STATEMENT OF
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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
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Chairwoman Miller-Meeks, Ranking Member Brownley, and other Members of the Subcommittee: thank you for inviting us here today to discuss 15 bills that would affect VA health care programs and services. Joining me today are Mark Koeniger, M.D., Acting Assistant Under Secretary for Health for Patient Care Services, and Mark Kobelja, M.D., Executive Director, National Programs, Veterans Health Administration.

H.R. 4398 Veteran Burial Timeliness and Death Certificate Accountability Act

Summary: Section 2 of the bill would state Congress' findings that states and counties have reported significant delays in the signing of death certificates for Veterans who pass away from natural causes, that such delays (caused by the refusal of, or postponement by, VA physicians) have, in some cases lasted as long as eight weeks, and that such delays prevent the timely burial of deceased Veterans and access to survivor benefits.

Section 3(a) of the bill would require VA physicians or nurse practitioners who are the primary care providers of a Veteran who dies of natural causes to certify the death of the Veteran not later than 48 hours after the physician or nurse practitioner learns of such death. It would further provide that if a VA physician or nurse practitioner could not comply with that requirement, a coroner or medical examiner in the jurisdiction where the death occurred could certify such death.

Section 3(b) would require VA, not later than 1 year from enactment and annually thereafter, to submit to Congress a report regarding compliance with subsection (a). Each report would have to include the percentage of cases in which a VA physician or nurse practitioner complied with subsection (a), the number of cases in which a VA physician or nurse practitioner could not comply, and an identification of the most common reasons why they were unable to comply.

Position: **VA supports the intent of this bill, subject to amendments, but is unable to assess the impact to budgetary resources and therefore will follow up with the committee once this evaluation is complete or CBO has provided a score.**

Views: VA supports the intent of this bill, subject to amendments, because alleviating delays in the certification of a Veteran's death would support continued collaboration and information sharing between the Veterans Benefits Administration (VBA) and the Veterans Health Administration (VHA) in support of faster claims decisions for survivors. VA recognizes and has proactively implemented measures to address concerns this bill aims to address. On June 25, 2025, VA published VHA Notice 2025-03, "Survivors Assistance and Memorial Support," which provides a framework to ensure standardized clinical and operational processes, training, and oversight to support primary survivors and next of kin. This Notice addresses a number of the provisions outlined in the bill.

VA recommends amending the bill in two ways. First, the bill's requirements for VA physicians or nurse practitioners to certify a Veteran's death within 48 hours is unduly specific and would be difficult or impossible to meet in some situations. VHA Notice 2025-03 requires VA health care providers to sign death certificates within 2 business days of notification, adhering to state and local laws. This standard of 2 business days allows for necessary information gathering, accommodates providers' schedules, and respects state and local laws. Over 95% of Veteran deaths occur outside VA facilities, making timely completion complex due to the need for collateral history from various sources and other jurisdictional requirements. VA recommends changing the 48-hour requirement to a 2-business day requirement. Further changes may be needed to account for variations that may arise based on where the Veteran died.

In addition, this bill would exclude Physician Assistants (PA) from certifying death certificates. VHA policy includes PAs as certifying health care providers because PAs are trusted, licensed clinicians who significantly contribute to VA's health care system. VA recommends amending the bill to allow PAs to certify the death, in addition to physicians and nurse practitioners.

We also note that the reporting provisions outlined in section 3(b) would require enhancements to current data systems and pose significant operational challenges.

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

H.R. 4805 Warrior Impact from Neurological and G-Force Stress (WINGS) Act

Summary: Section 2(a) would require VA to conduct a comprehensive, longitudinal study to assess the long-term physiological and psychological effects of military aviation (including with respect to high-performance flight and G-force exposure) on military aviators. Section 2(b) would require the study to examine, at a minimum: (1) the relationship between cumulative flight hours and exposure to G-forces and incidents of traumatic brain injury (TBI), sub-concussive trauma, or cognitive impairment; (2) long-term mental health outcomes, including with respect to incidence of depression, anxiety disorders, and posttraumatic stress disorder (PTSD) in military

aviators compared to other members of the Armed Forces; (3) the correlation between aviation-related physiological stress and suicide risk among aviators; (4) the prevalence of neurodegenerative conditions (including chronic traumatic encephalopathy (CTE), amyotrophic lateral sclerosis (ALS), and Parkinson's disease) in current and former military aviators; (5) the effect of helmet design, oxygen systems, flight suit pressurization, and other cockpit environmental factors on neurocognitive health; (6) current screening and diagnostic procedures used to detect early signs of neurological injury or psychological distress in military aviators; and (7) recommended improvements in the monitoring, prevention, and treatment of aviation-related brain trauma and mental health challenges.

Section 2(c) would require VA, in conducting the study, to consult with the Department of War (DOW), the Surgeons General of the military departments, the Director of the Defense Health Agency (DHA), and relevant academic institutions and Federally-funded research and development centers with expertise in aviation medicine, neuroscience, and psychiatry.

Section 2(d) would require VA to establish and maintain a centralized Military Aviator Neurohealth Registry (MANR) that would include anonymized health data of military aviators voluntarily participating in the study, flight exposure metrics (including cumulative hours and G-force profiles), relevant health outcomes tracked over time, and a mechanism for longitudinal follow-up with the military aviators.

Section 2(e) would require VA, not later than one year after enactment, to submit to Congress an interim report on the study under subsection (a), including any preliminary findings and recommendations. Not later than three years after enactment, VA would have to submit a final report on the study under subsection (a), including findings and recommendations.

Section 2(f) would define the term "military aviator" to mean a Veteran who, as a member of the Armed Forces (including a commissioned officer or a warrant officer), (1) had been designated as a pilot, naval aviator, or aircrew member by the Secretary of the military department concerned; (2) operated, or was regularly assigned as a flight crew member aboard, high-performance, crewed, fixed-wing or rotary wing aircraft designed for tactical, training, or reconnaissance missions, including fighter aircraft, attack aircraft, trainer jets, and tiltrotor or high-speed rotary aircraft; (3) was subject to sustained or repeated G-forces during the routine execution of flight duties; and (4) served in a role that may have included aircraft control, weapons employment, navigation, reconnaissance, or mission-specific operations requiring aircrew qualification and exposure to flight-related physiological stressors.

Position: **VA supports the intent of this bill, subject to amendments, but is unable to assess the impact to budgetary resources and therefore will follow up with the committee once this evaluation is complete or CBO has provided a score.**

Views: VA supports the intent of this bill to better understand the long-term physiological and psychological effects of military aviation on Veterans. However, VA has some concerns with the bill as drafted. Initially, the bill is unclear as to the duration and parameters of the study; in subsection (a), this is referred to as a "longitudinal study", but in subsection (e)(2), VA must submit a "final report" within three years of enactment. It is not clear that VA could complete a "longitudinal study" within three years. We note that VA is currently operating both a post-9/11 Veteran retrospective cohort (approximately 6 million Veterans, with data updated every few years and linked to occupational codes) and a prospective longitudinal cohort (approximately 4,000 Veterans with repeated neuroimaging, blood samples, and neurobehavioral assessments, among other measurements). Leveraging one or both of these resources might provide alternative ways of identifying risks associated with military aviation.

Additionally, the provisions regarding the MANR are unclear. Registries generally involve a free, voluntary medical assessment for Veterans to alert them to long-term health problems that may be related to their military service. Registries are used to track and monitor the health of specific groups of Veterans, and VA uses registry data to understand and respond to these health problems more effectively. However, the bill is unclear as to whether inclusion in the MANR would be voluntary or mandatory (for example, whether Veterans opt-in or whether VA includes data for all eligible Veterans). The bill also refers to the inclusion of "anonymized health data", but it is unclear what this term means. If the data are anonymized just for researchers or other individuals accessing the data, but VA can otherwise individually connect specific data to specific Veterans, that would be preferrable to barring VA from being able to connect any individual data to specific Veterans. In general, a registry is not likely needed because with occupational codes, the Federal electronic health record and VA's health record system, and other information, researchers can conduct epidemiological analyses on the de-identified retrospective cohorts.

