Employment Improvement and Accountability Act of 2025**

H.R. 6904, the Veterans Readiness and Employment Improvement & Accountability Act, would make several structural and policy changes to the VA's Veterans Readiness and Employment (VR&E) program. DAV strongly supports the VR&E program as a critical pathway for service-disabled veterans to achieve suitable employment, economic stability and, where necessary, independent living. VR&E is not merely a training or benefits program; it is a rehabilitative service designed to accommodate the individualized needs, limitations and employment barriers faced by veterans with service-connected disabilities. Legislation affecting VR&E must therefore preserve flexibility, clinical judgment and veteran-focused decision making.

Section 2 of the legislation would authorize VA to bar a person convicted under 18 U.S.C. §111 for an offense against a VA officer or employee from educational, training and rehabilitation benefits under chapters 30, 31, 33, 35, or 36. As VA stated in testimony, VR&E already has authority under 38 U.S.C. §3111 to discontinue services for veterans who fail to maintain satisfactory conduct or cooperation. Further, 18 U.S.C. §111 already provides criminal penalties up to 10 years in prison. We support maintaining safe working environments for VA personnel but believe establishing an additional statutory bar to education and rehabilitation benefits is unnecessary and inconsistent with the rehabilitative purpose of these programs; DAV therefore opposes this section.

Section 3 would allow veterans in need of rehabilitation services to overcome a serious employment handicap to remain eligible for vocational rehabilitation for the one-year period after training if they do not obtain employment in the occupation for which

they were trained. DAV supports this flexibility as a practical improvement to help veterans achieve meaningful, sustained employment.

Section 4 would require a second and higher-level VA approval process for equipment purchases exceeding $5,000 for veterans enrolled in a rehabilitation program. It would also require annual reporting to Congress identifying the equipment purchased, the reason for the purchase, and the total equipment purchased for the veteran's rehabilitation program. DAV is concerned that codifying fixed dollar thresholds and caps in statute, without sufficient flexibility to account for inflation, market-driven cost increases, and evolving rehabilitation needs, could compound administrative delays and unintentionally restrict timely access to essential rehabilitation services. We are also concerned about whether additional approval and reporting layers could delay time-sensitive rehabilitation support. We note that VA does not support this section, warning that implementing the reporting requirement without a centralized tracking mechanism could delay provision of essential rehabilitation equipment tied directly to employment readiness and independent living.

Section 5 would limit the total amount of federal funds paid for a rehabilitation program to $250,000, with annual adjustments to account for increases in education costs. DAV is concerned that rigid limits could restrict access to necessary services for veterans with substantial needs unless waiver authority is clearly provided. We note that VA does not support this section and has recommended that any cap apply only to funds under chapter 31 and that the Secretary have authority to waive the cap to avoid limiting access to needed services, including independent living services.

Section 6 would expand who may provide certain case management and follow-up services and would add a definition of vocational rehabilitation specialist that would include certain counseling psychologists. DAV takes no position on this section but emphasizes that VR&E planning requires specialized expertise and consistent quality safeguards. We note that VA does not support this section and stated that serious employment handicap and feasibility determinations require specialized knowledge typically held by Vocational Rehabilitation Counselors and warned the change could create confusion about qualifications and responsibilities.

Section 7 would change how subsistence allowances for eligible veterans attending rehabilitation and educational programs are calculated. Currently subsistence allowances are based on the location of the institution; however, if this provision were enacted, veterans who live more than 25 miles from the institution would instead have their subsistence allowance calculated based on their home location. DAV urges careful evaluation of veteran financial impact and administrative feasibility, particularly for rural veterans. We note that VA does not support this section, citing concerns about administrative and technological capabilities, equity across education programs, and potential payment disparities, including scenarios in which a VR&E participant could be paid less than a GI Bill participant based on residence-based calculations.

Section 8 would require VA, to the extent practicable, to employ an employment counselor at each VA regional office. DAV supports this proposal to strengthen employment placement capacity and access to counseling for VR&E participants regardless of where they live.

Section 9 would prohibit a veteran participating in a vocational rehabilitation program from receiving disability compensation for a disability rated total based on individual unemployability (TDIU). DAV strongly opposes this section because it would remove benefits from disabled veterans by significantly reducing basic living support for those who rely on their TDIU benefits to provide for themselves and their families. Further, this proposal would discourage participation in rehabilitation by destabilizing veterans' financial support while they pursue training and assessment. We note that VA testified it had significant concerns with this section because it would fail to account for independent living services, would require veterans to forfeit TDIU before feasibility assessments occur, would shift from individualized adjudication to categorical exclusion and could create inconsistent treatment across VA programs. DAV would oppose any legislation that includes this provision or similar proposals that reduce existing benefits for service-disabled veterans.

