STATEMENT OF
MARK KOENIGER, M.D.
ACTING ASSISTANT UNDER SECRETARY FOR HEALTH FOR PATIENT CARE SERVICES
VETERANS HEALTH ADMINISTRATION (VHA)
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
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Good afternoon, Chairwoman Miller-Meeks, Ranking Member Brownley, and distinguished Members of the Subcommittee. Thank you for the opportunity to testify today about the 12 proposed bills that would affect VA health care programs and services. Joining me today is Dr. Maria Llorente, the Acting Assistant Under Secretary for Health for the Office of Integrated Veteran Care.

H.R. 2283 Recognizing Community Organizations for Veteran Engagement and Recovery (RECOVER) Act

Summary: Section 2(a) of this draft bill would require VA to carry out a 3-year pilot program under which VA would make grants to eligible mental health care providers for the provision of culturally competent, evidence-based mental health care for Veterans. Section 2(b) would provide that eligible mental health care providers would have to: (1) be a non-profit organization, (2) have operated at least one outpatient mental health facility in the United States for a continuous period of at least 3 years; and (3) submit to VA an application containing such information and assurances as VA may require. Section 2(c) would provide that grantees would use the grant: (1) to provide culturally competent, evidence-based mental health care for Veterans; (2) to operate an existing outpatient mental health facility or establish a new outpatient mental health

facility for the purpose of providing such care; and (3) to encourage Veterans eligible to enroll in VA care to enroll and receive VA medical services. Grantees would be prohibited from charging any Veteran a fee associated with the receipt of mental health care or refusing to provide mental health care to a Veteran on the basis that the Veteran is not eligible for reimbursement for such care under a health plan contract or any Federal, State, or local government program. Grantees would not be prevented, under the pilot program, from seeking or receiving reimbursement for all, or a portion, of the mental health care provided to a Veteran, including reimbursement under a health plan contract, the Veterans Community Care Program (VCCP), or any other Federal, State, or local government program. Section 2(d) would require VA, in selecting outpatient mental health facilities for the receipt of grants under the pilot program, to ensure that grants are distributed evenly among outpatient mental health facilities located in rural and urban areas. VA could consider the proportion of Veterans historically served by the outpatient mental health facilities and could prioritize outpatient mental health facilities in areas VA determines are medically underserved, have a large Veteran population, are located near military installations, or have large number of Veterans at high risk of suicide. Section 2(e) would generally limit grants under the pilot program to $1.5 million for any fiscal year; however, if at least 50% of the operating budget of an outpatient mental health facility in the previous year was provided through Federal grants, no grant under the pilot program for the facility for any fiscal year could exceed the lesser of 50% of the operating budget or $1.5 million. Grantees under this pilot program could apply for, and receive, grants for more than one facility of the recipient for any fiscal year and could apply for, and receive, a grant for a facility that has already received a grant under the pilot program. Section 2(f) would require VA to establish the requirements for training referred to in subsection (b)(2)(A) [sic]. Section 2(g) would require VA to prescribe regulations to carry out this section, which would have to include a requirement that each grantee demonstrate the capacity to provide accountability, demonstrate clinical outcomes, and justify the effective use of any private investment funds or Federal grants through data collection and reporting metrics. Section 2(h) would require VA, not later than 180 days after the completion of the pilot program, to submit to Congress a report on the pilot program that includes six specific elements.

Section 2(i) would authorize to be appropriated to VA $20 million for each of fiscal years (FY) 2025-27 to carry out the pilot program.

Position: **VA cites significant concerns with the bill as written.**

Views: VA strongly supports efforts to expand access to and the availability of Veteran-centric and evidence-based mental health care, but VA has significant concerns with a number of the provisions in this bill.

Initially, it is unclear why a grant program would be the appropriate mechanism for this purpose. VA operates the VCCP, through which eligible Veterans can receive mental health care from non-VA providers. VA furnishes this care through contracts or other agreements (not through reimbursement, as described in the bill) that include established payment rates and responsibilities for VA and providers. This bill would have VA establish a grant program to provide financial support to these organizations, but it is not clear why a contract or agreement to participate in the VCCP would not be appropriate or sufficient. Specific provisions in this bill would expressly allow grantees to use grant funds, to bill VA for services under the VCCP, and to obtain reimbursement from other Federal, State, or local government programs. This would effectively amount to double (or possibly triple) billing for care and services. While eligible entities would have to be non-profit organizations, as designed this would be a lucrative source of income for grantees that would result in additional costs to taxpayers with zero improved benefit for Veterans; it would simply introduce opportunities for waste, fraud and abuse. The bill is also unclear as to how Veterans would receive care from grantees. Veterans seeking care through the VCCP receive an authorization from VA based on a determination of eligibility for VCCP and medical need for the care. It appears Veterans, including unenrolled Veterans (as seems to be contemplated by section 2(c)(1)(C)), could choose to access care from these providers without authorization by, or even knowledge of, VA. While not all care from VA must be authorized – walk-in or urgent care is available under 38 U.S.C. § 1725A and emergent care is available under 38 U.S.C. §§ 1720J, 1725, and 1728 – VA is generally

responsible for coordinating care to ensure high quality care that is cohesive and complementary. The receipt of care without authorization or coordination increases the risks of fragmentation of care and possibly contra-indicated treatments that could jeopardize patient safety.

Further, the bill is unclear as to who, exactly, can apply for and receive grants. In section 2(b), for example, the bill refers to a mental health provider that is a non-profit organization. On this level, it is unclear if the provider or the organization for whom the provider works is the applicant and grantee. Further, under section 2(b)(2), the provider must have operated at least one outpatient mental health facility in the US for a continuous period of 3 years, but it is unclear what "continuous" means in this period. Would any closure for any period of time during a 3-year period make it no longer continuous? If the provider changed locations during a 3-year period, would it no longer have operated at least one outpatient mental health facility? This confusion is further exacerbated by the language in section 2(d), which states that in selecting outpatient mental health facilities for the receipt of grants, VA must consider several factors. However, it appears from subsection (b) that either providers or organizations were grantees, not facilities. The bill needs to be clear about who can apply so VA could administer this program effectively. The bill is also silent as to qualifications or other requirements associated with grantees and providers; under the VCCP, VA has clearly established requirements that providers must meet, but it is not apparent that these standards would apply to grantees. In that context, this grant program might require VA to dedicate resources to providers that would be ineligible to furnish care to eligible Veterans under the VCCP. Additionally, section 2(b)(3)(B) would establish as a condition of eligibility to receive a grant that the mental health care provider have "a plan under which at least one clinician employed by the provider at each facility for which a grant is made is trained to provide culturally competent veterans mental health care". However, the presence of a single trained provider may be inadequate to meet the needs of Veterans, and perhaps more critically, the bill does not even require that the trained provider be the one that furnishes mental health care to Veterans. A facility might have 10 providers on staff, only 1 of whom is trained (and technically, the facility

only needs a “plan” to train the provider – whether that plan is ever executed is apparently immaterial to the applicant’s qualifications), and that 1 trained provider may furnish no mental health care to Veterans without any negative effect on the applicant’s qualifications to receive a grant.

VA also has significant concerns with the prescriptive language of many of the requirements in this bill. The bill, for example, would provide that grants would be made for the provision of culturally competent, evidence-based mental health care for Veterans. Tailoring every care encounter with any possible culture of which a Veteran might be a member could be incredibly burdensome on grantees, who would have to be prepared for dozens or even hundreds of different cultures. VA provides care that focuses on Veteran culture, recognizing the unique experiences of Veterans based on their military service and can provide culturally specific care for other populations (such as American Indians, Alaska Natives, and Native Hawaiians). The drafter’s intent is unclear because the bill offers no definition or explanation for what this means.