VA has some concerns with some of the stated elements of the study. For example, the bill refers to measuring the relationship between flight hours and exposure to G-forces and incidents of TBI; however, TBI is based upon diagnostic criteria that require alteration or loss of consciousness. While it is possible that strong vibrations and G-forces can result in brain injury, the lack of reporting by aviators of an alteration or loss of consciousness suggests this is not TBI. An alternative term, such as aviation-related brain injury, would avoid the specificity and diagnostic requirements associated with TBI. Additionally, the bill would include an element regarding the prevalence of neurodegenerative conditions, including CTE. However, CTE is a post-mortem pathology determination and cannot be determined reliably prior to death. If the bill is intended to focus on CTE, it may be difficult to find enough brain donations from those with appropriate occupations for a research study. Consequently, omitting or qualifying this requirement may be appropriate.

We note that the requirement to consult with non-Federal entities could implicate the Federal Advisory Committee Act (FACA); FACA applies to any committee

established or utilized by an agency that includes at least one non-Federal member and is intended to obtain advice or recommendations. FACA requirements would not apply to groups assembled solely to exchange facts or information, or to groups assembled to obtain individual advice from each attendee rather than a group recommendation. To avoid the additional administrative requirements that would otherwise apply, Congress could specifically exempt consultation from FACA by authorizing the committee with language that explicitly waives FACA's requirements or states they are inapplicable.

Finally, we note that the research and some of the measurements identified in the bill would require close coordination with the Department of War (DOW). We recommend the Committee contact DOW for any additional technical assistance or comments that may improve the bill.

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

H.R. 6835 Veterans Spinal Trauma Access to New Devices (STAND) Act

Summary: Section 2 of the bill would amend 38 U.S.C. § 1706 by adding a new subsection (d). The proposed subsection (d)(1) would require VA, in managing the provision of hospital care and medical services, to furnish (through direct provision of service, referral, or a VA telehealth program) a preventative health evaluation annually to any Veteran with an SCI/D who elects to undergo the evaluation. The proposed paragraph (2) would require that the evaluation include an assessment: (A) of any circumstance or condition the Veteran is experiencing that indicates a risk for any health complication related to the SCI/D; (B) regarding chronic pain and its management; (C) regarding dietary management and weight management; (D) regarding prosthetic equipment; and (E) with respect to the provision of any assistive technology, including spinal cord neuromodulation technology (such as non-invasive transcutaneous spinal stimulation) that could help maximize the voluntary motor or autonomic function, independence, or mobility of the Veteran, including suitability of such technology for home use and need for training, programming, and remote follow-up.

Proposed paragraph (3) would require VA, in maintaining, prescribing, or amending any guidance, rules, or regulations issued by VA regarding the requirements in the new subsection (d), to consult with VA's SCI/D program managers, VA clinicians employed as specialists in SCI/D, and representatives of organizations recognized under 38 U.S.C. § 5902 (generally, organizations that prepare, present, and prosecute claims for VA benefits). Before issuing any guidance, rules, or regulations regarding the requirements set forth in this new subsection, VA would have to consult with manufacturers of assistive technologies and other entities relevant to the provision of assistive technologies if the guidance, rules, or regulations would directly affect such manufacturers or entities. VA would have to ensure, to the extent possible, that any Veteran known by VA to have an SCI/D receive information annually about the annual evaluation and the benefits to undergoing this evaluation.

Proposed paragraph (4) would authorize VA, as clinically appropriate, to provide training, programming, and remote monitoring, and follow-up for assistive technologies through telehealth.

Proposed paragraph (5) would require VA, within 1 year of the enactment of this Act and every 2 years thereafter, to submit to Congress a report on the number of Veterans who received medical care or hospital services from VA and used an assistive technology, received VA care or services and were assessed for the provision of an assistive technology, and received VA care or services and were prescribed an assistive technology. VA would also need to, for any assistive technology prescribed, identify the category of such technology (including spinal cord neuromodulation) and summarize the functional outcomes associated with the prescription of such technology if available. Further, VA would have to report the year-to-year change in the percentage of Veterans with an SCI/D who received an evaluation described above.

Proposed paragraph (6) would require VA, in evaluating the performance metrics of a Veterans Integrated Service Network (VISN) for any year beginning after the date that is 1 year after the date of the enactment of this Act, to consider the provision of the preventative health evaluations described above.

Proposed paragraph (7) would define the term “assistive technology” to mean a powered medical device or electronic tool used to treat or alleviate symptoms or conditions caused by an SCI/D, including a personal mobility device (including a powered exoskeleton device), a speech-generating device, a spinal cord neuromodulation technology (including non-invasive transcutaneous spinal stimulation using sensory/afferent pathways intended to improve voluntary motor function, autonomic function, independence, or quality of life), and an implantable spinal cord stimulation system approved by the Food and Drug Administration (FDA), as clinically appropriate and consistent with VA prosthetic and sensory aids policy.

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

Views: VA is committed to providing comprehensive, lifelong, innovative, and specialized care that is safe and evidence-based for Veterans with SCI/D. VA does not support this bill because it would reduce VA’s ability to ensure the safety of Veterans and would compromise the integrity of the clinical decision-making process. It would also increase administrative costs to VA, burden clinicians’ time, and ultimately result in reduced access to clinically appropriate care.

In particular, VA is opposed to proposed subsection (d)(3), which would require VA to consult with the manufacturers of assistive technologies “and other entities relevant to the provision of assistive technologies” if VA’s guidance, rules, or regulations “would directly affect such manufacturers or entities.” Mandatory consultation with such entities in the development of clinical guidance would introduce a conflict of interest that could easily compromise patient safety. This would not only set a concerning precedent, but it would contradict best practice for the development of clinical protocols in health

care settings. Research indicates that increased stakeholder involvement in the development of clinical protocols or clinical practice guidelines (CPG) can result in poor quality protocols that fail to ensure safety and do not meet the needs of clinicians in guiding best care for patients. The recommended course of action for the development of high-quality clinical protocols is to utilize research and subject matter experts from a range of settings and expertise. VA's assessment and procurement of assistive technologies is consistent with the standard practice of care for Veterans with SCI/D.

Additionally, the provisions in proposed subsection (d)(5), which would require detailed reports from VA, would consume clinicians' and administrators' time without apparent value; this additional burden would reduce the ability to see more Veterans in clinical appointments and to process requests for assistive technology and other devices, ultimately reducing Veterans' access to timely and appropriate care. VA's current data systems capture when assistive technology is procured, but the other data elements in the bill are not available. VA's systems are not able to capture instances where Veterans are evaluated, but not found suitable, for assistive technology, or Veterans who decline assistive technology.

While VA already has the authority to prescribe and purchase the devices and technology required by the bill, VA is concerned about the breadth of the definition of the term "assistive technology" in the bill. The term would mean a powered medical device or electrical tool used to treat or alleviate symptoms or conditions caused by an SCI/D, including a personal mobility device (including a powered exoskeleton device), a speech generating device, a spinal cord neuromodulation technology, and an implantable spinal cord stimulation system approved by the FDA. Given the breadth of this term, the associated procedural requirements would apply in multiple instances; this would make practical implementation very difficult, if not impossible.

Provisions of this bill related to the preventative health evaluation and assistive technology assessment are unnecessary because VA is already meeting those requirements. VHA Directive 1176(2), Spinal Cord Injuries and Disorders System of Care, dated September 30, 2019, (amended February 7, 2020), already requires Annual Comprehensive Preventive Evaluations be offered to all Veterans with SCI/D, and these requirements meet or exceed all elements of the bill in this regard. Furthermore, explicitly prioritizing powered assistive technology during annual evaluations diminishes the value of all other aspects of the comprehensive medical and functional evaluation that is performed. While assistive technology is seen as a critical component of the evaluation, it is not weighted above other interventions or considerations in providing Veteran-centered care.

To the extent the bill is concerned that Veterans do not have an opportunity to determine which assistive technologies would be best for them, VA providers work closely with Veterans to identify their needs and recommend the best solutions for them. When devices like exoskeletons are identified as a potential option to improve independence and mobility of a Veteran, VA allows the Veteran to try the device for up to 90 days to determine whether it is the appropriate solution for them. However, as of

February 2025, data indicate that nearly one third of Veterans who use an exoskeleton during this trial period decide against using it beyond the trial period. VA is pursuing a similar approach with the emerging technology of transcutaneous spinal stimulation after FDA approval for this device for home use. This method ensures Veterans receive the device or technology that best meets their functional needs while avoiding waste that could otherwise result if these technologies were furnished without the Veteran's personal experience. This reflects VA's commitment to both clinically appropriate care as well as accountable fiscal stewardship.

