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BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

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LEGISLATIVE HEARING

TUESDAY, JANUARY 13, 2026

SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
U.S. HOUSE OF REPRESENTATIVES,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:15 p.m., in room 360, Cannon House Office Building, Hon. Mariannette Miller-Meeks [chairwoman of the subcommittee] presiding.

Present: Representatives Miller-Meeks, Bergman, Kiggans, Hamadeh, King-Hinds, Brownley, Cherfilus-McCormick, Dexter, Conaway, and Morrison.

OPENING STATEMENT OF MARIANNETTE MILLER-MEEKS, CHAIRWOMAN

Ms. MILLER-MEEKS. Come to order. The chair may declare a recess at any point.

I would like to welcome all the members and witnesses to today's hearing. Today we will discuss 12 bills designed to improve the lives of our Nation's veterans and the systems they rely on for healthcare and health-related matters. I am looking forward to a very productive discussion on each of these bills, including the many that are focused on improving access to mental healthcare.

Speaking of productive, I would just like to acknowledge that Ranking Member Brownley has decided to retire after this term. I envy her, but I also want to say that she has been longer on the Veterans Health Committee or the Veterans' Affairs Committee longer than I have. This is my sixth year on the committee and her dedication to our veterans and her input has been invaluable. Thank you so much, Ranking Member Brownley

Ms. BROWNLEY. Thank you. Thank you. Thank you. Thank you.

Ms. MILLER-MEEKS. Some of the bills that we will discuss today is the Recognizing in Recognizing Community Organizations for Veteran Engagement and Recovery (RECOVER) Act introduced by Chairman Bost, which would help fund programs targeted toward reducing nutrition and mental healthcare. Many veterans in areas with limited access to care still face barriers when seeking mental health services, especially in rural and remote parts of the country. Provider shortages and capacity constraints, for example, are but some of those many obstacles. We know that in all of these rural areas or even urban areas that telemedicine is beneficial, but still it can create problems and challenges if you do not have provider access.

The RECOVER Act would require the U.S. Department of Veterans Affairs (VA) to carry out a 3-year pilot program under which nonprofit outpatient medical health providers serving veterans, who, for reasons outlined in the bill, may be more likely to discontinue care, would be eligible for grant awards. This bill would use existing resources more effectively while working with providers to do more. As I said, telemedicine works well in this area, so it still is an option. I am thankful to Chairman Bost for his thoughtful legislation on this matter to bridge the gap in care.

The Veterans Mental Health and Addiction Therapy Quality of Care Act introduced by Representative Fallon would require VA to commission an independent study examining quality, access, and outcomes for mental health and addiction treatment provided both inside and outside the VA. This bill would ensure that we continue to provide veterans with the best possible care to meet their needs. I am proud to support it.

The Veterans TBI Breakthrough Exploration of Adaptive Care Opportunities Nationwide (BEACON) Act, introduced by General Bergman, would direct VA to support research and clinical trials focused on chronic mild traumatic brain injury, or mild TBI. This would include nonpharmaceutical and community-based rehabilitation approaches and independent research. Many veterans experience long-term and sometimes debilitating conditions because of mTBI. Despite the prevalence of these injuries, work remains in research, treatment options, and standard of care. This bill would lay the groundwork for future decisions guided by evidence rather than assumptions. I thank General Bergman for making sure the VA delivers care that reflects the realities we are facing.

I would also like to thank Representatives Mackenzie and Jackson for their work on legislation addressing brain injury and mental health issues affecting veterans. The Veterans Healthcare Dessert—Desert Reform Act—you can tell I have not had lunch yet; no, I am only kidding—the Veterans Health Desert Reform Act of 2025, a bill I introduced, would direct VA to pilot partnership with non-VA hospitals in an area where care is lacking. This would allow veterans to receive care equivalent to community care, and I have seen this in my own district.

Too many veterans living in rural areas across our Nation face the challenge of living in a healthcare desert, an area without a VA facility of any type within a realistically accessible distance. In a health desert, basic care is difficult to maintain and even the most routine care presents a significant burden for veterans. My bill would fill geographic gaps in access, again recognizing the importance of telemedicine, ensuring that when VA facilities are not realistically accessible, veterans can still access care closer to home. This issue is a top priority for me and my bill is a commonsense expansion of our veterans' access to healthcare. I look forward to continuing this discussion and working on this matter.

The Clarity on Cares Option Act introduced by Ms. Kiggans will would require VA to create and maintain a searchable directory of providers who accept the Civilian Health and Mental Program of the Department of Veterans Affairs, Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). This would help ensure that beneficiaries make informed choices about

their care. Often, CHAMPVA beneficiaries struggle to identify which healthcare providers will accept their coverage. This leads to delays and confusion for families already navigating a complex system, as we heard in an earlier hearing. CHAMPVA is an important healthcare program for dependents and survivors of our Nation's veterans. I appreciate Ms. Kiggans' continued efforts to make that coverage more usable in practice for families.

I also want to thank Ms. King-Hinds for her diligence in assuring that Freely Associated States (FAS) veterans are not ignored. Her work on this matter is appreciated.

This morning we are also joined by several of our colleagues who will speak in support of their bills. We appreciate their dedication to serving our Nation's veterans. In accordance with committee rules, I ask unanimous consent that the following members be permitted to participate in today's committee hearing: Representative Pat Fallon, Representative Ryan Mackenzie, Representative Greg Landsman, and Representative Chris Deluzio. Without objection, so ordered.

I now yield to Ranking Member Brownley for any opening remarks she may have.

OPENING STATEMENT OF JULIA BROWNLEY, RANKING MEMBER

Ms. BROWNLEY. Thank you, Madam Chair, and thank you to our witnesses today for providing your testimony on the legislation we are considering.

I am excited that we are considering several of my Democratic colleagues' bills on today's agenda. I know the sponsors of these bills will be on the first panel to speak about the importance of those bills, so I will try to keep my remarks brief. I appreciate my colleagues, Congressman Landsman and Congressman Conaway, for introducing bills to build on VA's work to protect veterans from the risk of opioid overdose.

I am also glad we will consider Congressman Crow's legislation to further our understanding of Amyotrophic Lateral Sclerosis (ALS) and the causes of veterans' increased risk of the disease.

Finally, I look forward to considering Congressman Deluzio's bill to ensure veterans are not overly burdened by copays for participating in VA Whole Health Services.

However, I must express some serious concerns about several of the Republican-sponsored bills on today's agenda. The RECOVER Act, the BEACON Act, the Health Desert Reform Act, and the Data Driven Suicide Prevention Act share a common theme: they all siphon money from existing VA programs and redirect it to outside organizations and providers to do the very same things VA is already doing, but with fewer guardrails and fewer requirements to ensure quality of care. Taken together, these bills represent a concerted effort to circumvent VA's direct care program and research enterprise and create no-strings-attached handouts of VA funding to private companies. Not only is this wasteful and duplicative, but it could lead to a further fracturing of continuity of care for are veterans.

Worse still, the grant programs that would be created by the RECOVER Act and the BEACON Act lack meaningful mechanisms of

oversight for VA to ensure that veterans are receiving the quality care and evidence-based standards of care through these grant programs.