**H.R. 8044, Get Justice-Involved Veterans Behavioral Assistance and Care for Key Health Outcomes to Maintain Empowerment (BACK HOME) Act**

DAV supports H.R. 8044, the Get Justice-Involved Veterans BACK HOME Act, in accordance with Resolution No. 136, to strengthen continuity of care, housing stability and benefits access for justice-involved veterans during incarceration and upon reentry into their communities. This legislation would require VA to carry out a pilot program furnishing mental health care to incarcerated veterans, prioritizing veterans with service-connected disabilities related to post-traumatic stress disorder, traumatic brain injury or military sexual trauma and establishing requirements related to pilot locations, interagency coordination and methods of service delivery.

Justice-involved veterans often face complex, service-related physical and mental health challenges that are compounded by incarceration and barriers to reentry. The bill is designed to address these challenges by furnishing mental health care during incarceration, including through tele-mental health where feasible and alternative delivery methods when it is not. The bill specifies that services under the pilot must be provided by VA health care providers, requires coordination with relevant state and federal correctional authorities and includes safeguards such as prohibiting copayments. Together, these provisions are intended to promote continuity of care, reduce crisis risk upon release and support successful reintegration.

The bill also establishes a statutory framework for structured housing and programming for incarcerated veterans. Where feasible, federal correctional institutions would create dedicated veteran housing units; where not feasible, structured veteran-focused programming would be required with coordination and support linked to

VA. These provisions acknowledge that veteran-specific peer support and environments can improve rehabilitation engagement and outcomes.

Another key component of the draft is the automatic resumption of disability compensation and dependency and indemnity compensation following release from incarceration to prevent gaps in income at a critical moment when veterans are attempting to secure housing, transportation, medical care and employment supports.

We agree with VA's concerns regarding implementation, including issues related to access within correctional facilities, copayment policy interactions, and the operational implications of automatic benefit resumption. VA has also raised concerns about system updates, verification requirements and improper payment risk. While we recognize these are real challenges, they underscore the need for statutory clarity, accountability and interagency coordination rather than maintaining the status quo for justice-involved veterans.

DAV supports refining the legislation to address legitimate implementation concerns, such as clarifying copayment provisions and recognizing practical access limitations within correctional settings, through technical assistance and targeted amendments, while preserving the bill's core intent to ensure continuity of care, structured support and timely restoration of benefits for justice-involved veterans returning home.

**Discussion Draft, Office for Toxic Exposure Implementation and Oversight**

In accordance with DAV Resolution No. 54 and consistent with our *Ending the Wait for Toxic-Exposed Veterans* report, co-authored by MOAA, we support this legislation to establish an Office of Toxic Exposure Coordination and Oversight designed to drive enterprise-level coordination across VA and maintain sustained attention to toxic-exposure implementation. This new Office would coordinate VA-wide strategies, workforce management and oversight necessary to implement the Honoring Our PACT Act of 2022 and other toxic-exposure-related laws administered by VA. As the *Ending the Wait* report documents, fragmented governance and lack of sustained accountability have repeatedly contributed to harmful delays for toxic-exposed veterans.

This legislation proposes creating a new Assistant Secretary for Toxic Exposure Coordination to oversee this office, though it is not clear where the office would be situated in VA's organizational structure. While we do not have a firm position on whether the head of the office should be an Assistant Secretary or a Director, we believe it is important for that person to have direct access to the Secretary and Deputy Secretary; making this office an Executive Office in the Office of the Secretary might be a more effective approach. VA has indicated concerns regarding scope clarity and potential duplication or overly broad responsibilities. We believe these concerns can be addressed through clarifying amendments that focus the Office squarely on toxic-exposure implementation, oversight and coordination while ensuring effective integration with existing VA health, benefits and research structures. Further, we believe

that this Office should be complimentary to a new Stakeholder Advisory Committee, as described below.

**Discussion Draft, Toxic Exposure Advisory Committee Establishment Act**

In accordance with DAV Resolution No. 54 and our *Ending the Wait* report, we support the intent of this legislation but recommend amendments to strengthen the role of veteran stakeholders. Specifically, we recommend the creation of an independent stakeholder advisory committee be included as an addition to or replacement for the bill's proposed advisory committee.

The draft bill proposes an Advisory Committee on Toxic Exposure that would perform certain functions in VA's presumptive decision process that are currently performed by the Working Group created by the PACT Act and codified at 38 U.S.C. § 1172. During congressional consideration and approval of the PACT Act, DAV and other VSOs sought to have VSO representation included in this Working Group; however, as enacted, it consists entirely of VHA and VBA employees. The Advisory Committee proposed in this bill would assume many of the current functions of the Working Group, while adding additional perspectives from other federal agencies, including the DOD and the Centers for Disease Control, as well as veteran stakeholders. The proposed Committee would consist of nine members appointed by congressional and VA leadership, with requirements that at least two members represent VA-recognized VSOs and at least one member possess expertise in toxicology and epidemiology.