Additionally, the bill would require VA to “ensure that grants are distributed evenly among outpatient mental health facilities located in rural and urban areas”. *See* section 2(d)(1). However, this could prove to be incredibly difficult to implement in practice, and it could easily result in thwarting the intended goal of the bill. For example, it is unclear what “distributed evenly” means. If it means the same number of rural facilities as urban facilities, this could severely restrict the ability of urban organizations to receive support. Specifically, if 10 facilities located in rural areas apply, and 5 of them are selected for a grant, while 50 facilities located in urban areas apply, only 5 of them could be selected (regardless of how many might meet application thresholds and requirements VA would establish) if “evenly” means “exactly the same number.” If, in the same context (10 rural applicants, 50 urban applicants), “evenly” instead meant “proportionately” based on location, then 25 urban facilities and 5 rural facilities could receive awards. We do not recommend the bill be amended to clarify what “evenly” means; we believe it would be sufficient to simply state that VA may give preference to applicants furnishing services in rural areas.

Section 2(c)(1)(B) would authorize the use of funds to "establish a new outpatient mental health facility" for the purpose of providing care. It is not clear if this section is intended to authorize building or purchasing a new facility or merely commencing mental health services at an existing facility. VA does not provide financial support in the form of grants to entities to support establishing new facilities (which may involve the acquisition of real property) without clear recovery provisions, which this bill lacks; where VA does provide such capital support, such as in the State Home construction grant program or the capital grant program for homeless Veterans, VA's authority includes these recovery provisions, and VA's long-standing relationships with these entities also helps ensure the appropriate use of Federal funds. The laws and regulations authorizing these investments are significantly more detailed given the challenges in recovering funds (when needed) that were used to procure real property. Government-wide regulations at part 200 of title 2, Code of Federal Regulations, also include specific requirements related to the use of grant funds for real property. Because it is not clear if this was intended in the language used in the bill, we strongly recommend Congress consider clarifying language. Congress could include a provision prohibiting the purchase of real property; making the purchase of real property subject to applicable law or regulations; or clarifying the requirements and conditions associated with the use of funds for such purposes.

Section 2(e) would provide an alternative cap on the amount of a grant based on the operating budget of the facility. This could prove exceptionally difficult to administer consistently and fairly as VA would have no way to validate the operating budget of the facility in the first place. Facilities could effectively report any amount they so choose, and VA would likely have no means to dispute that figure. Paragraph (2) of this subsection would permit grantees to apply for, and receive, grants for more than one facility (but as noted before, the bill is inconsistent as to whether providers, organizations, or facilities are the grant recipients); grantees could also "apply for, and receive, a grant for a facility that has already received a grant under the pilot program". *See* section 2(e)(2)(B). This provision appears intended to allow for renewal grants to

be awarded, but as written, the language suggests that a single grantee could receive multiple grants for the same time period. In this context, the cap for each grant set forth in paragraph (1) would be irrelevant if an applicant could apply for, and receive, multiple grants.

The provisions in section 2(f) and (g) also raise concerns. First, subsection (f) refers to "the requirements for the training referred to in subsection (b)(2)(A)", but there is no subsection (b)(2)(A). Second, in subsection (g), VA would have to prescribe regulations that would require each grantee to demonstrate the capacity to provide accountability, demonstrate financial outcomes, and justify the effective use of any private investment funds or Federal grant funds through data collection and reporting metrics. This would effectively mean that parties who have already received Federal funds would later have to prove they used those funds appropriately. We believe it would be far more advisable to require applicants to prove they could use these funds appropriately, in the ways described above, before they receive such funding. This is a common practice with other grant programs VA administers – applicants must often demonstrate their capacity, their past performance, and their financial accountability before VA will award them a grant. Similarly, section 2(d)(2) would allow VA, in selecting facilities to receive grants, to consider the proportion of Veterans historically served by the outpatient mental health facility. However, it is unclear how this "proportion" would be calculated, and there is no discussion of the outcomes or experiences of participants. In addition, it is unclear if "proportion" means only the percentage of patients who are Veterans or whether it would also include comparison to the percentage of Veterans in the overall population of the geographic area that is served.

To the extent the purpose of the legislation is to establish a grant program that provides support to Veterans at risk of suicide, we note that Congress has already enacted such legislation, and VA has implemented this authority through the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox SPGP). Additionally, Congress has authorized VA to provide emergent suicide care to any Veteran, along with certain former Service members, through section 201 of the

Veterans Comprehensive Prevention, Access to Care, and Treatment Act of 2020 (the COMPACT Act; 38 U.S.C. § 1720J). Through both the grant program and the COMPACT Act, VA is able to ensure that Veterans receive support to address risks of suicide that do not require authorization or engagement with VA; while some Veterans are reluctant to come to VA for care, we believe these existing authorities already address this need. In this context, we do not see the gap in VA's current authorities that this bill would fill.

There are additional provisions that are typically included in legislation authorizing a new grant program, and we recommend similar terms be included here to ensure that VA has the necessary statutory authority to regulate and implement this new program. We further recommend that Congress expressly delegate authority to VA to establish such terms and conditions to avoid any question about whether VA was authorized to include additional requirements or limitations.

Cost Estimate: VA does not have a cost estimate for this bill.

H.R. 2426 Veterans Mental Health and Addiction Therapy Quality of Care Act

Summary: Section 2(a) of this bill would require VA, within 90 days of enactment, to seek to enter into an agreement with an independent and objective organization outside of VA to conduct a study on the quality of care difference between mental health and addiction therapy care delivered by VA providers compared to non-VA providers across various modalities, such as telehealth, inpatient, intensive outpatient, and residential treatment. The organization would have to submit to Congress and publish on a publicly available website a report containing the final results of the study. Section 2(b) would require VA to ensure the organization is able to complete these requirements by not later than 18 months after the date the agreement is entered into. Section 2(c) would require the report to include an assessment of the amount of improvement in health outcomes from start of treatment to completion, including symptom scores and suicide risk using evidence-based scales (including the Columbia-Suicide Severity

Rating Scale); whether VA and non-VA providers are using evidence-based practices in the treatment of mental health and addiction therapy care, including criteria set forth by the American Society of Addiction Medicine; potential gaps in coordination between VA and non-VA providers in responding to individuals seeking mental health or addiction therapy care, including the sharing of patient health records; implementation of Veteran-centric care; whether Veterans with co-occurring conditions receive integrated care to holistically address their needs; whether providers monitor health outcomes continually throughout treatment and at regular intervals for up to 3 years after treatment; and the average length of time to initiate services (including a comparison of the average length of time between the initial point of contact after patient outreach to the point of initial service, as measured or determined by VA).

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

Views: VA certainly appreciates and understands the interest in ensuring that Veterans receive high quality mental health and addiction therapy care; indeed, VA already has the authority to compare VA and non-VA mental health and substance use disorder (SUD) care and VA already evaluates the quality of its programs under several existing authorities and reports its findings to Congress under several laws. We believe the bill could be amended to build on some of these requirements to assemble the requested information.

VA regularly conducts robust reviews of its mental health and SUD care. For example, since 2013, VA has been required to provide to Congress semi-annual reports on developing and implementing measures and guidelines for mental health services, pursuant to section 726 of the National Defense Authorization Act for Fiscal Year 2013 (P.L. 112-239; 38 U.S.C. § 1712A, note). Since 2015, VA has been required to provide for the conduct of an evaluation of the mental health and suicide prevention programs carried out by VA, pursuant to 38 U.S.C. § 1709B, as added by section 2 of the Clay Hunt SAV Act (P.L. 114-2). VA submits annual reports to Congress with this

information, which requires elements similar to those set forth in this bill, such as metrics that are common among and useful for mental health practitioners, the effectiveness of mental health and suicide prevention programs, the cost-effectiveness of these programs, and patient satisfaction. Further, since 2016, VA also has been required to submit annual reports to Congress under 38 U.S.C. § 1706(b)(5) to determine compliance, by facility and Veterans Integrated Service Network (VISN), with requirements under § 1706(b) that includes information on "recidivism rates associated with substance-use disorder treatment". Additionally, under section 104(e) of the Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act (P.L. 118-210), VA is required to conduct an audit, through one or more contracts with a non-VA entity, on the quality of care from VA, including through non-VA health care providers. Between these four reporting requirements, we believe VA could provide much of the information this bill would require. To the extent there are elements that would not be included in these reports, VA believes it would be easier to examine this information as part of its compliance with existing statutes, which could include conducting a study that addresses the elements of the bill with external independent review of VA's analyses. Of note, the marginal cost to do so as part of current efforts would likely be much less than the costs of an entirely new study. VA will work to address the concerns underlying this bill in its implementation of existing statutory requirements, such that further legislation would not be necessary.