I am on record acknowledging that there will always be a place for community care in geographic regions and in specialties where VA cannot directly provide needed care. However, there is a difference between participating in the community care network and creating competing and duplicative programs through which private providers can be paid to deliver care with minimal requirements for veteran cultural competency, care coordination, and communication with VA, all the while avoiding rigorous oversight of care outcomes. This is what will happen if the RECOVER Act and the BEACON Act and the Health Desert Reform Act are allowed to become law.

If private providers wish to provide care to veterans, they should ensure they can meet the VA Community Care Network requirements and enroll in that instead. I do not believe we should be creating carve-outs or grant programs that would allow private providers to avoid the requirements of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act and still financially benefit from VA funding.

I would note that many organizations who have gone on the record supporting these bills already participate in VA's Community Care Network and some are already receiving grants from VA's Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program. It seems to me that creating new grant programs for which these organizations are uniquely eligible under the RECOVER Act and the BEACON Act does nothing but enable these organizations to double or triple dip and receive reimbursements for community care in addition to the new grant funding. That does not seem fiscally responsible to me.

I will continue to oppose legislation that does nothing to ensure veterans receive quality care and instead simply siphons money from VA straight into the pockets of private entities without any guardrails. I am looking forward to hearing from our witnesses today and to some productive rounds of questions.

With that, I yield back, Chairwoman Miller-Meeks.

Ms. MILLER-MEEKS. We will limit the time to 3 minutes per bill to ensure we can move in a timely manner. General Bergman, if you are not ready to go, I am going to recognize Ms. King-Hinds. You are up unless you are not ready and I will go to Ms. King-Hinds.

Okay. Ms. King-Hinds, you are recognized for 3 minutes to speak on your discussion draft of your bill.

STATEMENT OF KIMBERLYN KING-HINDS

Ms. KING-HINDS. Thank you, Chairwoman Miller-Meeks, and thank you to the ranking member and to my colleagues for the opportunity to speak today. I am proud to discuss my bill, H.R. 6652, a bill that is about honoring a commitment Congress made just 2 years ago through the Compact of Free Association (COFA) Amendments Act and ensuring that the Department of Veterans Affairs follows through on that promise.

FAS citizens serve in the U.S. military at among the highest rates per capita. However, the brave FAS citizens who have chosen to return home after their service face disproportionate challenges to receiving their full benefits, including access to medical care when residing in their Pacific Islands. When the COFA Act was enacted, it recognized a longstanding obligation to veterans and families from the Freely Associated States. The United States agreed to expand access to care and to ensure that those veterans will no longer be left behind because of geography or administrative discretion. Despite that clear intent, implementation has remained stalled and too many veterans are still waiting for those commitments to translate into real, reliable care.

H.R. 6652 is necessary because the promise alone is not enough. This bill makes clear that VA must fully deliver on what they agreed to under the COFA Act. It ensures that essential components of care are not treated as optional, but as required parts of the services veterans receive.

This bill does not require anything extraordinary. It ensures access to telehealth, mail order pharmacy services, and makes beneficiary travel more accessible. This legislation provides clarity, consistency, and accountability so that veterans and their families can depend on the care they were promised rather than navigating uncertainty or delays.

Our veterans upheld their end of the bargain through their service to this country. Congress acted through COFA and now it is time for VA to make good on that agreement. I look forward to working with my colleagues in the Department of VA to ensure this promise is fully and finally kept.

I yield my time.

Ms. MILLER-MEEKS. Thank you, Representative King-Hinds.

The chair now recognizes General Bergman for 3 minutes for any comments he may have on his bill.

General Bergman yields.

The chair will now recognize off-committee members to speak for 3 minutes on behalf of their legislation. The chair recognizes Representative Landsman for 3 minutes.

STATEMENT OF GREG LANDSMAN

Mr. LANDSMAN. Thank you, Madam Chair. Thank you to all the members, Ranking Member, for having me in today's legislative hearing and allowing me to talk about my bill, H.R. 4590, the NOPAIN for Veterans Act. I also want to thank our co-leads, Representatives Van Orden, Pappas, Bergman, Sewell, and Hamadeh, for partnering with me on this important issue.

The opioid epidemic is a—it is a disaster, right, you know, across the board. It has really hit our veterans and you all know that. This is a really frustrating situation because there are all these U.S. Food and Drug Administration (FDA)-approved nonopioid pain treatments for veterans, for everybody. The VA will not provide those to veterans even though the FDA has approved them and they work and veterans are asking for pain relief that will not ruin their lives. The VA is saying no, no, no, it is going to require an act of Congress to update what we can provide to veterans.

As such, we are trying to get this bill onto the floor or, you know, onto the docket and pass. There is a companion bill in the Senate. We can get this done. It will make a big difference for veterans who are asking for, looking for nonopioid, you know, based pain relief.

You know, the statistics are staggering, but you all know just how problematic, you know, this addiction can be. Our veterans are going through all kinds of—you know, dealing with all kinds of issues that require some pain management. Again, this just would allow the VA to provide veterans with what Medicare folks and other folks in the private sector or with private insurance get, which is a slew of nonopioid-related or nonopioid-based pain relief.

Hopefully, we can get this on the floor or on the docket. I appreciate your efforts in letting me speak here and encourage everyone to vote for it, encourage their colleagues and folks in the Senate to do the same so we can get this passed.

Thank you. I yield back.

Ms. MILLER-MEEKS. The gentleman yields.

The chair now recognizes Representative Fallon for 3 minutes to speak on his bill.

STATEMENT OF PAT FALLON

Mr. FALLON. Thank you, Madam Chair, for the opportunity to discuss our bill, H.R. 2426, the Veterans Mental Health and Addiction Therapy Quality Care Act. This bill is an important step in ensuring that our veterans are receiving the best possible care across all treatment settings and to identify gaps and, for that matter, best practices that could inform future policy.

Today, approximately 18 veterans die of suicide daily. It is 18 too many. This is not an abstract number. These are real men and women who served our Nation. Not only they return home and they continue fighting battles, and all too well—or all too often, unfortunately, they fight those alone. This bill arises from a longstanding concern about how to best serve veterans' mental health and addiction care needs, particularly in light of the mixed delivery systems and persistent suicide and treatment access challenges.

Over the last decade, Congress has worked in a bipartisan way to expand access to care, including through community care programs that allow veterans to seek treatment outside the VA. That effort was necessary and well intentioned. However, access alone is not enough. Quality matters and outcomes matter. Lives matter depend on it.

H.R. 2426 addresses an important fundamental question: are we truly delivering the highest quality mental health and addiction care to our veterans, regardless of where that care is provided? What we still lack is an independent, objective assessment of how mental health and addiction therapy delivered by VA providers compares with care delivered by non-VA providers. Competition is a good thing. This bill directs that such a study be undertaken by the Department of the VA, and it will do two things primarily. One, assess the quality of care across a broad set of modalities, including telehealth, inpatient, outpatient, intensive outpatient, and residential treatments. Second, perhaps most importantly, the Department must make the findings of that report public.