Additionally, it is critical to ensure that Veterans can safely use any devices they are prescribed. VA was an early adopter of exoskeleton technology, and powered exoskeletons have been provided to Veterans with SCI/D since 2015, shortly after the FDA first approved powered exoskeletons for home use. To provide guidance and ensure consistency in screening, evaluation, and training, VA developed a rigorous clinical protocol, which was shared with VA facilities in December 2015. This clinical protocol was updated in 2026, reflecting current updated literature and additional exoskeleton products that have received FDA clearance for personal use in the community since the prior publication. VA is developing a similar protocol for transcutaneous spinal stimulation.

Further demonstrating VA's commitment to supporting exoskeletons and innovative technology, VA performed one of the largest national randomized, controlled multi-center exoskeleton research studies, investigating home/community use, efficacy, and safety of powered exoskeletons in Veterans with SCI/D. Powered exoskeletons can lead to assisted ambulation in individuals with SCI/D, yet they require careful evaluation of potential users, extensive training, inclusion of a companion for safe use, extensive clinician experience, and specific manufacturer training and expertise by staff for safe and effective use by individuals with SCI/D. Notably, the criteria for each device are largely based on FDA specifications. VA has taken an individualized approach to Veterans' exoskeleton training to minimize the burden on Veterans who are interested in and are evaluated for clinical appropriateness to utilize this technology.

Exoskeletons are complicated medical devices, and exoskeleton-trained clinicians must consider a number of factors when issuing this equipment. Factors include but are not limited to: level of spinal cord injury, height, weight, hip and leg length measures, joint range of motion (flexibility), skin integrity, spasticity, arm/hand strength, bone density, history of fractures, blood pressure, autonomic dysreflexia, cardiovascular health, cognition, environments of intended use, Veteran's goals for use of the device, vision, and the ability to develop the skill needed to operate this equipment. Due to the complexity of the devices, a large number of Veterans who are interested in exoskeletons are not appropriate for the use of these devices. Additionally, for safety reasons, the devices currently available in the United States require a companion to be present when an individual is utilizing this technology. Many individuals lack access to an appropriate companion to help with management of the device, which can weigh up to 51 pounds. Requiring the presence of a companion while utilizing the device can result in the perception of decreased independence to users

who are fully independent when using a wheelchair. The involvement of a companion also prolongs the training period and requires significant commitment from both the Veteran and companion.

Exoskeletons have been studied in a number of settings, and there are many potential benefits, such as standing, walking, cardiovascular response, spasticity management, weight loss, bowel function, and bone density. Evidence of adverse events, including fractures, falls, skin breakdown, autonomic dysreflexia, and soft tissue injuries have been reported across subjects, studies, and devices. Currently, there are no established CPGs regarding the use of exoskeletons. For each individual, it is still largely unknown if the benefits outweigh the risks and how to identify candidates who will most likely benefit from the technology. Therefore, VA has developed a clinical protocol that emphasizes patient preference and safety. Importantly, through safe, evidence-based services and devices, VA will continue its ongoing efforts to support Veterans with SCI/D in their goals of optimizing their health, functional mobility, and independence. Those efforts include careful evaluation and when appropriate, provision of assistive technology devices including powered exoskeletons.

Clinical application of transcutaneous and epidural spinal stimulation requires close safety monitoring as we implement this novel technology within VA. VA is focused on ensuring Veterans have access to and can use specialized technology to address their needs. VA is continually reviewing current clinical protocols to ensure Veterans receive timely, high-quality, and evidence-based care and technology.

H.R. 9018 Fostering Transparency, Understanding, and Support for Veterans Act of 2026 (Fostering TRUST Act of 2026)

Summary: Section 2 would amend 38 U.S.C. § 1720F, which requires VA to develop and carry out a comprehensive program for suicide prevention among Veterans and members of the reserve components of the Armed Forces, to include a new subsection (l) [sic].

Proposed § 1720F(l)(1) would require VA to report to Congress (the Veterans' Affairs Committees and the representative and senators representing the district where the facility is located and the Veteran's residence) in certain situations regarding suicides or attempted suicides. Specifically, VA would have to report in the case of a suicide or attempted suicide of any Veteran that occurred in, or on the grounds of, a VA facility or the facility of a non-VA provider through which VA furnishes care through the Veterans Community Care Program (VCCP) under 38 U.S.C. § 1703. This requirement would apply to the extent the Secretary or any employee or VA senior leader is aware of the suicide or attempted suicide. In such cases, VA would have to submit this report not later than seven days after the date on which the suicide or attempted suicide occurred. The report would have to include notice of the suicide or attempted suicide and the name of the facility and location where the suicide or attempted suicide occurred. Not later than 60 days after such date, VA would have to provide notice of the following information (if available) regarding the Veteran who died by suicide or attempted

suicide: (1) the enrollment status of the Veteran in VA care; (2) the date and circumstances of the most recent encounter before the suicide or attempted suicide occurred between the Veteran and any VA employee or facility or any non-VA provider; (3) whether the Veteran had other medical insurance or coverage (including TRICARE, Medicare, or Medicaid); and (4) confirmation that VA provided notice to the immediate family members of the Veteran of any VA support or assistance that might be available to such family members. VA would also have to include demographic information about the Veteran, including the Armed Force in which the Veteran served, the time period of service, age, marital status, employment status, gender, sexual orientation, race and ethnicity, and disability rating. In collecting and reporting this information, VA would have to take all steps VA determined necessary to respect the privacy and dignity of the Veteran and the Veteran's family. Each notice would have to include a copy of guidance developed by VA for purposes of dissemination that is designed to deter the sensationalism of suicide, provide information regarding warning signs that are often exhibited by Veterans at risk of suicide, provide notice of VA resources to Veterans who may be at risk of suicide (including the Veterans Crisis Line and readjustment counseling through Vet Centers), and provide information about best practices for lethal means safety and resources to secure lethal means available through VA.

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

Views: VA has significant concerns regarding the reporting requirements proposed in this legislation, particularly as they relate to suicide or suicide attempts that occur at the facility of a non-VA provider. The bill would require VA to collect and transmit to Congress highly sensitive Veteran information within short timelines, even in circumstances where VA may have no operational control over the facility in question and no immediate access to the information needed to comply.

VA seeks clarification regarding the aims of the bill and specifically regarding the provision of Veteran level (or even facility level information within such limited time periods) information to Congress. This would raise substantial concerns regarding Veteran privacy, as noted above, and it would require alterations to current systems for VA monitoring and analysis.

In addition, VA may be unable to obtain the data necessary to comply with the proposed deadlines, particularly the requirement to report to Congress within seven days of an event. VA currently does not maintain a surveillance system capable of tracking suicide or suicide attempt events that occur on non-VA provider property, and establishing such a process would require significant operational, contractual, and legal changes. The bill is also unclear as to whether any suicide or attempted suicide on the property of a non-VA provider who furnishes care through the VCCP would have to be reported, or if this requirement would only apply to Veterans who died by suicide or attempted suicide when they were on the property of a non-VA provider while seeking care through the VCCP. If any suicide or attempted suicide by a Veteran on the property of a provider who furnishes care through the VCCP had to be reported, this could also

pose a significant burden on these community providers and could disincentivize them from participating in the VCCP, which would reduce Veterans' access to care.

The bill would require VA to report information to Congress in such a way that would appear to implicate the Access to Congressionally Mandated Reports Act, which requires reports to Congress to be made publicly available. While this Act permits the Chair of a Committee to notify the Government Publishing Office to except certain reports, and also permits the head of an agency to withhold from publication reports that are exempt from public disclosure under 5 U.S.C. § 552 or required to be withheld under 5 U.S.C. § 552a, it would seem easier if the bill were amended specifically to exempt these reports from publication. This would ensure Congress is able to exercise proper oversight without risking the disclosure of protected information to the public, including disclosures that may cause undue harm to the privacy and wellbeing of surviving family members of the Veteran.