We note for the Committee's awareness that this bill would overlap with provisions in the Veterans' Assuring Critical Care Expansions to Support Servicemembers (ACCESS) Act of 2025, which could impair the ability of the non-VA organization contemplated in this bill to make valid comparisons and assessments. VA recommends the Committee consider carefully how these provisions would interact if both bills were enacted to ensure there is no frustration of purpose between them.

VA has technical comments on this bill we can provide to the Committee upon request. Element (6) under subsection (c), which would require an assessment of whether providers monitor health outcomes continually throughout treatment and at

regular intervals for up to 3 years after treatment, in particular is problematic. For example, this requirement would require bilateral contract modifications to compel providers to track and report certain information, which would increase VA costs and would not necessarily result in consistent data. Additionally, Veterans may have different choices in terms of where to receive care over time, and this could interfere with the non-VA organization's ability to determine whether providers continue to monitor patients over time. These and other factors could compromise the ability to make meaningful conclusions on outcomes. We would appreciate the opportunity to discuss this further.

Cost Estimate: VA does not have a cost estimate for this bill.

H.R. 4509 NOPAIN for Veterans Act

Summary: Section 2(a) would amend 38 U.S.C. § 8125, which generally deals with the procurement of health care items. A new section 8125(d) would require VA to include non-opioid pain management drugs or biological products in VA's national formulary not later than one year after the date on which the drug or biological product becomes eligible for temporary additional payment under section 1833(t)(16)(G) of the Social Security Act (42 U.S.C. § 1395l(t)(16)(G)) or eligible for separate payment under 42 C.F.R. § 416.174 (or successor regulations). VA also would have to include a non-opioid pain management drug or biological product in VA's drug standardization list. The bill would further amend this section to include a definition of the term "non-opioid pain management drug or biological product" to mean a drug or biological product approved, granted, or cleared by the Food and Drug Administration (FDA) to reduce post-operative pain, or to produce post-surgical or regional analgesia, without acting upon the body's opioid receptors. Section 2(b) would prohibit the use of funds in the Cost of War Toxic Exposures Fund (TEF) (under 38 U.S.C. § 324) to carry out these amendments. Section 2(c) would require VA, not later than 90 days after enactment, to implement these amendments.

Position: **VA does not support this bill because it would undermine VA's ability to get the best prices on drugs for Veterans and believes its current authority is generally sufficient to make approved medications available to Veterans.**

Views: VA supports the intent of this bill but believes that its current authority is generally sufficient to achieve the intended outcomes of the bill. Additionally, VA is concerned that the specific requirements in the bill would be inconsistent with VA's well-recognized, evidence-based formulary process that helps VA ensure access to the most clinically appropriate care for Veterans. Currently, all newly Food and Drug Administration (FDA)-approved medications are reviewed on the basis of safety and efficacy and considered for addition to the VA national formulary. Regardless of the formulary status, all drugs are available in the VA system through either the formulary or the non-formulary process. However, only those medications found to be safe, effective, and economical are added to the formulary. Examples of non-opioid pain relievers on formulary include acetaminophen, aspirin, nonsteroidal anti-inflammatory drugs, gabapentinoids, tricyclic antidepressants, serotonin-norepinephrine reuptake inhibitors, muscle relaxants, and topicals such as lidocaine patch and cream. As written, this bill would require VA to add medications to the formulary without considering these factors. There may be additional reasons to not include certain products, such as if they showed no particular efficacy, if their risk of side effects was significant, if subsequent review found them to be unsafe (and even potentially if FDA approval, grant, or clearance was rescinded), or if their costs were excessive compared with other options. However, the bill would provide VA no flexibility in this regard and act as a substitute for VA's deliberative decision making process; VA would have to include them in the national formulary and on the drug standardization list, which would allow providers to prescribe and order these medications more easily than if they were not included on the formulary or list. We recommend instead that the bill authorize, but not require, VA to include such drugs or products in the national formulary. We also recommend removing the provision requiring inclusion of the drugs or products in the drug standardization list, as this is a list of drugs with narrow therapeutic index where it may impact patient care to switch

between generics. No non-opioid medications fall in this category, so these drugs or products should not be added to this list.

Additionally, by requiring VA to include in the national formulary certain drugs or products within a specified time period (1 year from becoming eligible for additional payment or separate payment), VA would be under pressure to enter into contracts for such products within that time period as well. This would likely reduce VA's negotiating power and could result in VA paying higher costs than it otherwise would for the same products. Further, there may be instances where VA may not want or may be unable to enter into a contract for a particular product that would be automatically added to the formulary. For example, there may be issues with complying with the U.S. Trade Agreements Act or competition issues that could arise in the procurement process.

Finally, VA has concerns with section 2(b) regarding TEF. We interpret this limitation to apply to the specific activities associated with updating the formulary itself; in this regard, this provision is unnecessary because TEF would not be available for such a use. If, instead, this provision is intended to bar VA from using TEF to purchase drugs or products added to the formulary, VA would need to maintain a list of all such drugs or products added under this provision to ensure TEF was not used to procure such items. However, this would make executing TEF even more complex and would risk non-compliance, which could lead to violations of the Antideficiency Act (31 U.S.C. § 1341).

VA also has a number of technical comments on the bill. For example, it is not clear that inserting these requirements in 38 U.S.C. § 8125 would be appropriate given the other provisions currently in law. It would seemingly be clearer if these requirements, if enacted, were included in a new section of law in chapter 17, or potentially a new subsection in 38 U.S.C. § 1706 (which generally sets forth other requirements associated with the management of health care). Additionally, the bill's definition of "non-opioid pain management drug or biological product" would only include such drugs or products approved, granted, or cleared by FDA "to reduce postoperative

pain or to produce postsurgical or regional analgesia"; this would exclude other drugs or products, such as those designed to treat chronic pain or other conditions. We also note that FDA has not defined this term or these products, which could create issues for VA in the future.

Cost Estimate: VA does not have a cost estimate for this bill but expects it would result in higher drug prices for affected drugs than if this bill were not to be enacted.

H.R. 5999 Directing VA to Furnish Opioid Antagonists without a Prescription or Copayment

Summary: Section 1(a) would add a new section 1720M to title 38 U.S.C., requiring VA to furnish opioid antagonists to Veterans without requiring a prescription. Section 1(b) would amend 38 U.S.C. § 1722A, which generally establishes copayment requirements for medications, to amend the existing exception for opioid antagonists; specifically, it would expand the current exception to copayment liability for opioid antagonists by no longer requiring the Veteran be at high risk for overdose of a specific medication or substance to reverse the effect of such an overdose.

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

Views: VA supports the intent of the bill to expand access to opioid overdose rescue medications for Veterans. Currently, 38 U.S.C. § 1710(g)(3)(B) already exempts from copayment requirements for medical services for eligible Veterans with respect to education on the use of opioid antagonists to reverse the effects of overdoses of specific medications or substances. Similarly, 38 U.S.C. § 1722A(a)(4), which this bill would amend, already exempts enrolled Veterans from medication copayment requirements for opioid antagonists furnished to Veterans who are at high-risk for overdose of a specific medication or substance to reverse the effect of such an overdose.

Naloxone acts quickly to reverse opioid overdose, restore breathing and buy crucial time for emergency responders. It is safe and effective, is not a controlled substance, and VA emphasizes education about its use, overdose risk signs, safe medication storage, and disposal.

To expand access to opioid antagonists like naloxone, VA has permitted standing orders (or prescriptions), for any Veteran at risk of overdose. All over-the-counter medications, like naloxone, dispensed by VHA require a prescription, which allows for accountability of procured pharmaceuticals and stewardship of Government resources. While we are concerned that the bill would prohibit VA from using prescriptions, which could increase the risk for waste and fraud, VA stands ready to work with the Committee to mitigate these concerns and increase the availability of overdose reversal medications to save lives.