If the outcomes of this study show strengths, we should, of course, build on them. If they reveal gaps in community care, we should fix them because we must fix them. If it reveals exceptional care in any facet, we need to replicate that success everywhere.

Here is the bottom line. Suicide rates are unacceptably high. Doing nothing is not acceptable. Our veterans and their families are being devastated by suicide and we have the ability and the obligation to demand accountability and work toward improvements.

I want to thank my colleagues on both sides of the aisle who have supported this legislation, specifically our Democratic co-lead, Representative Sanford Bishop. I would also like to thank the veterans advocates who continue to rightfully push us to do better.

This is not a partisan issue. It is a national responsibility. I urge this esteemed subcommittee to give H.R. 2426 thoughtful consideration and swift action. Our veterans have already given us so much and given so much to this Republic. We owe them the care that is worthy of that sacrifice.

Thank you, Madam Chair. I yield back.

Ms. MILLER-MEEKS. The gentleman yields.

The chair now recognizes Representative Deluzio for 3 minutes for any comments he may have on his bill.

STATEMENT OF CHRIS DELUZIO

Mr. DELUZIO. Thank you, Chairwoman Miller-Meeks, Ranking Member Brownley. It is great to be back in front of the Health Subcommittee. Thank you for having me and considering my bill, H.R. 6848, the Whole Health for Veterans Act.

This bill will help more of my fellow veterans improve their health and well-being through access to the VA's Whole Health program. I know the subcommittee members know that VA Whole Health, it is a comprehensive program. It helps veterans build a personal health plan that works for them as directed by their care team. It does things like teach veterans to treat their health proactively, provides resources and oversight for things like strength and mobility training, and is tailor made to help each veteran meet their own unique goals. When veterans are more actively involved in their own care, it improves healthcare outcomes and in turns can lower healthcare cost.

I have seen this in action in VA Pittsburgh. I have heard from veterans who are part of this program and they talk about how it saved them from surgery or other interventions that could be much more costly and invasive in their lives. I think it is something for us to build on. I think it is common sense that we can make this program available to all veterans.

Unfortunately, last October, copays were introduced, charging Veterans Health Administration (VHA) priority groups 6 through 8 veterans $15 per visit. Around that time I heard from a constituent, a veteran who loves this VA Whole Health program and the care he gets there, but talked about how he would be unable to participate due to the cost now for the program.

My bill addresses this to fix the problem by codifying an already existing prohibition on copays for priority groups 1 through 5 veterans and then caps the monthly copayments for other priority groups at $30 a month. Veterans who want to improve their health

and work with their care team I think should be able to do it without paying a fortune. VA healthcare ought to be the best in the world.

As I understand it, VA has provided some feedback on the bill. I looked at it. I think there are issues that we can edit and incorporate and update on this bill and work through. I am excited to work with the subcommittee. I invite support from both parties here, Madam Chair.

I yield back.

Ms. MILLER-MEEKS. The gentleman yields.

The chair now recognizes Representative Mackenzie to speak for 3 minutes on his bill.

STATEMENT OF RYAN MACKENZIE

Mr. MACKENZIE. Thank you, Madam Chair. It is a pleasure to join the House Committee on Veterans' Affairs. Before I begin, I would like to extend my thanks to all of our veterans for their service to our country.

Veteran suicide remains an urgent challenge facing our country. Despite years of effort, the overall rate has remained stubbornly high. Too often we learn after the fact that many of the warning signs were missed. One of the most troubling realities is that more than half of our veterans who died by suicide were not engaged with VA healthcare in the years before their death. That tells you something important, that traditional episodic screening, often based on self-reporting, is not enough to identify risk early and consistently.

That is why I am introducing the Data Driven Suicide Prevention and Outreach Act of 2025. The bill directs the VA to establish a time-limited competitive grant program to support the development of predictive models that can identify risk factors before the crisis point. They can do that by responsibly integrating benefits data, service records, and clinical information.

By leveraging new technologies, we have the potential to revolutionize how we treat and monitor the crisis of veteran suicide, providing more opportunities for timely intervention that will ultimately save lives. Importantly, this bill does not replace clinicians, nor does it create a black box algorithm. Instead, it empowers decision-makers and builds on the VA's knowledge of what works. Initiatives like the Recovery Engagement and Coordination for Health-Veterans Enhanced Treatment (REACH VET) program have shown that predictive analytics can help flag veterans at elevated risk and prompt earlier outreach and care engagement.

What this legislation does differently is encourage innovation with guardrails. Grants are limited to organizations with demonstrated expertise in healthcare Artificial Intelligence (AI), data security, and clinical deployment. Models must be explainable, interoperable, and clinically actionable. They must comply with VA cybersecurity standards and any findings must be shared with the VA for systemwide evaluation.

We also intentionally prioritize areas with elevated suicide risks and high crisis volumes with the suicide hotline. Also, we look at where there are long mental health wait lines and we can help prevent duplication of efforts or a missed opportunity to intervene.

Artificial intelligence holds promise, but it is still new and carries real risks which we want to recognize and this bill takes a balanced and measured approach with a pilot program. Stakeholders have emphasized that these predictive schools can be helpful. I have seen it in my local community where health networks utilize AI running in the background. Again, it becomes a force multiplier where doctors can then go out and actually treat more of these situations that deserve their attention and should be prioritized.

I would like to thank the chair for recognizing us and allowing me to be able to be with the committee today and appreciate the consideration of this important legislation.

Thank you. I yield back.

Ms. MILLER-MEEKS. Thank you, Representative Mackenzie.

As is our practice, we will forego a round of questioning for the members. For those off-committee members, you may remain to ask questions later if you desire.

Our first panel is already at the table. Excuse me. The chair now recognizes General Bergman to speak for 3 minutes on his bill.

STATEMENT OF JACK BERGMAN

Mr. BERGMAN. Yes. Thank you, Chairwoman. There seemed to be a slight disconnect here when I walked in. I did not think I was going to be speaking on this. We will get our staffs together to make sure that we know when the timing is right. Thanks for the opportunity. This is a discussion draft of the—what we have titled the BEACON Act, and it is Veterans TBI Breakthrough Exploration of Adaptive Care Opportunities Nationwide Act.

The bill would direct the Secretary of the VA to carry out programs awarding grants to eligible entities to study and conduct randomized control trials with respect to the neurorehabilitation treatments for chronic mild traumatic brain injury. Additionally, grants would be available to design those treatments as well as measure the effectiveness of already funded treatments. Nonprofits, academic institutions, and healthcare providers with expertise in neurorehabilitative therapies would be eligible.

In the analysis of this, the randomized control trials measure the effectiveness of a new intervention or treatment and have been recognized as the gold standard for effectiveness research. The bill would dedicate resources to a prevalent issue, like lost TBIs that occur each year as mild TBIs or concussions.

This is not about, as we hear so many times, privatizing the VA. This is enabling the Veterans Administration through grant process to enable other scientific entities to do more breakthrough therapies that are going to not only help veterans, but also others that suffer from mild TBI.

With that, I yield back.

Ms. MILLER-MEEKS. Thank you, General Bergman.