VA has a number of technical comments on the bill. First, there already is a section 1720F(l), so the bill would need to create a new subsection (m) instead. Additionally, the bill is unclear as to the deadlines for reporting, specifically in proposed § 1720F(l)(1)(B), which refers to "60 days after such date". It is unclear if "such date" means the date of the suicide or attempted suicide or if it means the date of the first report (within seven days of the suicide or attempted suicide). The bill would also only apply these requirements to Veterans, while VA's authority under § 1720F includes members of the reserve components of the Armed Forces, who may not be Veterans.

VA can provide further technical assistance on this bill if needed.

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

H.R. XXXX VA Coaching into Care Act

Summary: Section 2(a) would require VA, not later than one year after enactment, to establish a pilot program to maintain a toll-free hotline to provide access to licensed mental and behavioral health support providers to eligible recipients. Section 2(b) would require VA, in carrying out the pilot program, to ensure that the hotline is staffed by psychologists and social workers employed by VA and hired by VA for the program; such employees would have to provide to eligible recipients advice on how to discuss mental and behavioral health with a Veteran and appropriate referrals to VA programs and non-VA entities that provide mental health services or resources. Section 2(c) would require VA, not later than 60 days after establishing the pilot program, to provide information on the services available through the program to Veterans Service Organizations (VSO) and other organizations that serve Veterans, family members of Veterans, or caregivers of Veterans as VA determined appropriate. Not later than 90 days after establishing the pilot program, VA would have to furnish, in each Vet Center or VA medical facility, promotional flyers, brochures, and posters that provide information on the services available through the pilot program; VA would also have to promote the pilot program on a publicly accessible VA website and in other

outreach campaigns and activities conducted by VA. Section 2(d) would require VA, not later than 180 days after the pilot program terminates, to submit a report to Congress that includes information on calls received (the number of such calls, the average time to answer, and the average duration), the number and types of referrals provided, a summary of VA's actions to comply with subsection (c), and recommendations regarding whether continuing or expanding the pilot program is feasible and advisable and any additional or modified authorities or resources required to conduct or expand the program. Section 2(e) would provide that the pilot program would terminate three years after the day on which VA established the program. Section 2(f) would define four terms: "eligible recipient" would mean, with respect to a Veteran, a family member, an individual who resides with a Veteran, or a friend; "family member" would include a spouse, parent, dependent, or sibling; "Vet Center" would have the meaning given that term in 38 U.S.C. § 1712A; and VSO would mean an organization recognized under 38 U.S.C. § 5902.

Position: **VA supports the intent but cites concerns. VA is unable to assess the impact to budgetary resources and therefore will follow up with the committee once this evaluation is complete or CBO has provided a score.**

Views: VA supports the intent of ensuring that caregivers of Veterans have access to support services. VA's Caregiver Support Line (CSL) is a toll-free number (1-855-260-3274) that caregivers, family members, friends, Veterans, and community organizations can contact VA for information related to caregiving and available support and services. Our dedicated CSL team provides information on caregiver support services, counseling, educational services, and referrals (electronic notification) to local Caregiver Support Program (CSP) staff at VA medical centers. We believe the requirements in this bill would duplicate services already being provided through CSL.

While VA supports the intent of the bill, we have concerns with the bill as written. We note the bill is unclear in several critical respects. First, it is unclear if the licensed mental and behavioral health support providers answering calls through the toll-free hotline would be providing health care to callers, and if so, whether such care is independent of the needs of the Veteran or related exclusively to such needs. Currently, VA can provide readjustment counseling through Vet Centers, and can also provide counseling, training, and mental health services for certain family members under 38 U.S.C. §§ 1712A and 1782, respectively. Further, but related, the bill notes that providers answering calls to the hotline would provide "appropriate referrals to programs of the Department or to non-Department entities that provide mental health services or resources", but it is unclear if VA would assume financial responsibility for any services provided pursuant to a referral to a non-VA provider or entity. If the hotline is intended only to provide information (such as general advice on how to discuss mental or behavioral health with a Veteran and contact information to other resources), it is not clear that VA would need to hire psychologists and social workers to perform such tasks, as doing so would be a poor use of their time and qualifications. The bill is also unnecessarily prescriptive in this staffing requirement, as it would stipulate that such psychologists and social workers would have to be "hired by the Secretary for the

program". This would seem to require VA to hire staff dedicated exclusively to answering calls through the hotline. It would be more appropriate to allow VA to place staff in positions to answer calls through the hotline as needed, such that if actual demand was less than the number of staff hired to answer calls through the hotline, VA would not have clinical providers who were unable to furnish care and services to Veterans and other VA beneficiaries.

We also have concerns with specified required outreach through Vet Centers which could interfere with the unique mission of VA's Readjustment Counseling Service. Beyond these concerns, VA has identified a number of technical issues with the bill and could provide technical assistance to the Committee if needed.

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

H.R. XXXX Expanding Eligibility of Veterans with Service-Connected Disabilities Who Reside in Certain Territories or the Freely Associated States for Beneficiary Travel

Summary: Section 1 would amend 38 U.S.C. § 111(b), which generally defines who is eligible for beneficiary travel payments or reimbursement, to include any Veteran with a service-connected disability, without regard to rating, who resides in a covered jurisdiction in which no VA medical facility is located. The term "covered jurisdiction" would be defined to mean a territory or the Freely Associated States (FAS). The term FAS would have the meaning given that term in § 111(h) (generally, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau). The term "territory" would have the meaning given that term in section 5 of the Puerto Rico Oversight, Management, and Economic Stability Act (Public Law 114-187; 48 U.S.C. § 2104), which defines the term to mean Puerto Rico, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, or the U.S. Virgin Islands.

Position: **VA supports the intent, subject to amendments, but is unable to assess the impact to budgetary resources and therefore will follow up with the committee once this evaluation is complete or CBO has provided a score.**

Views: As VA has previously testified to this Committee, we support the bill's underlying objective of improving access to care for Veterans residing in the FAS. The Department also recognizes that access to health care for Veterans residing in the FAS is an important component of the United States' broader commitments under the Compact of Free Association and are a matter of strategic significance.

We note that the bill would create ambiguity in terms of the provision of beneficiary travel benefits to Veterans in the FAS. On the one hand, the bill would amend subsection (b)(1), which generally sets forth those individuals who must be provided beneficiary travel for examination, treatment, or care. It is unclear if the drafter and the Committee intend that the bill would make Veterans in these areas eligible for beneficiary travel for any travel (including for compensation and pension examinations,

vocational rehabilitation, counseling under chapters 34 or 35 of title 38, U.S.C., etc.). Further, while the bill would amend subsection (b)(1), it provides no clarity as to how this new authority would interact with the existing authority in subsection (h). Currently, § 111(h) authorizes VA to make payments to or for any person traveling in, to, or from the FAS for receipt of care or services authorized to be legally provided by VA in the FAS under 38 U.S.C. § 1724(f). Section 1724(f) authorizes VA to furnish care in the FAS subject to agreements with the FAS Governments. It is unclear if the bill is intended to supersede this requirement to enter into agreements with the FAS Governments. If that is the intent, we note the potential that this could have on U.S. diplomatic relations by superseding the agreement process.

VA would welcome the opportunity to work with the Committee to address underlying technical issues with the bill, including clarifying the intended scope of this benefit. This Committee favorably reported last month a bill, H.R. 6652, the U.S. Vets of the FAS Act, that would require VA to furnish beneficiary travel to Veterans traveling in, to, or from the FAS for care that VA is legally authorized to provide there. In this context, it is unclear if this draft bill is an alternative to H.R. 6652 or if it is intended to do something different.

VA further recommends amending this bill to include additional changes to improve VA's beneficiary travel program overall. We would welcome the opportunity to discuss broader reforms, such as authorizing pre-payment, clarifying eligibility, and addressing payment rates to improve VA's beneficiary travel program.

Finally, as a technical matter, the bill's definitions of "covered jurisdiction" and "territory" would mean only the FAS are covered jurisdictions, as VA operates clinics or medical centers in each of the territories covered under the bill's definition of "territory". The bill would exclude other possessions or territories of the U.S., including sparsely populated outlying areas such as Midway Atoll, Palmyra Atoll, and Wake Island.