Naloxone is already available free of charge to enrolled Veterans in various forms, including nasal sprays. VA distributes naloxone not only through VA pharmacies but also at Community Resource and Referral Centers, resource fairs, and mobile medical units. Veterans can request naloxone by speaking to a provider, contacting a pharmacist (who can then facilitate a naloxone order from the Veteran's provider if a standing order does not exist), or messaging their care team through the VA Mobile App or VA's website.

VA has concerns with the proposed section 1720M, as this would contain no limitations or qualifications related to the rest of chapter 17, such as being limited to enrolled Veterans. This provision is not even subject to the availability of appropriations. It also contains no language about how VA would furnish opioid antagonists. These omissions could create an open-ended obligation for VA to furnish opioid antagonists, in any form, in any amount, and at any frequency to any Veteran. The resource implications of this could be significant. We would be happy to work with the Committee to address these concerns and ensure the bill operates as intended.

Cost Estimate: VA does not have a cost estimate for this bill.

H.R. 6001 Veterans with ALS Reporting Act

Summary: Section 2(a) would require VA, not later than 1 year after enactment to submit to Congress a report on the incidence and prevalence of amyotrophic lateral sclerosis (ALS); this report would have to be prepared in consultation with the Centers for Disease Control and Prevention (CDC). This report would have to include: (1) an assessment of the incidence and prevalence of ALS in Veterans; (2) a description of the resources and support that CDC and VA provide to Veterans with ALS; (3) a description of any deficiencies in the resources and support that CDC and VA provide to Veterans with ALS; (4) a strategy to develop and test risk reduction strategies intended to lower the incidence and prevalence of ALS among Veterans; (5) a strategy to develop a pathway for Veterans receiving care for ALS in VA clinics to participate in clinical trials and research sponsored by VA; and (6) any recommendations for the enactment of legislation to address the challenges or needs associated with lowering the incidence and prevalence of ALS among Veterans.

Section 2(b) would require VA to track the prevalence of ALS in Veterans using the CDC's ALS registry and biorepository (which we interpret to mean CDC's National ALS registry and National ALS Biorepository).

Section 2(c) would require VA, not later than 3 years after the date of enactment, and every 3 years thereafter, to submit to Congress an update to the initial report required by subsection (a) and information on the prevalence of ALS tracked under subsection (b).

Position: **VA supports the intent of this bill but cites concerns**.

Views: VA supports the intent of this bill but cites concerns with the bill as written. VA shares the commitment to improving care, research access, and outcomes for Veterans living with ALS. However, VA already possesses the necessary authority and infrastructure to carry out many of the bill's objectives. Additionally, several provisions in the bill would duplicate existing efforts or impose new requirements without accompanying resources; this could inadvertently hinder the delivery of direct care.

Specifically, VA already works with CDC and has the authority to do so. VA collaborates with CDC and reliably provides data on ALS cases; this work began after VA's own ALS registry concluded in 2008. Statutorily requiring this work would not provide new resources or authority but would require additional administrative effort. Similarly, the recurring reports required by section 2(c) would create a significant and unfunded reporting burden that could divert resources and staff away from direct patient care. This could negatively impact the very population the bill aims to support.

Further, recent findings published by the National Academies of Sciences, Engineering, and Medicine (NASEM), *Living with ALS* (2024) already includes a comprehensive analysis of ALS prevalence, care systems, and gaps in service delivery. The report that would be required by this bill would then be redundant. The NASEM report also included recommendations for legislation, including Recommendation 4-4, which urges Congress to allocate specific funding to create a VA network for ALS clinical care, research, education, and innovation to align with the new system of care outlined in the report. Congress has not yet acted on this recommendation, so requiring VA to produce another report with recommendations without providing resources to implement existing recommendations would delay meaningful action for affected Veterans and families.

Finally, VA has some concern with the requirement to develop a strategy to allow Veterans receiving care for ALS in VA clinics to participate in clinical trials and research sponsored by VA. Specifying VA sponsorship carries regulatory implications and may limit opportunities for collaboration with external entities (including industry) that may be

better positioned to sponsor and conduct such trials. It is possible the bill intended to refer to two distinct categories – clinical trials, and research sponsored by VA – but the language is unclear in this respect.

VA can provide technical assistance on these and other aspects of the bill.

Cost Estimate: VA does not have a cost estimate for this bill.

H.R. 6526 Clarity on Care Options Act

Summary: Section 2(a) of the bill would require VA to require each third-party administrator (TPA) that administers a network of health care providers for VCCP, on an annual basis, to query each provider in the network to determine whether they accept assignments under CHAMPVA and submit the results of such queries to VA.

Section 2(b) would require VA, in utilizing this information and any other information available to VA, to establish and maintain a publicly available directory of providers in these networks that accept assignments under CHAMPVA.

Section 2(c) would require the first queries be completed, and the reports submitted to VA, by not later than 90 days after enactment. VA would have to make the first list of providers available publicly not later than 180 days after enactment.

Section 2(d) would require VA, not later than 1 year after the date of enactment and annually thereafter for 4 years, to submit to Congress a report on the extent to which providers in the TPA networks accept assignments under CHAMPVA. These reports would have to include detailed information broken down by state and Veterans Integrated Service Network (VISN).

Section 2(e) would define the term “accept assignment”, with respect to CHAMPVA, to mean accepting responsibility for the care of a CHAMPVA beneficiary

and agreeing to accept the among determined allowable under CHAMPVA as full payment for services and supplies rendered to the beneficiary.

Position: VA supports the intent of this bill but cites concerns.

Views: VA supports the intent of this bill but cites concerns with it as written. VA currently has a CHAMPVA Modernization project underway that will develop a provider directory to allow CHAMPVA beneficiaries to access health care providers who accept assignments under this program. VA is pursuing this modernization project under its existing authorities and believes this will more effectively meet the proposed goal of this bill by enhancing provider transparency and accessibility for program beneficiaries. If this bill were to become law, it could delay these efforts and produce more confusion regarding provider availability than VA's modernization project.

The TPAs that administer a network of health care providers for VCCP focus on contracting with providers to treat Veterans. While this arrangement with the TPAs can be beneficial in certain contexts, it may not be well-suited to the unique demographic needs of the CHAMPVA population, which includes children. The CHAMPVA population has distinct needs from Veterans that require specialized considerations around provider types and accessibility, making it essential that the network accommodates various health care needs, particularly for pediatric care.

Further, the TPA networks of providers are not the sole providers who furnish care to CHAMPVA beneficiaries under that program, so any directory assembled would necessarily be incomplete. Further, given constant fluctuation in terms of the providers who are in a TPA's network, the surveys themselves may be of limited value and the directory would likely include inaccurate information in two different ways – including providers who no longer are in a TPA's network or no longer furnish care to CHAMPVA beneficiaries, and not including providers who are in a TPA's network and who do furnish care to CHAMPVA beneficiaries. In this light, VA recommends allowing current efforts to continue without new legislation.

VA's planned directory will allow beneficiaries from VA's five primary family member health care programs to identify and locate accepted health care providers quickly by location. The directory will identify those providers who already accept assignments and actively participate in these programs; this approach is grounded in analyses of prior years' claims data, ensuring the directory is built upon a foundation of reliable and proven provider relationships. By focusing on these established providers, VA can streamline access to care for eligible family members and ensure continuity and quality in health care delivery. VA is working to develop this directory in tandem with the implementation of the Community Care Network (CCN) Next Gen Provider Network.

VA has additional concerns with the bill as well. For example, the timelines set forth in this bill, particularly under subsection (c), are not realistic. VA would need to modify its contracts, bilaterally, with its current TPAs to include a requirement that they survey their providers and submit information to VA on accepting CHAMPVA beneficiaries and payments. These bilateral modifications alone could take 90 days or more, without accounting for VA's need to develop the survey, define the process, and allow providers time to respond to the survey. The TPAs would not have enough time to actually survey providers, validate responses, and submit information to VA.