Joining us today from the Department of Veterans Affairs are Dr. Mark Koeniger, VA's acting assistant undersecretary for Health for Patient Care Services. He is accompanied by Dr. Llorente, VA's acting assistant under secretary for Health for Integrated Veteran Care.

Dr. Koeniger, you are now recognized for 5 minutes to present the Department's testimony.

STATEMENT OF MARK KOENIGER

Dr. KOENIGER. Good afternoon, Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the subcommittee. Thank you for the opportunity to testify today on several bills that would impact VA healthcare programs and services.

As a family practice physician, I understand the importance of comprehensive patient-centered care and the trust that veterans place in us. My nearly 37 years in uniform have strengthened my commitment to delivering the highest quality care. I had the privilege of commanding the largest U.S. military hospital in Iraq during 2009 to 2010, an experience that underscored the value of coordinated, timely care in saving lives. Today, as acting assistant undersecretary for Health for Patient Care Services, I oversee 16 national program offices that support a wide range of clinical professions and care settings, including geriatrics, rehabilitation, and whole health. These experiences guide my work as we strive to strengthen VA healthcare for all who have served.

I am joined by Dr. Maria Llorente, acting assistant undersecretary for Health for Integrated Veteran Care.

Before we begin, I would like to apologize for the delay in providing testimony to this committee. VA is working on process improvements internally as well as externally to make sure this is prevented in the future. While I will briefly highlight VA's position on several bills, my full written testimony provides detailed views on all 12 bills under consideration.

Turning to the substance of the legislation, several of the bills on the agenda would require VA to establish new grant programs. VA has concerns with these bills as grants may not be the most appropriate means of providing the intended support. Grants are one way, but not the only way for providing financial assistance to nongovernmental agencies. VA would welcome the opportunity to discuss these bills further with the committee and to determine if a different structure might be more appropriate.

First, regarding the RECOVER Act, VA strongly supports efforts to expand access to veteran-centric, evidence-based mental health. While we have concerns with certain provisions in the bill, we greatly value the committee's leadership in this issue and welcome the opportunity to work together on approaches that strengthen care coordination and deliver the greatest impact for veterans.

Second, VA supports the Veterans Mental Health and Addiction Therapy Quality of Care Act, subject to amendments and the availability of appropriations. This bill is consistent with VA's current efforts to compare the quality of VA and non-VA mental health and addiction therapy care.

Third, although VA appreciates the intent of the NOPAIN for Veterans Act, this bill would undermine VA's well-established evidence-based formulary process which ensures medications are safe, effective, and economical.

Fourth, regarding H.R. 5999, VA supports expanding access to opioid antagonists subject to amendments and appropriations. While naloxone is already widely available at no cost to enrolled veterans, eliminating prescription requirements could increase risks of waste and fraud.

Fifth, regarding the Veterans with ALS Reporting Act, the VA supports the intent, but some provisions may duplicate existing efforts. We welcome the opportunity to collaborate on strategies that advance research and care without diverting resources from patients.

Similarly, the Veterans Health Desert Reform Act underscores the importance of improving access for rural veterans, a goal VA strongly supports. However, the bill as written appears to create no new authority to further this goal.

Finally, VA appreciates the committee's focus on innovation through research and technology, including proposals related to traumatic brain injury and suicide prevention. These are critical areas where VA invests heavily.

In closing, VA remains steadfast in its commitment to delivering world-class healthcare to veterans. We share the committee's goals of improving access, quality, and outcomes, and we look forward to working with you to refine these proposals so they strengthen care without unintended consequences.

We are happy to answer any questions you may have.

[THE PREPARED STATEMENT OF MARK KOENIGER APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Dr. Koeniger.

As is my usual practice, I will reserve my time until after all members have had a chance to ask their questions.

I now recognize Ranking Member Brownley for 5 minutes for any questions she may have.

Ms. BROWNLEY. Thank you, Madam Chair. I think I wanted to direct this question to Dr. Llorente. As I cited in my opening comments, and VA cited as well, significant concerns with the RECOVER Act. Among other things, your written testimony points out that grantees would be able to receive financial support from VA in the form of grant funds, still be able to bill the VA for services under the existing VA Community Care Program, and also be able to bill veterans' other healthcare insurance. I cannot see how this makes sense to me. Well, three opportunities to perhaps triple dip with the VA.

VA already has a community care network. Why is it important to adhere to the community care eligibility and authorization process that was established under the MISSION Act?

Dr. LLORENTE. As you pointed out, the Community Care Program does have a series of requirements to make sure that the providers who are delivering services to veterans have the needed credentials, have the privileges, and offer the quality of care that we expect they will deliver. That is, in fact, one of the concerns that we do have with the bill as written. It does not really specify requirements and, as written, a community provider could potentially get one of these grants and offer services through one of these grants that might not be eligible, might not meet the requirements under the Community Care Program. It is why we really do welcome an opportunity to work with Congress to revise the language so that we can address some of these concerns.

Ms. BROWNLEY. Thank you for that. To follow up on another bill, VA already administers the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program, which is intended to address the

upstream factors that contribute to suicide risk, such as housing and employment instability and lack of social support and engagement. We also have the Veterans Comprehensive Prevention, Access to Care, and Treatment (COMPACT) Act, which allows VA to cover emergency treatment for veterans experiencing acute suicidal crises. Both the Fox Grant Program and the COMPACT Act program serve veterans regardless of whether they are enrolled in or otherwise connected to VA healthcare.

Given that, does VA think it needs the grant program that would be created under the RECOVER Act, or would it be duplicative?

Dr. LLORENTE. As was described by Dr. Koeninger, one of the questions that we have is whether a grant process or a grant program is the most effective mechanism to expand access to especially mental health and suicide prevention care for veterans. VA is always looking for opportunities to expand access to those types of services because we recognize that there are areas of the country where it may be more difficult to access those types of services.

Again, we would really like to work with the committee, first, to determine what is the most effective mechanism to be able to conduct a pilot program so that we can be cost-effective. At the same time, if there is an opportunity to expand services, we take that opportunity.

Ms. BROWNLEY. Thank you for that. Probably the last question that I have time for, Dr. Koeninger, is there any statutory or practical barrier to VA, either through its existing research infrastructure or through its academic affiliates program, being able to research, develop, and implement novel or alternative treatments for TBI?

Dr. KOENIGER. Ma'am, I will have to take that question back to look in to make sure that there are no or are statutory requirements. I just do not have that information offhand, but I can get back to the committee.

Ms. BROWNLEY. Okay. Let us see. I think I do not have time for this, so I will yield back.

Ms. MILLER-MEEKS. Thank you, Ranking Member Brownley.

The chair now recognizes Representative Hamadeh for any questions he may have.

Mr. HAMADEH. Thank you, Chairwoman. President Trump has made veterans his priority again. He has expanded community care, slashed bureaucratic red tape, and put the veteran, not the bureaucracy, first. I am with him all the way.

Now the Veterans Assuring Critical Care Expansions to Support Servicemembers (ACCESS) Act and my Coordinating and Aligning Records to Improve and Normalize Governance for Our Veterans Health (CARING) Act are built on the same foundation. Veterans deserve seamless access to care, whether it is inside the VA or in the community. Dr. Koeniger, can you explain to me step by step, how are you implementing the President's directive to ensure medical records actually follow the patient?