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

H.R. XXXX Veterans Health Administration Online Publication and Easy Navigation of Policies Act of 2026 (VHA OPEN Policies Act of 2026)

Summary: Section 2(a) would require VA, not later than 90 days after enactment, to make publicly available on an appropriate website of VHA all national policies of VHA, including directives, handbooks, memoranda issued by the Under Secretary for Health (USH), and guidance and procedure guides necessary for understanding the implementation of the VHA national policies and any programs governed by such policies. Section 2(b) would require VA, in the case of any national policy that is established or revised after the date of enactment, to include the new or revised national policy on the website by not later than 30 days after the date of the establishment or revision of the policy.

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

Views: VA fully agrees with the goal of ensuring that sub-regulatory guidance, like directives and handbooks, are available online, and VA already maintains and regularly updates a website with this information: https://www.va.gov/vhapublications/index.cfm. This website includes directives, handbooks, notices, and VHA's Records Control Schedule. In this context, the bill appears unnecessary.

VA does not currently publish internal guidebooks or processing documents that only direct VA staff how to carry out requirements set forth in statutes, regulations, and the types of policy described above. We do not believe sharing such information publicly would make VHA programs easier to understand, and many of these resources include links to other material that is not publicly available (such as internal email addresses, pre-decisional materials, etc.). We also have concerns that posting internal guidebooks and other related documents would significantly delay our ability to make improvements to VA policy. These documents would need to be 508 compliant, require translation, and go through additional review processes. Many of these documents are living documents that need to be updated on a regular basis. Additionally, guidebooks and processing instructions are not written today for external audiences, so editing them to be suitable for the public could both limit their utility for VA staff and still be of limited value to the public. We are concerned that requiring the publication of internal guidance could reduce VA's ability to respond quickly and appropriately to emerging issues. For those interested in reviewing these documents, they can be accessed through a Freedom of Information Act request, and Congress can, of course, request such documents through its oversight authority.

VA has some technical comments on the bill and would be happy to provide technical assistance to the Committee if needed.

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

H.R. XXXX Biennial Report on Staffing of VA Medical Facilities

Summary: Section 1(a) would require VA, not later than 180 days after enactment and not later than December 31 of each even-numbered year thereafter, to submit to Congress a report assessing the staffing of each VA medical facility. Section 1(b) would require each report include the results of a system-wide assessment of all VA medical facilities to ensure staffing levels are appropriate and that sufficient space is available to meet VA's capacity needs. The report would also have to include a plan to address any issues identified in this assessment, a list of the current wait-times and workload levels for various clinics, a description of the most current determination of the Inspector General under 38 U.S.C. § 7412(a) and a plan to use direct appointment authority under § 7412(b) to fill staffing shortages. Additionally, the report would have to include VA's current staffing models in several clinics, a detailed analysis of succession planning at VA medical facilities, the number of health care providers who

have been removed, retired, or left their positions, and of such providers, the number who were reassigned to other positions in VA, left VA, or who left and were re-hired.

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

Views: VA does not support this bill because it is duplicative of existing statutory reporting requirements, particularly 38 U.S.C. § 7412, which mandates Inspector General determinations on staffing shortages and direct appointment authority to address them, and section 505 of the VA MISSION Act of 2018 (Public Law 115-182; 38 U.S.C. § 301 note; as amended), which already requires VA to submit a comprehensive system-wide assessment of VA medical facility capacity, staffing, and infrastructure needs. Additionally, VA provides reports to the appropriations committees on clinical care vacancies and staffing that capture much of the same staffing and vacancy data contemplated by this bill. A substantially similar report is already required and captured through these existing frameworks, creating an additional biennial report covering the same information would impose unnecessary administrative and financial burdens on the Department without providing meaningful new transparency or benefit to Veterans.

VA also has concerns with some of the specific provisions in the bill and can provide technical assistance on the bill if needed.

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

H.R. XXXX Veterans Health Administration Personnel Transparency and Accountability Act

Summary: Section 2 would amend section 505 of the VA MISSION Act of 2018 (the MISSION Act; Public Law 115-182; 38 U.S.C. § 301 note) to require VA to include on a public website certain information about staffing and vacancies. Specifically, the bill would require VA to publish information relating to VHA positions by occupation, and except for the number of accessions and separation actions, by medical facility. It would also require VA to report on a monthly basis the number of personnel encumbering positions, the number of accessions and separation actions processed, and the number of vacancies (by occupation) for positions in VHA; VA would have to continue reporting on a quarterly basis other information required by section 505 of the VA MISSION Act of 2018.

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

Views: VA supports the intent of this bill for increased personnel transparency for VHA. However, the proposed bill includes both an expansion of the dataset (occupational series for VHA) and an increase in the reporting frequency (quarterly to monthly). The current quarterly MISSION Act dataset accurately captures VA's staffing trends since 2018 and continues to support increased personnel transparency for VHA. Increasing the reporting frequency to monthly would result in a significant administrative

workload requiring multiple program offices to compile, analyze, and review the dataset for precision and accuracy every month, with unclear benefits. Additionally, monthly reporting can be distorted by human resources processing lags and does not accurately portray normal cyclical staffing trends (for example, beginning of fiscal year gains and end-of-year losses due to retirements). Monthly reporting is also too granular and introduces excessive short-term volatility, while quarterly reporting smooths the data enough to reveal meaningful trends. Monthly data also does not reflect Federal hiring timelines (under OPM's Merit Hiring Plan, the average time-to-hire goal is 80 days). Quarterly reporting better captures trends, aligns more closely with the actual cadence of hiring, and is easier to compare with quarterly budget and performance reports.

Cost Estimate: VA estimates this bill would cost approximately $230,000 annually.

H.R. XXXX National Task Force on Caregiving Youth of Veterans Act

Summary: Section 2 would state Congress' findings regarding youth who are providing unpaid care to Veterans and members of the Armed Forces with disabilities, illnesses, or injuries. It would state that the responsibilities of caregiving youth often include physical assistance, emotional support, household management, and advocacy, which may adversely affect their economic opportunities. It would find that research indicates that millions of youths are engaged in caregiving roles and are at increased risk for academic disruption, social isolation, and long-term health challenges of their own. It would state that caregiving youths contribute significantly to the well-being of Veterans and their families, reducing institutional care needs and strengthening family cohesion. It would state that existing Federal programs do not adequately identify or support caregiving youth, and that there is no coordinated strategy across agencies to address their needs. Finally, it would conclude that a national task force is necessary to assess the scope of caregiving youths, support ongoing research, and develop policy and programmatic solutions to ensure they receive appropriate recognition and assistance.

Section 3(a) would require VA, not later than 180 days after enactment, to establish the National Task Force on Caregiving Youth (the Task Force). Section 3(b) would require the Task Force be composed of not fewer than 15 members, including representatives designated by VA from VA (including a representative of the Veterans Benefits Administration, the National Cemetery Administration, VHA, the Caregiver Support Program, and the Veterans Experience Office), the Department of Health and Human Services (HHS) (including a representative of the Centers for Medicare & Medicaid Services (CMS), the Administration for Community Living, the Indian Health Service, the Administration for Children and Families), the Department of Education (including a representative of the Office of Elementary and Secondary Education Programs, the Office of Special Education Programs, and the Office of Student Support and Accountability), and DoD (including a representative of the DoD Education Activity, the Office of Military Community and Family Policy, and the Defense Health Agency). Section 3(c) would require VA to designate the Under Secretary for Health (USH) to

serve as the Chairperson of the Task Force. Section 3(d) would require the Task Force to meet at least once per quarter per calendar year; two-thirds of the members of the Task Force would constitute a quorum.