Cost Estimate: VA does not have a cost estimate for this bill.

H.R. 6652 US Vets of the FAS Act

Summary: Section 2(a) would require VA to work expeditiously with the governments of the Freely Associated States (FAS) to enter into the agreements described in 38 U.S.C. § 1724(f) and section 209(a)(4)(A) of the Compact of Free Association Amendments (COFA) Act of 2024.

Section 2(b) would require VA, in furnishing services under these agreements, and consistent with 38 U.S.C. § 1724(f) and section 209(a)(4)(A) of the COFA Act of 2024,

to furnish to Veterans in the FAS services that include, at a minimum, health services provided by telehealth and pharmaceutical products delivered by mail.

Section 2(c) would require VA, to the maximum extent practicable, to (1) initiate outreach to each FAS government not later than 30 days after enactment; (2) enter into each agreement required by subsection (a) within 1 year of enactment; and (3) begin furnishing the telehealth and pharmaceutical services required by subsection (b) within 1 year of enactment.

Section 2(d) would amend 38 U.S.C. § 111(h), which authorizes VA to provide beneficiary travel benefits to Veterans traveling in, to, or from the FAS for the receipt of care or services authorized to be legally provided by VA in the FAS, to now require VA to make such payments in any fiscal year if VA provided any beneficiary travel payments to any Veteran. This amendment would apply to travel occurring on or after the date that is one year after enactment.

Section 2(e) would require VA, not less frequently than quarterly, to submit to Congress a report on the implementation and costs of these amendments. Until VA enters into agreements with the FAS governments and begins furnishing required services, the report would also have to describe the technical and logistical factors that have prevented or impeded VA from doing so.

Section 2(f) would define certain terms.

Position: VA supports the intent of the bill subject to amendments.

Views: VA supports the bill's underlying objective of improving access to care for veterans residing in the Freely Associated States. The Department recognizes that access to health care for Veterans residing in the Freely Associated States is an important component of the United States' broader commitments under the Compacts of Free Association and a matter of strategic significance. Phased implementation is

required by VA because the agency cannot legally, operationally, or diplomatically deliver durable care in the FAS until multiple issues – some outside of VA's control – are sequentially resolved.

The Department's concerns are not with the objectives of the legislation, but with ensuring that implementation occurs in a manner that is legally sound, operationally resilient, and sustainable under conditions of disruption. Given the sovereign, logistical, and interagency dependencies involved, the Department continues to support a phased implementation approach to ensure durable access to care and continuity of services, particularly in geographically isolated and high-risk environments.

However, the Department notes that the authority to furnish care and to provide beneficiary travel payments is contingent on reaching agreements with each FAS government on what care to furnish and how. If VA is unable to reach agreements with the FAS governments for any reason, VA would be placed in a Catch-22 where it must furnish care under these amendments but it cannot furnish that care because the underlying agreements have not been reached. The Department would welcome the opportunity for further discussion with the Committee on this matter.

Additional coordinated implementation across the Federal agencies and alignment with negotiated agreements with sovereign partners is necessary to ensure services are durable and resilient. The VA would welcome the opportunity to work with the Committee and interagency partners to refine the legislation to support reliable, scalable care delivery while preserving the flexibility necessary for successful implementation.

Cost Estimate: The cost models developed for this bill were constrained to the targeted population of the FAS. The Department acknowledges Congressional intent for the targeted population and notes that further expansion beyond the FAS would significantly increase costs. While the Department does not yet have a refined cost estimate for this bill as drafted, VA has previously developed preliminary rough order-of-magnitude estimates to inform internal planning under discretionary authorities. This bill would

convert those authorities into mandatory requirements, expand the scope of required services, and impose statutory timelines that materially affect cost, staffing, and contracting assumptions.

The ultimate cost of implementation would depend on factors outside the Department's control, including the timing and terms of agreements with the governments of the Freely Associated States, beneficiary utilization patterns, logistics and pharmaceutical delivery arrangements, and the availability of appropriations. VA looks forward to working with Congress and interagency partners to refine cost estimates as implementation pathways and funding mechanisms are clarified. Absent additional appropriations or clarifying amendments, implementation would require VA to absorb new mandatory costs within existing discretionary resources.

H.R. 6848 Whole Health for Veterans Act

Summary: This bill would add a new section 1730D regarding copayments for whole health well-being services; proposed section 1730D(a) would prohibit VA generally from requiring a Veteran to make any copayment for the receipt of whole health well-being services, except as provided in this section. Proposed section 1730D(b) would prohibit VA from requiring Veterans enrolled in Priority Groups 1-5 from making any copayments for the receipt of whole health well-being services. Proposed section 1730D(c) would allow VA to require a monthly copayment for whole health well-being services from Veterans enrolled in Priority Groups 6-8, but such copayment could not exceed $20. Proposed section 1730D(d) would define "whole health well-being services" as (1) educational and skill-building services that educate, instruct and impower Veterans to understand and implement the principles and practices of whole health, such as whole health coaching, whole health partner sessions, and whole health education and skill-building courses; and (2) complementary and integrative health well-being services that promote health, well-being, and self-care independent of treatment of a specific medical condition or diagnosis, such as guided imagery, meditation, Tai Chi/Qigong, and yoga for well-being."

Position: **VA does not support this bill**.

Views: VA does not support this bill because some of the provisions in this bill appear unnecessary or could be unduly complicated in administering. For example, proposed section 1730D(b) would prohibit VA from requiring Veterans in Priority Groups 1-5 from making a copayment for "such services". First, these Veterans do not generally owe copayments for the delivery of care, although they may owe copayments for medications under section 1722A. Second, the bill expressly excludes Veterans enrolled in Priority Group 6, who are generally not subject to copayments for their care; VA is unclear why this Group would not be included. Third, the phrase "such services" is not defined; it presumably refers back to whole health well-being services, but the bill should be clear on such a critical point. Fourth, proposed section 1730D(c) would allow VA to require Veterans who are not exempt from copayments under proposed section 1730D(b) to "make a monthly copayment", which could not exceed $20. However, this would be a very different approach to copayment liability than VA currently administers, which would likely require both systems and process changes. It would also result in further delays for care, and it is unclear how these copayments would affect other copayment liabilities. For example, under current law, if a Veteran has more than one appointment on the same day, and the Veteran would owe a copayment for both appointments, the Veteran is only liable for the higher of the two copayments. VA currently charges a $15 copayment for a primary care outpatient and a $50 copayment for a specialty care outpatient visit. Under the proposed authority, where VA could charge a monthly $20 copayment for whole health well-being services, if a Veteran had a primary care outpatient appointment and a whole health well-being services appointment on the same day, the $20 copayment would technically be more than the $15 copayment, but it is unclear how VA would apportion the $20 amount if the Veteran had multiple whole health well-being appointments in a single month.

VA recommends further discussions with the Committee to better understand the intended operations and effects of this section before further consideration or action on this bill.

Cost Estimate: VA does not have a cost estimate for this bill.

H.R. XXXX Veterans TBI Breakthrough Exploration of Adaptive Care Opportunities Nationwide (BEACON) Act of 2025

Summary: Section 2(a) of the bill would require VA to establish a grant program known as the TBI Innovation Grant Program. This program would award grants to eligible entities for the development, implementation, and evaluation of approaches and methodologies for prospective randomized control trials for neuro-rehabilitation treatments for the treatment of chronic mild traumatic brain injury (TBI) in Veterans.

Section 2(b) would define which entities would be eligible for grants, including non-profit organizations, academic institutions engaged in research with respect to TBI, non-VA health care providers with expertise in neuro-rehabilitative therapies, and an entity VA determines appropriate for an award of a grant under this section.