Dr. KOENIGER. I am going to defer to my colleague, Dr. Llorente.

Dr. LLORENTE. The medical records are really bidirectional. When we refer veterans to community providers, we first have to provide them with some sort of consultation or referral. In some cases that referral will include information about laboratories, di-

agnostic imaging, so that the community provider understands what is being asked when the veteran is referred.

Similarly, once the community provider completes their evaluation, their treatment recommendations, they send those records back to the VA. At the present time, unfortunately, there are several different ways in which those records come to the VA. One of the things that we are in the process of doing through the Request for Proposals (RFP) that is currently in solicitation, that has been published, is to be able to streamline those efforts where the Third Party Administrators (TPA) that received the award will create essentially a portal where the medical records from the community providers will now be centralized in order to be able to streamline that process.

Mr. HAMADEH. Has this been attempted before?

Dr. LLORENTE. To the best of my knowledge, no, but I am happy to take that back and get additional information.

Mr. HAMADEH. How long until the RFP is selected?

Dr. LLORENTE. We are expecting to make the awards, I believe in March. There is a 90-day review period and I think the awards—the solicitation closes at the end of this month.

Mr. HAMADEH. How long will it take to be implemented?

Dr. LLORENTE. It will take approximately a year.

Mr. HAMADEH. You know, that is the biggest concern that when I go back to my district, there are a lot of veterans, you know, they lose their medical records, the VA does, the community care. I really encourage the Department to really prioritize this because this is a constant theme I hear.

Can you assure us after this is implemented, hopefully when you have the right RFP that you select, that the veteran is not going to be waiting weeks for community providers' records to actually reach the VA.

Dr. LLORENTE. You have my assurance that that is—the absolute goal, is that we are going to be receiving these records and then being able to upload them into the veteran's electronic health record. The specific mechanics are not currently in place, unfortunately, that is about the extent of what I can say right now.

Mr. HAMADEH. Do you anticipate this actually cutting it, time, significantly?

Dr. LLORENTE. Yes.

Mr. HAMADEH. Arizona has many rural communities that are miles from the nearest VA facility. President Trump understands that the veteran in rural Arizona matters just as much as the one here in Washington, DC. Now, the Veterans Health Desert Reform Act we are considering today addresses this head-on. How is the VA proactively identifying these medical deserts right now?

Dr. KOENIGER. The VA has certain processes in place that—within the Office of Rural Health. That office has been up and running for quite some time now. They have identified a lot of areas in—where veterans have to travel extended periods to get to healthcare. They have—again, through the Office of Rural Health, we are engaging with those veterans on a regular basis.

Mr. HAMADEH. Do you wait for the veteran to bring this issue to you or are you being proactive about it?

Dr. KOENIGER. No, the office is proactive in terms of outreach to veterans.

Mr. HAMADEH. I yield back.

Ms. MILLER-MEEKS. The gentleman yields.

The chair now recognizes Dr. Conaway for 5 minutes for any questions he may have.

Mr. CONAWAY. Thank you, Madam Chair, and thanks to Ranking Member Brownley for bringing us here today to discuss these important pieces of legislation.

I want to discuss a particular vulnerability that veterans have with respect to their use of opioids. Many people in the service have chronic pain from service-related injuries and other trauma. People with chronic pain, as I am sure you are aware, are at higher risk of opioid reliance. Some 289,000 vets have used opioids in the short term and there are 162,000 veterans who are on long-term opioid use as of data in 2023. Thank you.

Would you describe, and the standard of care is that, particularly for people on long-term opioid use, that naloxone be available as a preventative for death related to opioid use. Would you describe the current process by which a veteran who has VA benefits can receive naloxone, this standard of care treatment to prevent preventable opioid-related deaths?

Dr. KOENIGER. Right now a veteran can walk up to a pharmacy and if they are high risk, there are standing orders with the pharmacy, so they can ask the pharmacist and the pharmacist uses those standing orders to provide the veteran with the naloxone. Again, the naloxone is provided free of charge to veterans. We also distribute naloxone through health fairs and other means.

Mr. CONAWAY. That is very good. They can get the prescriptions—they can get their naloxone in the various forms without a prescription. Also, I guess in pill form because it does have uses in helping people that have alcohol dependence as a problem and preventing—or helping people to relieve themselves or at least get beyond alcohol dependence. It is free access. It mirrors a lot. You would say, the VA system is mirroring what many states have done in this area by providing easier access to this life-saving chemotherapeutic?

Dr. KOENIGER. Yes, sir.

Mr. CONAWAY. Moving on, discussing another piece of legislation on the list today. Can you—I understand there is a current process through which providers and patients can submit formal requests for new drugs to be included in the VA National Formulary. Can you briefly explain what that process is and how long it takes on average for requested drugs to be added to the formulary?

Dr. KOENIGER. Veterans, of course, we have medications that are on the formulary and that are not. All FDA approved medications, veterans have access to all of them. If it is not on the formulary, a veteran can go to their provider, ask the provider for a prescription, and generally within 96 hours will get the medicine.

Mr. CONAWAY. Now, my understanding is that the U.S. Department of Defense (DOD) formulary and the TRICARE formulary is broader than what is available to veterans receiving VA care. One of the pieces of legislation seeks to ensure that the veteran who relies on VA care for their healthcare, that they have the same easy

access to drugs that are already approved in other Federal formularies. Your thoughts on that?

Dr. KOENIGER. I am not aware of the specifics of what DOD has on their formulary. I would have to get back to you with specifics.

Mr. CONAWAY. Okay, thank you. That ends my questions. Thank you both.

Ms. MILLER-MEEKS. The gentleman yields.

The chair now recognizes Representative King-Hinds for 5 minutes for any questions she may have.

Ms. KING-HINDS. Thank you, Madam Chairwoman. Fun little fact, the Northern Mariana Islands is a part of the Greater Micronesia. The folks from the COFA states, the Republic of the Marshall Islands, the Federated States of Micronesia, Palau, you know, we are all Micronesians. One of the commitments that I made was that I was going to be their champion here in Congress because they do not have representation, although they have served this country. I thank you for the opportunity to have this conversation today regarding my bill.

Dr. Koeniger, you, in your testimony, you referenced the unique legal consideration involved in extending VA benefits to veterans from the Freely Associated States. You specifically mentioned that 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. I guess I want to understand that statement a little bit more and I wanted a clarification on what specific legal questions the VA is still working through.

Dr. KOENIGER. Ma'am, I am going to defer to Dr. Llorente on that question.

Dr. LLORENTE. To provide some examples, let us talk about the medications. There are certain medications that can be transported based on Department of Transportation regulations and laws. Then there are others that are considered hazardous and cannot be transported or cannot be easily transported. There are certain medications that require certain types of refrigeration. Those would be logistically complicated to be able to send via mail order to, as you described, very—you know, in some cases, some fairly isolated areas over a broad geographic distance. I am not saying that it is impossible to do some of these things, but we would need to be able to figure out how to do it. That is on our side.