Section 3(e) would define six duties for the Task Force. First, not later than 180 days after the Task Force was established, it would have to seek to enter into an agreement with a Federally-funded research and development center to conduct a national study on caregiving youth. The study would have to be completed within two years of the date of enactment, and would have to include: an analysis of the prevalence, demographics, and socio-economic impacts of caregiving youth; short- and long-term effects on the education, employment, safety, and physical and mental health of caregiving youth; geographic disparities in access of caregiving youth to support services; and barriers to Federal, State, and local assistance programs for caregiving youth. Second, not later than 30 days after the Task Force was established, it would have to consult directly with stakeholders, including caregivers and survivors of Veterans and members of the Armed Forces, relevant Federal advisory commissions, and representatives of non-profit organizations that specialize in military family support, caregiving youth initiatives, mental health advocacy, or educational access for caregivers. Third, not later than 180 days after the Task Force was established, it would have to develop targeted policy recommendations to Congress, and Federal, State, and local agencies on how the Departments participating in the Task Force can expand program support, resources, and accommodation for caregiving youths, including school-based resources and scholarship programs, improved mental health support by integrating trauma-informed care for caregiving youth within frameworks of such Departments, creating support programs within each Department, and establishing financial assistance models. Fourth, it would have to explore the feasibility and advisability of the development of a standardized database to track the demographics and services used by caregiving youth, develop joint initiatives between relevant Federal agencies to provide comprehensive support, and align Federal programs with state and local resources to ensure no caregiving youth is overlooked. Fifth, it would have to formalize non-profit engagement by establishing a Caregiving Youth Advisory Council composed of advocates for caregivers that hosts quarterly roundtables to incorporate front-line perspectives and provide recommendations to relevant Federal agencies regarding the allocation or usage of Federal grant funding to support non-profits by expanding direct service programs for caregiving youth. Finally, the Task Force would have to conduct a survey of all existing efforts of Federal agencies to support caregiving youth, including past and ongoing efforts to collect data, research, and other relevant information.

Section 3(f) would authorize the Task Force to enter into agreements with entities (including academic institutions, research entities, and non-profit organizations) to assist in conducting the national study and developing policy recommendations. Section 3(g) would require the Task Force to submit to Congress an initial report within one year of enactment outlining the research methodology and preliminary findings related to the Task Force's duties (including stakeholder consultation, national study design, and early policy considerations). Not later than one year after submitting this initial report, the

Task Force would have to begin submitting to Congress annual reports detailing progress on such duties (including updates, policy recommendations, Federal collaboration efforts, non-profit engagement, and survey results). Section 3(h) would provide that the Task Force would terminate on the date that is five years after enactment. Section 3(i) would define the term "caregiving youth" to mean an individual under the age of 18 who provides unpaid care (including physical assistance, emotional support, household management, medication oversight, or advocacy) to a Veteran or member of the Armed Forces with a disability, illness, or injury. This definition would apply without regard to whether the youth qualified for VA's Program of Comprehensive Assistance for Family Caregivers.

Position: **VA defers to Congress on section 2 of the bill and cites concerns with section 3 of this bill.**

Views: VA supports the intent of the bill and recognizes that Veterans and their families face unique challenges. The experience of a youth providing care to a disabled adult is not categorically different depending on whether the adult is a Veteran or not. Section 2 of the bill describes caregiving youth in broad national terms, identifying risks and unmet needs that apply across the entire population of youth caregivers. However, section 3 would narrowly address only caregiving youth of Veterans and Service members without explaining why this subset should be the exclusive focus of a Government-wide task force. If the intent is to better understand the prevalence, impacts, and policy needs of caregiving youth, VA recommends that Congress consider a broader, cross-population approach. Such an approach would align more closely with the Congress' own findings, allow Federal agencies with primary expertise in child welfare and youth development to play lead roles, and ensure that any coordinated strategy reflects the full scope of caregiving youth Nationwide.

VA has a number of technical concerns with the bill as drafted. Initially, the bill seems to contemplate the Task Force operating independently of the Secretary and the USH; while the USH would be the nominal chair of the Task Force. As a result, it is not evident that all decisions or recommendations of the Task Force would require unanimity or the approval of the chair. Consequently, the Task Force could make recommendations or take positions inconsistent with the policy goals and priorities of the Secretary and the Administration. It is unclear if that is if the intent, but if it is, that raises legal and even constitutional concerns, particularly in terms of the requirement to present recommendations to Congress for legislation. Additionally, the timelines associated with the Task Force could present significant challenges. For example, the Task Force would need to be formed within 6 months; once formed, it would have to consult with caregivers and survivors, organizations, and Federal advisory commissions within 30 days of being established. Within 180 days of being established, it would have to develop targeted policy recommendations, presumably based on this consultation. During this same time period, it would also have to seek to enter into an agreement to conduct a national study. On approximately the same timeline, the first interim report would also be required. It is not clear that the Task Force would have the resources or bandwidth to handle all of these various tasks simultaneously.

VA has a number of additional technical edits and comments on the bill and would be happy to provide technical assistance on the bill if needed.

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

H.R. XXXX Foreign Medical Program Integrity and Improvement Act

Summary: Section 2(a) would amend 38 U.S.C. § 1724, which generally limits VA's ability to furnish care outside the United States and which, in part, authorizes VA's Foreign Medical Program (FMP), by adding a new subsection (g). Proposed § 1724(g)(1) would provide generally that the rate VA would pay for hospital care or medical services under § 1724 would be the lesser of the amount billed or the rate paid under the Medicare program. However, VA could make a payment in excess of that rate to ensure that Veterans have access to hospital care or medical services, including in an emergency.

Section 2(b) would add a new § 1724(h), which would prohibit VA from using any Federal funds to pay for hospital care or medical services furnished under this section to or by an individual who appears in the Death Master File after the date of death of the individual. The term "Death Master File" would have the meaning given that term in section 203 of the Bipartisan Budget Act of 2013 (Public Law 113-167; 42 U.S.C. § 1306c)).

Section 2(c) would add a new §1724(i), which would provide that in the case of a claim for hospital care or medical services under this section that VA suspected constituted fraud, waste, or abuse, VA: (1) would have to refer such claim to the VA Office of Inspector General (OIG); (2) could withhold payment during the investigation of the claim; (3) would have to approve the claim and release such payment as soon as practicable if OIG determined that the claim was proper; and (4) if OIG determined the claim constituted fraud, waste, or abuse, deny the claim and take action VA determined appropriate to recover any Federal funds already paid in relation to such claim, claimant, or provider. It would also add a new § 1724(j), which would require VA to maintain a list of providers of hospital care or medical services furnished under § 1724 who have submitted fraudulent claims for such care or services. VA could not use any Federal funds to pay for hospital care or medical services furnished under § 1724 by a provider whose name appeared on the list. Each time VA added the name of a provider to the list, VA would have to distribute the list electronically to Veterans registered in the FMP. Finally, the bill would add a second § 1724(j) [sic] that would require VA designate a Fraud Detection and Prevention Coordinator to carry out the new subsections (h)-(j).

Section 2(d)(1) would add a new § 1724(k), which would authorize VA to enter into an agreement with an entity to serve as a third-party administrator (TPA) of claims for hospital care or medical services furnished under this section. Section 2(d)(2) would authorize VA to enter into an agreement with an entity pursuant to which the entity would provide VA access to an information technology (IT) system for the administration

of claims for care or services under § 1724; if VA exercised this authority, VA would have to ensure that implementation of the system was complete not later than one year after enactment.

Position: **VA supports this bill, subject to amendments, but is unable to assess the impact to budgetary resources and therefore will follow up with the committee once this evaluation is complete or CBO has provided a score**

Views: VA strongly agrees with the need to enhance and improve its authority to operate the FMP. VA has operated the FMP for several decades, but both its statutory authority and its implementing regulations have not kept pace with growth in the Program. The Government Accountability Office (GAO) issued a report last year on actions needed to improve the FMP; this report noted that reimbursements under the FMP increased more than 260% between FY 2018 and FY 2024. VA agreed with GAO's findings regarding the fraud risks in the Program, concurred with its recommendations, and has been working to improve the FMP since that time.

While well-intentioned, the bill, as written, would not address many of the issues VA is experiencing with the FMP and would potentially create more issues. For example, the bill would apply its requirements to every aspect of § 1724, including care VA may furnish in the Freely Associated States (FAS) under § 1724(f). However, care under § 1724(f) is subject to agreements entered into between VA and the FAS Governments, so subjecting these agreements to the limitations otherwise set forth would seem inappropriate. Further, in terms of payment rates, the bill would prescribe the use of Medicare rates, while there are other Federal program rates (including TRICARE) that may be more appropriate, particularly for international areas. The bill would create an exception to payment at the lesser of the billed rate or the Medicare rate, but it does not provide an operable standard to use to determine when the exception in proposed § 1724(g)(2) ("to ensure that a veteran has access to hospital care or medical services, including in an emergency") would be applied.