Section 2(c) would provide that grantees would have to use these funds to support activities that include designing and testing novel or innovative treatments for mild TBI (mTBI) that prioritize patient-centered care, including non-pharmacological therapies; conducting clinical studies and assessments to measure the effectiveness of funded approaches to improve mental health outcomes, reduce suicidality, and mitigate long-term effects of mTBI; providing training for clinicians and outreach to Veterans and their families to improve awareness and accessibility of innovative mTBI treatments; and establishing partnerships with community organizations, academic institutions, and VA health care facilities to implement and evaluate best practices.

Section 2(d) would prohibit VA from awarding an eligible entity a grant under this section in an amount that exceeds $5 million per fiscal year.

Section 2(e) would require VA, in awarding these grants, to give priority to eligible entities that have demonstrated experience in delivering or researching effective treatments for mTBI.

Section 2(f) would require eligible entities seeking a grant to apply to VA, at such time, in such form, and containing such information and assurances as VA determines appropriate, including a detailed description of proposed activities, expected outcomes, and plans for evaluating effectiveness. Grantees would have to submit to VA regular reports, not less frequently than annually, describing how the grant was used, the progress of activities funded by the grant, and measured outcomes relating to these activities. VA would be required to ensure rigorous oversight with respect to this grant program and evaluate the efficacy of activities funded by a grant on an annual basis.

Section 2(g) would require VA to ensure this grant program aligns with the SSG Fox SPGP to provide for cohesive and comprehensive support for Veterans with mTBI and associated mental health conditions and increase research and development on integrated mTBI and mental health interventions outside the scope of traditional VA pathways, interventions, programs, procedures, and pharmaceuticals.

Section 2(h) would require VA to prescribe regulations to carry out this section not later than 180 days after enactment.

Section 2(i) would allow VA, in carrying out the program, to use amounts available to VA for general mental health care programs; specifically, there would be authorized to be appropriated to VA $30 million for FY 2026-28 to carry out the pilot program. These funds would remain available until expended.

Section 2(j) would authorize VA to carry out the grant program for three years from the date of enactment. During this period and annually, VA would have to review the effectiveness of the grant program to determine the potential of such a grant program for continuation or expansion.

Position: VA supports the intent of this section but cites concerns.

Views: VA supports the intent of this section but cites concerns. Fundamentally, this section would require the creation of a new grant program, but the purpose and scope of this grant program would be unlike any other grant program VA currently administers. This program would be focused on developing, implementing, and evaluating "approaches and methodologies for prospective randomized control trials" for treatments for mTBI. This kind of support is more commonly provided by the National Institutes of Health, the Department of Health and Human Services, or the Department of War. Within VA, larger clinical trials, including those pertaining to mTBI (for example, Growth Hormone Replacement Therapy in Veterans with mTBI and Adult Growth Hormone Deficiency (AGHD); the GRIT Study) are evaluated for funding and implemented by the Cooperative Studies Program (CSP). In part, the CSP infrastructure, which has been iteratively developed and improved upon over the years, allows VA to address common challenges related to the implementation of randomized control trials (for example, large sample sizes, data collection across sites via secure means, necessary adherence to study protocols). Moreover, those in control arms of CSP trials continue to benefit from treatment as usual care provided by VA. In fact, CSP trials are often designed to ensure that Veterans' immediate clinical needs are addressed. There are some concerns that for those participating in trials outside VA, who are allocated to control conditions, immediate clinical needs may not receive the same level of priority. In addition, efforts are currently underway to create a brain health focused clinical trials network (via the Brain Health Coordinating Center, or the BHCC). To this end, the BHCC and CSP would work together collaboratively with funders inside and outside of VA (such as the pharmaceutical industry) to match Veterans living with mTBI symptoms to appropriate clinical trials.

Further, VA research programs are competitively evaluated, but funds are only available for VA researchers. This section would create a new funding mechanism – derived from funds otherwise appropriated by Congress for "general mental health care programs" – to develop new methodological approaches for "control trials". These methodologies and approaches would not result in or contribute to actual clinical care; at most, they seem to be a preliminary step toward research that may eventually produce new treatment approaches. This uncertain return on investment of funds VA could otherwise use to provide evidence-based treatments for mTBI is inadvisable. Funds made available for clinical care should be used to deliver clinical care.

Additionally, the bill appears to contemplate that VA would provide funds to organizations that would allow them, in part, to establish partnerships – an undefined term and one that is probably not appropriate in this context – with other organizations, including VA health care facilities. We do not see the value in providing VA funds to organizations to allow them to enter into relationships with VA itself. Other potential uses of the funds, such as mitigating the long-term effects of mTBI, would likely be unable to be accomplished or demonstrated without years of sustained funding. It should be further noted that awarding funds to academic institutions would likely result in a substantial reduction in available appropriated funds (or a reduced percentage of funds being used for their intended purpose) due to overhead costs at these institutions.

VA is unclear as to the intended effect of subsection (g), which would require VA to ensure this grant program "aligns" with the SSG Fox SPGP. Individuals with mTBI may or may not be at risk of suicide, which is a key criterion in eligibility for benefits through the SSG Fox SPGP. Moreover, the SSG Fox SPGP is Federal assistance in the form of competitive discretionary awards, while this section would constitute a research and development grant and would thus not align with the SSG Fox SPGP.

The bill rightly notes that VA would need to promulgate regulations for this grant program, but VA would be unable to publish final and effective regulations within

180 days of enactment. The rulemaking process takes, on average, about two years to complete. Once regulations are published and effective, VA would then need to solicit applications, review and score them, and then award grants, a process that takes between 6 and 12 months. This would also make the sunset provision in subsection (j), where VA's authority would end 3 years after enactment, too short a time period to even make initial awards, let alone develop any meaningful information or results.

Summary: Section 3(a) would require VA to establish and carry out a research grant program to award grants to eligible entities for studies and applied programs on approaches and methodologies for the treatment of TBI in Veterans.

Section 3(b) would define which entities would be eligible for grants, including an academic institution that conducts significant research on TBI; non-profit organizations with expertise in TBI research and neuro-rehabilitation, as well as demonstrated capabilities in clinical trials and TBI treatment evaluation and patient care delivery; and an entity, or a partnership among entities, that VA determines appropriate to receive a grant under this section.

Section 3(c) would require eligible entities seeking a grant to apply to VA, at such time, in such form, and containing such information and assurances as VA determines appropriate, including a summary of proposed research and treatment activities, methodology, and expected outcomes.

Section 3(d) would require VA, each fiscal year, to award four grants (at least three of which would have to be to non-profit organizations) in an amount of not more than $625,000 for exploratory or pilot research and treatment projects; VA would also have to award five grants in an amount of not more than $1.5 million for collaborative or multidisciplinary research and treatment initiatives.

Section 3(e) would require VA to enter into an agreement with an independent third-party organization comparable to VA's National Center for Posttraumatic Stress Disorder (NCPTSD) to administer the research grant program and carry out studies and implement efforts that include analyzing data from TBI treatment methodologies developed pursuant to this grant program to assess the effect of such methodologies on Veterans' mental health outcomes and long-term recovery, identifying evidence-based best practice and providing recommendations for further research or clinical application, and randomized controlled clinical trials to validate and deliver treatments, establish a standard of care, and improve access to such treatments for Veterans. The independent third-party organization would have to submit to Congress and VA a comprehensive report that includes the findings of the studies required under this agreement and recommendations with respect to the expansion of successful TBI treatment methodologies and standard of care recommendations (if any) developed pursuant to the research grant program.

Section 3(f) would allow VA to use amounts available for the operating budget of the NCPTSD to carry out this research grant program. There would be authorized to be appropriated $10 million for each of FY 2026-28.

Section 3(g) would require VA, not later than 2 years after VA commences the research grant program, and annually thereafter, to submit to Congress a report that includes the findings of the studies under section 2(f)(2) and the agreement required by section 3(e), as well as VA's recommendations with respect to policy and programmatic improvements to VA services to treat TBI among Veterans.

Section 3(h) would provide that VA's authority under this section would end three years after enactment.

<u>Position:</u> VA supports the intent of this section but cites concerns.