On the FAS side, we would also need to understand what are their regulations, what are their restrictions, if they have any, with respect to the use of medications? Are there some medications that they do not allow? That is just an example of the types of things that would have to be worked out in agreements.

Similarly on the provider side. We have the authority for U.S. providers to deliver services, for example, via telehealth, but those providers do not necessarily right now have licenses, if you will, to practice medicine in the Federated States. It is something that would have to be worked out in the agreement.

These are just a couple of the examples of just the types of logistical issues that would need to be worked out. We welcome the opportunity not only to work with Congress, but to work with our

interagency partners in order to see what we can do with respect to the options that would be available to deliver the services.

Ms. KING-HINDS. Are those regulatory changes that are required or are there specific laws which prohibits these agreements from being negotiated? How does that interplay with regards to what the commitments that we have made with the COFA agreement that was passed 2 years ago?

Dr. LLORENTE. I would respectfully request that you allow me to take that back for the record because I do not know the answer to your question.

Ms. KING-HINDS. Okay. Well, thank you for that.

My other question is, you know, one of the issues that were raised with regards to this legislation is the cost, right, and what has been done basically to kind of more fully vet what that looks like. Whenever cost comes up, it kind of aggravates me because we did not talk about costs when, you know, folks from the FAS signed up and served our country. Right? Where are we at with that?

Dr. LLORENTE. Yes, so we have been working at trying to examine and evaluate what some of the potential costs would be based on the types of services that would be offered, the types of medications that are likely to be needed, and then the beneficiary travel component to try to come up with an estimate. The cost estimates also would necessarily be a result of what the actual utilization turns out to be. That is not something that we know right at this point in time. It is something that we are working on to try to see if we would not be able to obtain an estimate and a projection.

Ms. KING-HINDS. All right, thank you. I am out of time. I yield back.

Ms. MILLER-MEEKS. Thank you very much, Representative King-Hinds.

The chair now recognizes Representative Cherfilus-McCormick for 5 minutes for any questions she may have.

Ms. CHERFILUS-MCCORMICK. Thank you so much. Thank you for our witnesses who are here.

I have so many questions. Florida's district is—Florida has some of the top numbers of our veterans who we serve. I hear a lot from them that one of the issues they have, not just the distance and how long it takes them, I have some people who tell me it takes them a day to actually get to the VA, and so distance is a huge issue. Also I hear from them that cultural competency is also when they have to go outside. What are some of the safeguards that you have in place?

We know our veterans are facing specific needs and they have had specific harms that are unique to their situations, especially when it is service-related. Are there any safeguards in place to make sure that they are getting similar or care that the VA would give them?

Dr. LLORENTE. When we talk about cultural competency, it is important to define which culture we are talking about. In the VA, of course, we first and foremost start with veteran culture because the needs, the experiences, and the health outcomes of veterans are quite different than what one typically would see in a civilian population. There is a strong component of cultural competency with respect to the military culture, veteran health outcomes. The Ser-

geant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act recently mandated toxic exposure training for every VA provider, just as an example. I think that there is very, very strong training for the VA with respect to the veteran culture.

There are—those same types of trainings are afforded on some external websites that the VA uses. The one that is most used by our community providers is called TRAIN. There, too, we offer training to community on cultural competency for military culture and for veteran culture.

Beyond that, of course, one could think of being a woman as a subtype of culture. Being a woman veteran is also very, very unique. It is one of the reasons why VA has established not only the Women's Health Program and women's health clinics in our VAs, but also providers that have specific training to be women's healthcare primary providers.

Ms. CHERFILUS-MCCORMICK. I wanted to pause on that because that is getting to the root of the issue that we have been finding is that there is so much uniqueness when it comes to our veterans, not just from the military culture, but then when we are looking at individuals, such as women, which are growing populations, and the concern really comes in because the training right now is voluntary. There is no real standardization when it comes to the community-based care that they are receiving.

We submitted an amendment that would introduce that kind of standardization where anybody who is actually helping or servicing our veterans were trained the same way, so they can recognize burn pits or they can recognize whatever they have gone through, which would save our veterans a lot of time as they are trying to decipher what issues they have. Do you have anything in place that would be mandatory or do you believe that any kind of mandatory standardization when it comes to community care would actually be more advantageous to our veterans?

Dr. LLORENTE. Thank you. That is a wonderful question. To the best of my knowledge, we do not have anything in place right now that is mandatory. It does not mean that there have not been many conversations and discussions about that topic. I think that the biggest challenge is if we started creating a whole host of mandatory requirements, would that then limit and/or restrict the availability of those community providers?

Ms. CHERFILUS-MCCORMICK. Now, in other areas, because I know there is continuing education for our healthcare professionals all the time, have we seen any burdens before? I do not see any other continuing education when we actually look at priorities, right? The priority is to make sure our veterans are taken care of and to make sure if our veterans are presenting any kind of issue that the VA can pick up, that community care can pick it up just as fast, and they are not going through a system for years where the VA could have found it. Have you seen that before, that the actual training has caused less accessibility?

Dr. LLORENTE. I would have to take that back for the record in order to be able to provide you with that answer.

Ms. CHERFILUS-MCCORMICK. Thank you. I yield back.

Ms. MILLER-MEEKS. The gentlewoman yields.

The chair now recognizes General Bergman for 5 minutes for any questions he may have.

Mr. BERGMAN. Thank you, Madam Chair.

Dr. Koeniger, one of the biggest challenges with mild chronic TBI, traumatic brain injury, is that it can be hard to recognize and is often masked by other conditions. From the VA's perspective, what are the consequences of underdiagnosis or misdiagnosis for veterans?

Dr. KOENIGER. Well, certainly the consequences of underdiagnosing or misdiagnosing any medical problem would have a negative impact on the veteran. Whether it is mild TBI or any other medical condition, VA providers strive hard not to underdiagnose or misdiagnose.

Mr. BERGMAN. Yes. You know, you are a medical professional. The idea, I am sure from your perspective, is you want to get it right as best you can the first time.

Dr. KOENIGER. Absolutely.

Mr. BERGMAN. You know, I mean, that is the oath you have, you know, sworn to uphold, and I thank you for that. You know, on a different note here, but still along the same lines, Dr. Koeniger, many veterans struggling with mental health challenges never enter the VA system before engaging in self-destructive behaviors like suicide. They just do not—they are not in the system. How do we, you know, calculate the numbers?

As such, the true scope of need is likely far greater than existing data would reflect. Reducing suicide risk requires meeting veterans where they are within their communities. The expectation, especially in districts like mine where it is rural and remote, I mean, hours of drive from any kind of clinician. This underscores the need for flexible, accessible care that engages veterans the moment they first seek help. If implemented, and I am being specific here, how could the RECOVER Act, sponsored—you know, introduced by Chairman Bost, change the way veterans experience mental healthcare at the moment they first raise their hand for help?

Dr. KOENIGER. Sir, I am going to actually defer to Dr. Llorente.

Dr. LLORENTE. We welcome the opportunity to be able to identify mechanisms in which to expand just the type of access that you described. I think one of the advantages in the language as written is that the providers would be encouraging veterans to enroll and engage with the VA to receive VA healthcare services in addition to any services offered in the community. However, we do have some significant concerns as written and would like to work with the committee to best address those concerns.