We strongly support the inclusion of veteran stakeholders throughout the presumptive decision process so that their lived experiences and perspectives can appropriately influence outcomes. However, we believe this could also be accomplished by adding VSO and veteran stakeholders to the existing Working Group, while creating a new, separate and independent stakeholder advisory committee.

DAV, together with MOAA, the VFW, The American Legion, and Wounded Warrior Project, have developed a proposal for a "Veteran Stakeholder Toxic Exposures and Environmental Hazards Advisory Committee." It would be an independent, non-governmental Advisory Committee that would be able to set its own priorities, hold public meetings with VA participation, make information requests from VA, deliver recommendations to the Secretary and use its standing to inform and educate the public and Congress about federal toxic exposure policies. Rather than having a "seat at the table" on a federal advisory committee, this proposal would empower veteran stakeholders to comprehensively represent the interests of veterans and family members impacted by the devastating wounds and illnesses from military toxic exposures.

**Discussion Draft, to provide for the modernization of the electronic health record system and other health information technology activities and systems of the Department of Veterans**

The discussion draft would authorize VA to modernize its electronic health record (EHR) system, either by modifying the existing EHR Modernization Program or establishing a new program, with the stated goals of improving health outcomes, coordination of care and timely access. It also emphasizes interoperability, including planning for broad implementation of common data standards, and strengthening protections for veterans' personal health information against cyber and security threats.

The draft further outlines detailed governance and implementation requirements, including defined leadership roles, enterprise-wide clinical workflow baselines, quality metrics, site-readiness certifications and system uptime standards. It also includes extensive reporting requirements and an independent verification and validation framework.

DAV supports the goal of modernizing the VA EHR; however, we do not have an adopted resolution that endorses the specific governance, funding control, or internal management changes proposed in this discussion draft, and we take no position on the bill. Our existing resolutions support the outcomes of modernization, interoperability, continuity and record access, but they do not address or approve a particular statutory allocation of authorities or EHR account funding control inside VA. Given the technical and operational complexity of EHR modernization, DAV's primary concern is whether these efforts result in real, measurable improvements in the care veterans receive. Any modernization effort must first and foremost support clinicians at the point of care, enhance patient safety, and improve reliability, continuity and access to services. DAV supports reforms that advance these outcomes.

The central purpose of EHR modernization is to ensure that veterans' health information follows them seamlessly across the VA system and with partner providers, supporting coordinated care throughout their lives. As this effort continues, it is essential that decisions remain anchored to that core objective and evaluated by their effect on veterans' experiences and outcomes.

## Discussion Draft, HONOR Vets Act of 2025

DAV supports the HONOR VETS Act of 2025, in accordance with Resolution No. 650, which affirms that veterans receiving care through the Veterans Community Care Program (VCCP) must be treated by providers held to the same quality and veteran-specific standards as VA facilities. By requiring mandatory training for non-VA providers furnishing care under the VCCP, this legislation gives that policy force and helps ensure community clinicians are prepared to meet veterans' unique clinical and safety needs. We believe this legislation addresses a critical gap in the delivery of community care by ensuring that veterans receiving care outside VA facilities are treated by providers who are trained in veteran-specific clinical risks, safety considerations and the unique context of military service.

Community care plays an important and expanding role in the VA health care system, particularly for veterans who face geographic, specialty or access barriers to receiving care directly from VA facilities. However, expanding access to community care must be accompanied by safeguards that ensure quality, safety and continuity of care comparable to those provided within VA. The HONOR VETS Act seeks to establish baseline training requirements as a key safeguard.

The bill would require non-VA providers to complete specified training as a condition of furnishing care under the VCCP. Veterans face elevated risks related to suicide, opioid use and complex physical and mental health conditions that may not be adequately recognized or addressed by providers unfamiliar with veteran populations. Training in opioid safety, suicide prevention and evaluation and veteran-centered care is intended to better prepare community providers to identify risks, intervene appropriately and coordinate care with VA when necessary.

The bill also establishes a graduated enforcement framework, including warning, remediation, suspension and removal provisions. This approach sets clear expectations for providers while allowing opportunities for compliance before removal from the program, reinforcing that participation in the VCCP carries responsibilities commensurate with the trust placed in providers who care for veterans.

Training requirements should be viewed as a floor rather than a ceiling. Ongoing evaluation of training effectiveness, updates to course content as clinical best practices evolve and continued coordination with VA clinicians will be essential to ensuring community care delivers safe, veteran-centered outcomes over time.

Mr. Chairman, that concludes my testimony, and I would be pleased to answer any questions you or the members of the Committee may have.