Views: VA supports the intent of this section but cites concerns. Many of VA's concerns with section 2 of this bill apply to section 3 as well. More specifically, VA is concerned with the provisions regarding the "third-party organization" under subsection (e), where such organization would "administer the research grant program". This phrase, in particular, is unclear. Grant administration involves soliciting applications, reviewing and scoring these applications, awarding funds, and monitoring the use of those funds. In particular, the scoring and awarding of funds are inherently governmental functions that should not be performed by a non-governmental entity. Similar to section 2, this section would derive funding from amounts otherwise available to VA for the operation of the NCPTSD. Funding for NCPTSD is also available for research, education, and consultation, all of which are aimed at improving care for Veterans with PTSD. Like section 2, this bill would fund research that may or may not improve outcomes for Veterans with PTSD and is seemingly inconsistent with other statutes addressing the responsibilities of the NCPTSD. VA also has technical edits on this section as well.

Summary: Section 4 would define various terms, including TBI, treatment (which would mean clinical interventions, therapeutic devices, or rehabilitation care provided directly to Veterans with TBI), and Veteran (which would have the meaning given that term in 38 U.S.C. § 101).

Position: VA has no objection to this section.

Views: VA has no objection to this section, as it simply defines terms used elsewhere in the bill.

VA has technical edits and comments on the legislation beyond those identified above. Notably, we recommend the bill include specific language expressly authorizing VA to develop additional parameters associated with the grant programs to ensure that

any reviewing court or body would treat this as an express delegation under the Supreme Court's holding in Loper Bright v. Raimondo, 603 U.S. 369 (2024). We would be happy to provide technical assistance to the Committee, but further discussion of the intended outcomes first would likely make such technical assistance more meaningful.

Cost Estimate: VA does not have a cost estimate for this bill.

H.R. 6444 Blast Overpressure Research and Mitigation Task Force Act

Summary: Section 2(a) would require VA, through the VA-Department of Defense (DoD) Joint Executive Committee (JEC), to establish the Blast Overpressure Task Force of the Department of Veterans Affairs (Task Force) not later than 180 days after enactment.

Section 2(b) would require the Task Force to: (1) improve how VA, in consultation with DoD, provides health care and other benefits to Veterans or members of the Armed Forces diagnosed with TBI, PTSD, or other symptoms, from blast overpressure or blast exposure; (2) align VA's research agendas and acquisition strategies regarding such health care; (3) establish physiological and cognitive performance baselines for such Veterans and members; (4) prioritize translational research regarding such Veterans and members in different clinical areas; (5) monitor sensory decline and stress-related impairments among such Veterans and members; and (6) support continuity of care by integrating mobile and longitudinal diagnostic tools.

Section 2(c) would require the Task Force to issue annual reports to Congress that include details of research initiatives, coordination outcomes, and clinical advancements of the Task Force, as well as the Task Force's recommendations regarding how VA claims processors should evaluate evidence that links such conditions to active military, naval, air, or space service and best practices regarding the evaluation of neurological injuries in examinations for benefits under chapters 11 or 15 of title 38, U.S.C.

Section 2(d) would provide the Task Force would terminate on September 30, 2029.

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

Views: VA supports the intent of this bill, subject to amendments and the availability of appropriations. VA supports efforts to expand work in this critical research area involving sharing research data, advancing brain health, blast exposure, and potential treatment for specific Veterans adversely affected by their military service. However, we note the requirements of this bill could generally be conducted with current authority, but they would require additional resources. We would appreciate the opportunity to discuss current research efforts in this area and how legislation might support these. We also would appreciate the opportunity to discuss how this bill might affect eligibility for benefits more broadly under the Honoring our PACT Act of 2022 (P.L. 117-168). Some elements of this bill may be better suited to DoW being the responsible agency.

VA currently invests over $30 million annually in research centers, studies, and clinical trials focused on brain injuries resulting from blast exposure. This includes support for an open-field blast center in Missouri and development of calibration devices to improve MRI accuracy in detecting white matter damage.

VA investigators are also developing a precision brain health diagnostic tool that integrates neuroimaging, blood biomarkers, neurobehavioral assessments, and physiological measures using machine learning algorithms. Additionally, VA and DoW jointly secured $2.1 million in incentive funding to study the effects of low-frequency acoustic energy and vibrations from weapon systems on brain health.

Beyond research, VA and Dow collaborate on clinical care through VA's Polytrauma Rehabilitation Centers and jointly developed Clinical Practice Guidelines for mTBI. The Military Occupational Blast Exposure Working Group, which includes representatives from VHA, the Veterans Benefits Administration, and DoW, continues to advance interagency efforts in this area.

VA welcomes the opportunity to participate in providing recommendations. However, the ability to provide any actionable recommendations under section (c)(2)(A) will be contingent upon the availability of conclusive scientific findings and conclusions in section (c)(1). Consequently, there may be limited or no actionable recommendations under section (c)(2)(A) until the scientific findings and conclusions evolve sufficiently to permit developing actionable recommendations for how Veterans Benefits Administration (VBA) claims processors should evaluate evidence of occupational blast exposure during service.

VA has some technical comments on the bill. We would welcome the opportunity to discuss these concepts further with Congress, as another approach – such as a commission or Federal advisory committee – may be more effective. VA can provide technical assistance following these discussions to ensure the appropriate form of collaboration is reflected in the bill.

Cost Estimate: VA does not have a cost estimate for this bill.

H.R. XXXX Data Driven Suicide Prevention Act of 2025

Summary: Section 2(a) would require VA, acting through the Center for Innovation for Care and Payment, to establish and carry out a program to award grants to eligible organizations to use artificial intelligence (AI) to develop a predictive model to evaluate risk factors contributing to the incidence of suicide among Veterans.

Section 2(b) would define eligible organizations as non-profit entities, academic institutions, private research organizations, or other entities with demonstrated capability and experience developing and deploying AI and machine learning solutions, analyzing health care data (including de-identification and protection of personally-identifiable information and protected health information), developing predictive models or decision-support tools used in clinical or population health settings, applying advanced statistical methods or machine learning techniques to large, complex health datasets, and complying with VA data security and interoperability standards.

Section 2(c) would require eligible organizations desiring a grant to submit to VA an application in such form, at such time, and containing such information and assurances as VA determines appropriate.

Section 2(d) would require VA to select not fewer than two eligible organizations to receive a grant. In selecting eligible organizations, VA would have to consider several criteria, including: (1) with respect to the VISN in which the organization is located, the geographic distribution, the complexity of applicable VA medical facilities, and the density of the Veteran population; (2) geographic proximity to VA medical facilities; and (3) demonstrated experience in collaborating with local VA facilities and community partners. VA would have to give priority in awarding grants to eligible organizations (1) located in areas with a high rate of suicide among Veterans, a high rate of calls to the Veterans Crisis Line, and long wait-times for mental health care at VA facilities; (2) with experience in administering predictive analytics or population health solutions for Government-owned health care systems pursuant to an agreement with the Federal Government; (3) with a demonstrated capability to deliver tools that are explicable, interoperable, and clinically actionable; (4) that employ data scientists, clinicians, and suicide prevention specialists; (5) with existing infrastructure for secure data storage and transmission that complies with Federal cybersecurity requirements; and (6) that agree to make any predictive model or finding resulting from activities funded with a grant under this section available to VA for Department-wide implementation and

evaluation. VA could not select an organization located in a VISN in which another eligible organization in receipt of a grant under this section is located.

Section 2(e) would state VA's authority to carry out this pilot program would end on September 30, 2029.

Section 2(f) would define, among other terms, "artificial intelligence" to have the meaning given that term in section 238 of the John S. McCain National Defense Authorization Act for FY 2019 (P.L. 115-232; 10 U.S.C. § 4001, note).

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

Views: VA supports this bill, subject to amendments and the availability of appropriations. VA fully supports efforts to advance suicide prevention among Veterans through innovative approaches, including the use of AI and data science. We recognize the urgency and importance of developing tools that can help identify and address modifiable risk factors for suicide, and we appreciate the intent behind this bill to support such work. However, we recommend several amendments to ensure the bill is both operationally feasible and aligned with VA's statutory, regulatory, clinical, and privacy frameworks.