Mr. BERGMAN. Well, and I appreciate that. You know, the MISSION Act became the Veterans Access, Choice, and Accountability (CHOICE) Act and then, you know, became community—you know, all of those things that have morphed over time here over the last decade. Unfortunately, still we are in some ways as a committee struggling with dealing with the Veterans Administration to shape the environment for the ability to, first of all, get the first step of diagnosing the issue, which means contact with the veterans. I appreciate your willingness to take a look at different ways to make that initial contact because, you know, there is not a one size fits all, especially in those rural and remote areas.

With that, Madam Chair, I yield back.

Ms. MILLER-MEEKS. The gentleman yields.

The chair now recognizes herself for 5 minutes for any questions she may have.

Dr. Koeniger, if the pilot in my Health Deserts bill proves effective, how could it reshape access to care for veterans living in healthcare deserts nationwide and, in fact, worldwide?

Dr. KOENIGER. Ma'am, it is—we are—the VA is always in support of trying to engage veterans in health deserts or, you know, in very rural areas. Again, the Office of Rural Health has done a lot of work in those areas to identify and, again, define, you know, what a rural area is. Then reach out to the vets who live in those rural areas and try and get them, first, enrolled in the VA and then figure out how to best work with them so that they can have access on a regular basis, whether it be through things like ride sharing or telehealth or services like that.

Ms. MILLER-MEEKS. Dr. Llorente, just in response to a comment from my colleague about standardization and mandatory training for individuals, whether they are within the VA providers, whether they are in the VA system or in a community care system, is it mandatory that a veteran go to community care or is that something they request?

Dr. LLORENTE. It is, first of all, they have to meet the eligibility criteria for community care. Then second, we offer them the choice. It is the veteran's preference. If they want to go to community care and are eligible, then, you know, we will do everything that we can to facilitate. If they prefer to receive care from the VA, then we will honor their preference.

Ms. MILLER-MEEKS. Thank you. I just wanted to emphasize that point, that it is voluntary and the choice of the veteran where they receive that care.

Dr. Koeniger, why is it important to explore care delivery models that leverage existing non-VA health systems in health deserts?

Dr. KOENIGER. I think what the VA wants to do is to make sure that it provides the absolute best care to veterans as possible. As Dr. Llorente just said, you know, we need to consider all aspects of care, whether it is in the VA or outside of the VA and make sure that veterans have access to the best care.

Ms. MILLER-MEEKS. Thank you. As a veteran married to a veteran, could not agree more. I yield back.

On behalf of the subcommittee, I want to thank you all for your testimony and for joining us here today. You are now excused and we will wait for a moment for the second panel to come to the witness table.

I welcome everyone and thank them for their participation today.

On our second panel, we have Hon. Charles Rudolph Paul, Ambassador to the United States of the Embassy of the Republic of the Marshall Islands; Mr. James Whaley, chief executive officer for Mission Roll Call; Ms. Elizabeth McCoy, associate director of government affairs, Wounded Warrior Project; Ms. K. Conwell Smith, deputy chief of military and veterans policy at the American Psychological Association (APA). Thank you once again for attending today.

Ambassador Paul, you are now recognized for 5 minutes.

STATEMENT OF CHARLES RUDOLPH PAUL

Mr. PAUL. Madam Chairwoman, ranking member, members of the subcommittee, thank you for the opportunity to testify on veterans' healthcare issues affecting the Republic of the Marshall Islands and the other Freely Associated States.

The Republic of the Marshall Islands is in the closest relationship that the United States can have with any sovereign country. Under the Compacts of Free Association, which is enacted into U.S. law, the three Freely Associated States permit the United States to exercise a core element of our sovereignty, strategic denial of access of other nations across the region spanning from Hawaii to Asia. In the Marshall Islands, we also host a critical U.S. military installation that the Joint Chiefs of Staff describe as the world's premiere range for missile testing and space operations support.

The United States also actively recruits in the Marshall Islands as if we are a U.S. State or territory. Our citizens enlist at some of the highest per capita rates of any U.S. jurisdiction. They serve honorably, deploy globally, and retire as U.S. veterans. Yet today, many of these veterans are effectively unable to return home because they cannot access the healthcare they earned through their service.

The issue was central during negotiations of the Compact of Free Associations Amendments Act of 2024. Congress clearly intended that veterans' healthcare be made available in the Freely Associated States. That intent was reinforced in last year's Continuing Resolution and the National Defense Authorization Act.

However, despite clear, repeated statutory direction authority, the Department of Veterans Affairs has not acted to implement this commitment on the ground. As a result, veterans must choose between remaining in the United States or returning home without access to VA healthcare. The Republic of the Marshall Islands strongly supports congressional action to resolve this gap and ensure the Compact Act commitment is fulfilled.

The issue is deeply personal at the highest levels of our government. The Minister of Foreign Affairs and Trade of the of the Republic of the Marshall Islands, Hon. Kalani Kaneko, is himself a retired U.S. Army veteran who honorably served 20 years, qualifying for full retirement. For more than a decade, he served as an Army recruiter and personally recruited approximately 200 Marshallese men and women to the United States Armed Forces, individuals who trusted the United States and answered its call to service.

This issue is also personal to me. My younger brother medically retired from the United States Army after 13 years of service, including three combat tours in Iraq. He now lives in the Marshall Islands and cannot access the healthcare he would receive if he remained in the United States. My nephew is currently serving on Active Duty. He wants to return home after his service but worries whether he will be able to receive the care if he does. No veteran's decision to return home should depend on whether they can access basic medical care.

Importantly, I am not requesting new benefits. Section 209(a)(4) of the Compact Amendments Act explicitly directs the Secretary of Veterans Affairs to negotiate agreements to ensure the provision of

veterans health services in the Freely Associated States. Congress has spoken clearly. The authority exists. The obligation is explicit.

This is also a national security issue. Veterans living in the Marshall Islands strengthen local capacity, reinforce trust in the Republic of Marshall Islands (RMI)-U.S. relationship, and serve as a stabilizing force in a strategically sensitive region. The Republic of the Marshall Islands stands ready to work constructively with Congress, the Department of Veteran Affairs, and the Administration to implement what the Compact Act already promises. Our veterans honored their commitment to the United States. Implementing veterans' healthcare in the Freely Associated States is not an expansion of benefits. It is the fulfillment of a solemn obligation.

Thank you and I look forward to your questions.

[THE PREPARED STATEMENT OF CHARLES RUDOLPH PAUL APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Ambassador Paul.

Mr. Whaley, you are now recognized for 5 minutes for your testimony.

STATEMENT OF JAMES WHALEY

Mr. WHALEY. Good afternoon, Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the Health Committee, distinguished guests. Thank you for the opportunity to testify today on behalf of Mission Roll Call and the veteran community.

Our mission is straightforward. We collect data from veterans and we make sure that that information helps inform decisions made in Washington. We use polling and direct engagement to bring real, unfiltered veteran perspectives to policymakers and the public. Amplifying this data on behalf of veterans and their families allows us to advocate for meaningful change that improves the lives of those who have served.