Additionally, the bill would prohibit any payment for care or services furnished to or by an individual after the date of the death of the individual, but this language is ambiguous. The language, as written, could be read to mean that VA cannot pay after the death of the individual, regardless of when the services were furnished. Providers may have furnished care or services before their death, and their estate should be paid; similarly, a Veteran may have died, but the provider who furnished services before the person's death should still be paid. We believe the intent is to ensure that VA should not pay for care allegedly furnished to a Veteran after the Veteran's death or furnished by a provider after the provider's death. We recommend revisions to this language to more clearly state this intent. From our review of existing law, we have not found a similar prohibition for any other Federal health care program, and so we are unsure how a court of law would interpret and apply this.

Another area the bill should address is due process protections to ensure that Veterans or providers have an opportunity to contest a determination by VA that

payment cannot be made. The bill would require VA to take certain actions but would provide no means for review either before or after such actions. Beyond the immediate problem that VA could make a mistake that would deny payment, this also raises both statutory and constitutional concerns.

The bill also raises administrative concerns; for example, proposed § 1724(j)(3) would require VA inform all Veterans registered in FMP each time VA added the name of a provider who submitted fraudulent claims for care or services under the FMP. However, this could be confusing for Veterans, who would be notified of providers in other countries where they have never been and never plan to travel, and demanding on VA, particularly if VA regularly updates the list with new providers. Further, this provision does not address notice requirements when a provider is removed from the list (as in the case of error), which could lead Veterans to conclude a provider is ineligible under the FMP when that provider actually can furnish care and be paid. Similar to a prior concern, section 2(d)(1), regarding the use of a TPA, raises concerns about the breadth of the TPA's potential work (including claims in the FAS), as well as concerns regarding the scope of work the TPA would do (particularly if the bill contemplated the TPA performing inherently Governmental functions). Section 2(d)(2), regarding entering into an agreement to access an IT system for the administration of claims, also raises concerns given its short timeline for implementation.

VA has further technical edits and concerns with this bill. However, VA believes there are ways to address its concerns with this legislation and with FMP more broadly. VA would welcome the opportunity to meet with the Committee to discuss how § 1724 could be amended to reflect current programs and concerns, including many of the themes proposed in this bill.

Cost Estimate: VA does not have a cost estimate for this bill, but many of the proposed changes would likely result in savings by reducing payment rates and eliminating waste, fraud, and abuse.

H.R. XXXX Trauma Outreach, Understanding, and Resiliency through Spirituality (TOURS) Act

Summary: Section 2 would amend 38 U.S.C. § 1720F, which generally requires VA to develop and carry out a comprehensive program to reduce the incidence of suicide among Veterans and members of the reserve components of the Armed Forces, to add a new subsection (l). Proposed § 1720F(l)(1) would require VA, acting through the Office of Mental Health and Suicide Prevention, to produce an annual report on suicide prevention. Proposed § 1720F(l)(2) would require VA submit this report to the Committees on Veterans' Affairs of the Senate and House of Representatives, while proposed subsection (l)(3) would require VA to provide an annual briefing on the most recent such report to these Committees.

Section 3(a) would require VA, not later than January 1, 2027, to conduct a two-year study on the relationship between Veterans' engagement with the Chaplain

service and other faith-based programs in VA and the risk of suicide among Veterans. Section 3(b) would require VA, in carrying out the study, to: (1) identify and define measurable categories of such engagement (including group activities, outreach events, and non-confidential interactions); (2) track Veterans' use of mental health services that involve chaplains; (3) track Veterans' use of faith-based VA programs; (4) collect and analyze data on such engagement across VA facilities; (5) assess correlations, if any, between such engagement and mental health outcomes (including suicide-related behaviors); and (6) identify best practices and programs that demonstrate positive outcomes. Section 3(c) would require VA, in carrying out the study, to ensure that Veterans are informed of data collection, that no data is collected or reported that would compromise the confidentiality of protected religious communications, and that the use of chaplaincy services remains voluntary. Section 3(d) would require VA to submit to Congress a report, not later than 90 days after the end of each year of the study. These reports would have to include a summary of data collected, an analysis of trends and outcomes, a list of programs VA determines have a measurable effect on the risk of suicide, and VA's recommendations regarding how to improve data collection regarding, and resource allocation for, suicide prevention.

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

Views: Regarding section 2 and the proposed reporting and briefing requirements on suicide prevention, VA already is required to conduct an evaluation of its mental health and suicide prevention programs, pursuant to 38 U.S.C. § 1709B, as added by section 2 of the Clay Hunt SAV Act (Public Law 114-2). In addition, under section 149 of the Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act, VA is required to submit annually to Congress and publish online a report known as the National Veteran Suicide Prevention Annual Report. It is unclear how the report and briefing required by section 2 would differ from these existing requirements.

Concerning section 3, VA supports the intent to better understand the relationship between Veterans' engagement with chaplaincy services, spiritual care, faith-based outreach, and suicide risk. However, VA already has sufficient authority to study the relationship between VA services, including chaplaincy and spiritual care services, and suicide prevention outcomes. VA can work within existing authorities to evaluate the role of chaplain engagement and spiritual care in suicide prevention, coordinate between the Office of Suicide Prevention and the National Chaplain Service (NCS), and determine the most appropriate methodology. VA anticipates beginning planning for this study later this year.

In addition, it is unclear whether this should be described as a "study" or whether this is more generally an evaluation. Particularly given the specific focus and timeline, VA would interpret this to be an evaluation and not a formal research study under VA's Cooperative Studies Program. Additionally, while the bill would require VA, in carrying out the study, to ensure that no data is collected or reported that would compromise the confidentiality of protected religious communications, the requirement to submit a report

to Congress would also seemingly implicate the Access to Congressionally Mandated Reports Act, which requires reports to Congress to be made publicly available. While this Act permits the Chair of a Committee to notify the Government Publishing Office to except certain reports, and also permits the head of an agency to withhold from publication reports that are exempt from public disclosure under 5 U.S.C. § 552 or required to be withheld under 5 U.S.C. § 552a, it would seem easier if the bill were amended specifically to exempt these reports from publication. This would ensure Congress is able to exercise proper oversight without risking the disclosure of protected information to the public.

VA has other technical concerns with this bill.

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

The final three bills on today's agenda are centered on a common theme of sharing information between VA and the Department of Health and Human Services (HHS) or the Centers for Medicare & Medicaid Services (CMS). Given the similarity in the bills, we will address them together.

H.R. XXXX Veterans Care and Cost Coordination Act (Bill #1)

Summary: Section 2(a) would require VA, not later than one year after enactment, to seek to enter into a memorandum of understanding (MOU) with HHS for purposes of coordinating the costs, care, and management of hospital care and medical services furnished under the laws administered by VA. The MOU would have to provide for reciprocal access between VA and CMS to data and information on Veterans who are concurrently enrolled in VA health care and the Medicare program or a Medicare Advantage plan.

Section 2(b) would include requirements regarding the MOU. The MOU would have to include an agreement through which VA would transmit to HHS information relating to Veterans who are enrolled in VA health care and in receipt of hospital care or medical services administered by VA and such other information as VA determined appropriate (including billing codes and diagnostic codes for hospital care or medical services). The MOU also would have to include an agreement through which HHS would use such information to identify Veterans who are concurrently enrolled in VA health care and either the Medicare program or a Medicare Advantage plan and transmit to VA a list of such Veterans and such other information as HHS determined appropriate.

Section 2(c) would require VA to use information transmitted by HHS to inform utilization management under the Community Care Network (CCN) Next Generation procurement contract, or other successor contract awarded under the VCCP under

38 U.S.C. § 1703, to avoid duplicate or unnecessary medical services and inform Veterans of beneficial or follow-up to services.

Section 2(d) would amend section 1853(c)(1)(D)(iii) (42 U.S.C. § 1395w-23(c)(1)(D)(iii)) to require HHS to use information transmitted by VA pursuant to the MOU in developing estimates for fee-for-service costs for the purposes of calculating Medicare Advantage benchmarks.