Similar to VA's concerns regarding the BEACON Act, VA is concerned about the grant-making aspects of this bill as well. This bill includes additional features that raise concerns. First, the bill would require VA act through the Center for Innovation for Care and Payment (the Center), but it is unclear if this language is intended to mean this would constitute a pilot program subject to the limitations otherwise established for the Center in 38 U.S.C. § 1703E. Second, the Center has no experience in developing or administering a grant program, so requiring the Center to be engaged in this program would seem inappropriate; VA should be able to determine where responsibility for a new program should rest. Third, as noted in VA's discussion of the BEACON Act, VA

would need to engage in rulemaking to award grants; however, it appears this would be an exceptionally small program with potentially only a handful of grants. The potential value, if any, resulting from these grants may not justify the investment in time and resources associated with rulemaking. Fourth, the prioritization requirements in proposed subsection (d)(3) would be incredibly prescriptive; it is possible that no applicant could actually satisfy these requirements. Fifth, the sunset date of September 30, 2029, would likely be too short a period of time given the need to engage in rulemaking and to proceed through the grant application and award process.

From a programmatic perspective, we recommend the bill's focus be expanded to include AI and data science approaches to improve the identification of modifiable risk factors that contribute to the incidence of suicide among Veterans. This approach would be more actionable for clinical teams and better aligned with VA's immediate care priorities. Supporting a broad range of AI and data science methods – such as natural language processing and pattern recognition – would allow for more practical solutions that can be integrated into existing VA workflows and directly support suicide prevention efforts. We also recommend the bill focus on supporting "researchers in residence", where scientists from non-VA organizations embed with VA clinical and data science teams to provide scientific contributions within a clinically implementable framework within the secure VA data environment. Independently, non-VA organizations are unlikely to develop models or tools that are practical to implement, use clinically and maintain in real-world VA health care practice.

Importantly, the bill's current language raises concerns regarding the use and disclosure of protected health information (PHI). VHA supports the goals of the bill and recognizes the potential of artificial intelligence to improve patient outcomes by identifying suicide risk factors. The proposed grant activities would require access to PHI, and legal authority under all applicable Federal privacy laws. Although the proposed grant criteria would require the grantee to have experience implementing these privacy protections, we recommend expressly requiring the grant activities to be subject to all applicable information privacy and security laws. Note that onboarding

non-VA organizations into VA to work under the supervision of VA staff in secure VA data environments does not bypass these challenges.

Additionally, we recommend that the bill language be revised to more clearly reflect the intent to use VA and DoW health data in developing predictive models. This would help ensure alignment with VA's data governance policies and operational capabilities. We also suggest that any references to compliance include VA's privacy requirements, data security protocols, and interoperability standards to ensure consistency with existing VA policies.

In terms of eligibility and selection criteria, VA recommends focusing on organizations with demonstrated expertise in developing AI and data science solutions that can be integrated into VA workflows. As noted above, the prioritization requirements outlined in the bill are overly prescriptive and may be difficult for any applicant to satisfy. Criteria that do not directly support the goal of developing practical, implementable solutions should be reconsidered or removed.

Cost Estimate: VA does not have a cost estimate for this bill.

H.R. XXXX Veterans Health Desert Reform Act

Summary: Section 2(a) would require VA, through the Center for Innovation for Care and Payment, to establish and carry out a pilot program under which VA can enter into agreements with certain hospitals to furnish hospital care and medical services to covered Veterans.

Section 2(b) would require VA, in selecting hospitals, to select not fewer than three hospitals to seek to enter into an agreement; in selecting hospitals, VA would have to give priority to hospitals located in rural areas that VA determines have a high population of covered Veterans and are appropriate for participation in the pilot program.

Section 2(c) would state that VA could furnish to covered Veterans the same hospital care and medical services for which the Veteran would be eligible under the VCCP.

Section 2(d) would require VA develop a process to reimburse hospitals with which VA enters into agreements under this pilot program; the process would have to ensure such hospitals are reimbursed at a rate not less than the rate at which the hospital would be reimbursed under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. § 1395 et seq.) for substantially similar hospital care or medical services and that covered Veterans in receipt of hospital care or medical services under the pilot program are not required to pay a fee for such care or services; however, VA could require covered Veterans to make a copayment for the receipt of hospital care and medical services under the pilot program. In developing this process, VA would also have to carry out a review to identify Government-proven management and payment best practices used under the Medicare Program under title XVIII of the Social Security Act, title XIX of such Act (42 U.S.C. § 1396 et seq.), and the TRICARE program (as defined in 10 U.S.C. § 1072); VA also would have to determine which best practices identified could be adopted and implemented by VA for use in the pilot program.

Section 2(e) would require VA, during the period in which an agreement with a hospital under this section is in effect, to monitor the provision of hospital care and medical services at such hospital, including by tracking access, costs, quality, and Veteran satisfaction. At least 180 days before the end of the pilot program, VA would have to submit to Congress a report that includes a description of all oversight activities and an evaluation of the provision of hospital care and medical services at each hospital under the pilot program.

Section 2(f) would provide that the pilot program would end on September 30, 2029.

Section 2(g) would define the term “covered veteran” to have the meaning in 38 U.S.C. § 1703(b), which generally refers to Veterans enrolled in VA health care. The term “rural” would have the meaning given that term in the Rural-Urban Commuting Areas (RUCA) coding system of the Department of Agriculture.

Position: **VA supports the intent of this bill but notes the need for additional clarity.**

Views: VA supports the intent of this bill and strongly agrees with the apparent intent to improve the quality and availability of care to Veterans in rural areas. We support the goal of improving access for rural Veterans and want to work with the Committee to clarify how this new authority would integrate with existing VA care processes.

However, VA would need clarification on the purpose of the bill because, as drafted, the bill appears to differ in no appreciable way from current authority under the VCCP in 38 U.S.C. § 1703. VA can and already does contract, directly or through TPAs, with rural hospitals to provide hospital care and medical services to covered Veterans; VA already pays Medicare rates (or above, in some cases) for care from such hospitals, and VA already collects copayments from Veterans who are liable for such payments. Section 2(c) of the bill expressly states that VA can only furnish under the pilot program “the same hospital care and medical services for which the covered veteran would be eligible under the Veterans Community Care Program”, which would limit this to Veterans otherwise eligible for community care. The bill’s requirements generally mirror what VA is already doing through rural hospitals currently under the VCCP.

There appear to be only two intentional differences between this bill and current practice. First, the requirement in subsection (d)(3) to review and identify Government-proven management and payment best practices and determine which best practices could be adopted and implemented by VA. However, VA already has the authority to conduct such a review and would not need to implement a new pilot program for that

purpose. Second, the bill would require VA to monitor the provision of hospital care and medical services at participating hospitals by tracking access, costs, quality, and Veteran satisfaction and to report to Congress on this oversight. However, VA already collects some information from providers participating in the VCCP, and the additional reporting required here would result in additional costs (likely both for VA and the participating hospitals). Studying the effect of best practices on care at rural hospitals is not a stated purpose of the bill; similarly, the required reports do not appear to be central to the bill, either. The bill appears to unintentionally differ from the VCCP in that it refers to "reimbursement" rates for care under section 2(d). Under the VCCP, however, VA makes payments pursuant to contracts or agreements with providers. 38 U.S.C. § 1703(i), for example, sets forth "Payment Rates for Care and Services" under the VCCP. This distinction is important and needs to be preserved.

VA also has concerns with the bill's definition of rural as having the meaning given that term in the Department of Agriculture's RUCA coding system. We believe a clearer definition would state that an area is considered rural if it has a code other than 1 or 1.1 in the RUCA coding system.

VA would appreciate the opportunity to discuss the intended goal of this bill to determine if any legislation is needed at all. VA has technical edits and comments on the bill as written, but VA can provide more meaningful technical assistance following such discussions.

Cost Estimate: VA does not have a cost estimate for this bill.

Conclusion

This concludes my statement. We look forward to responding to any questions you or other Members of the Subcommittee may have.