Section 2(e) would require VA to submit to Congress, not later than one year after VA entered into the MOU and biennially thereafter during the period the MOU was effective, a report that includes a summary of the activities VA carried out pursuant to the MOU and VA's assessment with respect to the effectiveness of the MOU in avoiding duplicative, improper, or erroneous billings or payments for hospital care and medical services furnished under the laws administered by VA.

Section 3 would define the term "Medicare Advantage plan" to mean a plan under the program established under part C of title XVIII of the Social Security Act (42 U.S.C. § 1395w-21 et seq.). The term "Medicare program" would mean the Medicare program under that title. The term "specialized MA plan for special needs individuals" and "special needs individuals" would have the meaning given those terms in section 1859(b)(6) of the Social Security Act (42 U.S.C. § 1395w-28(b)(6)).

H.R. XXXX Directing VA to Coordinate with HHS in Administering the Veterans Community Care Program (Bill #2)

Summary: Section 2(a) would require VA, not later than one year after enactment, to seek to enter into a memorandum of understanding (MOU) with HHS for purposes of coordinating medical benefits, hospital care, and medical services furnished under the laws administered by VA. The MOU would have to provide for reciprocal access between VA and CMS to data and information on Veterans who are concurrently enrolled in VA health care and the Medicare program or a Medicare Advantage plan.

Section 2(b) would require, in administering the VCCP under 38 U.S.C. § 1703, acting through the Office of Integrated Veteran Care (IVC), to use information transmitted by HHS pursuant to the MOU to ensure, with respect to patients who are concurrently enrolled in VA health care and the Medicare program, VA does not furnish duplicative health care to Veterans or make erroneous or duplicative payments for health care furnished to Veterans. The MOU would also have to require VA to use information transmitted by HHS to identify specialized MA plans for special needs individuals that VA determines offer benefits important for Veteran health care, including at least three of the following benefit categories: adaptive sports equipment; hearing aids and related audiology services; integrated traumatic brain injury rehabilitation; hyperbaric oxygen therapy; massage therapy; residential rehabilitation; complementary and integrative health services; and other benefits or services VA determines are effective in improving health outcomes for Veterans.

Section 2(c) would authorize VA, acting through IVC, to coordinate with HHS to establish an office (known as the MA-Medicare Dual Eligibility Coordination Office) within IVC. HHS, acting through CMS, would be authorized to coordinate with VA to establish an office (known as the Medicare-VA Dual Eligibility Coordination Office) within CMS.

Section 2(d) would define the term "Medicare Advantage plan" to mean a plan under the program established under part C of title XVIII of the Social Security Act (42 U.S.C. § 1395w-21 et seq.). The term "Medicare program" would mean the Medicare program under that title. The term "specialized MA plan for special needs individuals" and "special needs individuals" would have the meaning given those terms in section 1859(b)(6) of the Social Security Act (42 U.S.C. § 1395w-28(b)(6)).

H.R. XXXX Directing VA to Seek to Enter into a Memorandum of Understanding with HHS to Avoid Duplicative, Improper, or Erroneous Billings or Payments for Hospital Care and Medical Services (Bill #3)

Summary: Section 1(a) would require VA, not later than one year after enactment, to seek to enter into a memorandum of understanding (MOU) with HHS with respect to reciprocal access between VHA and CMS to data and information on Veterans concurrently enrolled in VA care and Medicare, Medicaid, or a Medicare Advantage plan. The purpose of this MOU would be to avoid duplication, improper, or erroneous billings or payments for hospital care or medical services furnished by VA.

Section 1(b) would require the MOU to include an agreement through which VA would transmit to HHS information relating to Veterans who are enrolled in VA care and in receipt of hospital care or medical services administered by VA and such other information as VA determines appropriate (including billing codes and diagnostic codes for such care and services). HHS would have to agree to use this information to identify Veterans who are concurrently enrolled in VA care and Medicare, Medicaid, or a Medicare Advantage plan; HHS would have to transmit to VA a list of Veterans identified and such other information as HHS determined appropriate.

Section 1(c) would provide that the MOU would be effective for a two-year period beginning on the date on which VA entered into the MOU.

Section 1(d) would require VA, not later than one year after entering into the MOU and on a biennial basis thereafter during the period in which the MOU is effective, to submit to Congress a report that includes a summary of VA's activities carried out pursuant to the MOU and VA's assessment with respect to the effectiveness of such MOU in avoiding duplicative, improper, or erroneous billings or payments for hospital care or medical services furnished by VA.

Section 1(e) would define the terms Medicare program, Medicaid program, and Medicare Advantage plan to have the meanings given those terms in title 42, U.S.C.

Position: **VA does not support these bills.**

Views: We agree with the premise of the bills – that the Government should not pay twice for the same medical services – but VA does not support these bills as written. Last year, VA announced an agreement with CMS to eliminate instances in which both agencies are billed for the same health care episode. VA and CMS have a data-matching agreement to identify medical providers who have submitted claims for payment to both VA and Medicare, helping eliminate overpayments and future instances of double billing.

While VA supports efforts to reduce and eliminate duplicative, improper, or erroneous billings and payments, VA does not support these bills primarily for two reasons: first, they do not provide VA new authority, and second, they do not address the fundamental issue limiting coordination between the Departments, namely limitations in current law on data sharing. To the first point, VA does not require new authority to enter into an MOU with HHS; as noted above, VA entered into an agreement with CMS last year. To the second point, VA and HHS currently share information as authorized by law. The bills, however, would not expand VA's or HHS's authority to share billing and payment information between the Departments, and the successful sharing of information is critical to eliminating duplicate payments. Without addressing this fundamental issue – ensuring each Department can share all necessary information with the other – the bill will not address the root problem.

We further note that the bills do not include the Department of War (DOW), and individuals eligible for VA and CMS programs may also be eligible for TRICARE as well. We believe a coordinated effort between VA, DOW, and HHS would be most effective in identifying and eliminating duplicative, improper, or erroneous billings and payments.

VA has additional technical edits and comments on the bill. For example, the bills refer to types of care and services inconsistently; in certain provisions, they refer to hospital care and medical services, while in others they refer only to medical services. Institutional extended care services (such as nursing home care or residential rehabilitation treatment programs) are not addressed in any of the bills. Additionally, section 2(c) of Bill #1 includes a requirement that VA use information to "inform utilization management under the Community Care Next Generation Procurement Contract", but it is not clear what this means and whether this would delay award of the CCN Next Generation contracts.

Regarding Bill #2, VA is unclear as to the intent or purpose of the requirement in section 2(b) regarding the VCCP. The VCCP and Medicare are both options for Veterans eligible for both programs, but there would only rarely be a situation where a provider may not know which organization to bill, as providers furnishing care through the VCCP do so pursuant to a contract or agreement with a TPA that defines whom they bill, and they furnish care on the express authorization by VA to furnish particular services to a particular Veteran. The only situations where a provider may be unsure would be in the case of emergency care, but even in that situation, VA's regulations and

contracts require that VA receive notice within 72 hours of the beginning of treatment, and providers regularly furnish such notice to ensure payment under the contract. While Medicare does not require pre-authorization to access most services, Veterans cannot choose to access VCCP care on their own; VA must authorize such care and services after determining the Veteran is eligible to participate in the VCCP. It is also unclear what purpose identifying specialized MA plans for special needs individuals would do; presumably, VA would then share information about these MA plans with eligible Veterans, but that is not clear.

We are also concerned that the bills, in some respects, may be too broad. Bill #1, for example, would appear to require VA to share information on all VA health care enrollees, regardless of whether they are enrolled in (or even eligible for) a Medicare or Medicare Advantage plan. VA also may not have specialized knowledge to inform Veterans of beneficial follow-up care that may be available under Medicare plans.

VA would be happy to work with the Committee to ensure the bills provide VA and other agencies the appropriate authority to support the intended goals of the bills.

Cost Estimate: VA does not have a cost estimate for this bill, but successful efforts to reduce or eliminate duplicative, improper, or erroneous billings and payments could result in significant savings to VA, DOW, and HHS.

Conclusion

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