The legislation under consideration today seeks to address and improve the lives of multiple generations of veterans addressing traumatic brain injury, suicide prevention, access to care in remote and rural areas, mental health, opioid addiction, and more. Mission Roll Call's survey data shows a strong need within the veteran community to address these issues in ways that place veterans first and delivers care when and how a veteran will benefit most.

One area where this need is especially clear is suicide prevention and mental healthcare delivered outside of VA facilities. In Mission Roll Call's national suicide prevention polling in July 2025, nearly 80 percent of veterans told us that preventing suicide requires clinical treatment and community-based support working together, not in isolation. More than 90 percent said it is extremely or very important to include community-based organizations and prevention efforts, and an equally strong majority emphasized the importance of training, coordination, and accountability.

The RECOVER Act reflects those priorities by strengthening evidence-based mental health capacity in the community, ensuring providers are trained to understand veterans' risks, and requiring outcome reporting so Congress and the VA can assess what is actually working. To veterans this is about a system that meets veterans where they are, especially when timely access to care can be the difference between stability and crisis.

While suicide prevention only brings veterans into mental health systems, many of the underlying drivers of risk begin earlier and go untreated. Mission Roll Call's survey data shows that over 95 percent of veterans say it is extremely or very important to have access to specialized TBI care, including care delivered outside the VA. Yet among veterans seeking care for TBI-related symptoms, 73 percent report that assessing appropriate treatment is somewhat or very difficult.

The BEACON Act responds directly to that gap by creating a structured evidence-based framework for evaluating innovative approaches for veterans with chronic TBI. Veterans are asking the VA to test promising therapies responsibly, publishing results, and expand access where evidence supports it. From the veterans' perspective, the BEACON Act is about restoring function, reducing downstream mental health risk, and giving clinicians better tools to intervene before injuries compound into lifelong disability.

In addition, Mission Roll Call supports efforts to modernize veteran care by expanding evidence-based options while holding the system accountable for outcomes. The NOPAIN for Veterans Act moves VA toward broader use of effective nonopioid pain management therapies, while the Veterans Mental Health and Addiction Therapy Quality of Care Act ensures Congress and the VA have reliable independent data on how mental health and addiction care performs across VA and community programs. These measures reflect what veterans consistently ask for in our surveys: care that is grounded in evidence, reduces risk, and is evaluated based on real world results.

Mission Roll Call has always advocated that geography should not determine where a veteran—if a veteran receives timely care, and supports legislation that addresses access gaps for veterans who live far from VA facilities or outside the Continental United States. The Veterans Health Desert Reform Act and the U.S. Vets of the Freely Associated States Act recognize this reality and seek to leverage community providers, telehealth, and mail order pharmacy service to close those gaps.

We believe good policy starts with listening to the veteran community and ends with accountability. Veterans overwhelmingly seek better access to care in a manner that supports their life and family, rules that can be easily understood, and outcomes that can be measured and improved. The legislation before you reflects meaningful progress toward those goals and we appreciate the subcommittee's continued focus on practical solutions that make the veteran and family central to the provision of care. Thank you, Chairwoman.

[THE PREPARED STATEMENT OF JAMES WHALEY APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Mr. Whaley.

Ms. McCoy, you are now recognized for 5 minutes.

STATEMENT OF ELIZABETH MCCOY

Ms. MCCOY. Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the subcommittee thank you for the opportunity to testify. Today's agenda includes many bills that are aligned with Wounded Warrior Project's mission to honor and em-

power warriors, and I am pleased to speak on several that would have a heightened impact on the post 9–11 wounded, ill, and injured veterans that we serve. My remarks today focus on the link between mental health and brain health and why investment in brain health is essential.

Military-related traumatic brain injury, a signature wound of post 9–11 service, can significantly increase neurological conditions that influence physical and psychological functioning, such as chronic pain, depression, and anxiety. To that end, a traumatic brain injury can both directly and indirectly elevate suicide risk. These realities underscore the need for continued investment and innovation. Scientific advancements have demonstrated that brain health must be treated as a long—lifelong whole health priority both during and after military service, just as we have learned with mental health. Yet much about brain function remains unknown, reinforcing the need for bold investment in research and advancement to improve outcomes.

To address these challenges, we must move toward a strategic framework that integrates three pillars: prevention, treatment, and innovation. First, prevention and early identification of brain injuries are critical. Servicemembers in training and combat can be exposed to blast overpressure and repetitive head impacts that accumulate over time. We encourage alignment of life cycle data and standards from the Department of War to the Department of Veterans Affairs, shared baselines, common measures, and longitudinal tracking so that no veteran falls through the cracks during their transition.

Legislation such as H.R. 6444, the Blast Overpressure Research and Mitigation Task Force Act, strengthens blast exposure research and seeks to translate evidence into standardized screening and safeguards while assuring assessments migrate with the veteran from their time in uniform to civilian life. For these reasons, we are pleased to support this legislation.

Second, personalized outcome-driven treatment is essential because brain injury manifests differently for every veteran. Precision approaches, tailored neurorehabilitation, nonpharmacologic therapies, and integrated mental health support offer pathways to measurable improvements in cognition, mood, and functioning.

We support H.R. 6993, the BEACON Act, which would seed innovation and clinical evaluation across nonprofits, academia, and community partners. We encourage streamlined funding so pilots add capacity rather than divert existing mental health resources.

Third, proactive suicide prevention should take brain health into account. Predictive analytics can help clinicians identify veterans at higher risk and engage them earlier with safety planning, follow up, and tailored treatment. Technology should not be used as a shortcut. Innovation should enhance proven strategies, not replace them. To that end, Wounded Warrior Project supports the Discussion Draft Data Driven Suicide Prevention and Outreach Act of 2025.

Veterans have earned care that is consistent. While public and private collaboration is essential to ensuring veterans receive the highest quality of care, VA should remain as the coordinator of programs and grant funding. Where shortages persist, especially in

rural areas, we support piloting practical access solutions that meet veterans where they live, making sure data flows back to VA and measures outcomes. We are pleased to support the Discussion Draft Veterans Health Desert Reform Act of 2025.

The legislation included in today's hearing moves beyond incremental fixes and strives toward a bold, integrated vision for brain health that supports the servicemember to veteran life cycle. Wounded Warrior Project stands ready to partner with the subcommittee, VA, the Department of War, and community innovators to identify and prevent injury of the brain, create personalized outcome-driven treatment, and build proactive suicide prevention programs that take brain health into consideration.

Thank you for your leadership and for the opportunity to testify this afternoon.

[THE PREPARED STATEMENT OF ELIZABETH MCCOY APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Ms. McCoy.

Ms. Conwell Smith, you are now recognized for 5 minutes for your testimony.

STATEMENT OF K. CONWELL SMITH

Ms. SMITH. Chairwoman Miller-Meeks, Ranking Member Brownley, and distinguished members of the subcommittee, thank you for the opportunity to testify. I am Conwell Smith, the deputy chief for military and veterans policy for the American Psychological Association.

APA is the Nation's largest scientific and professional organization representing psychology with more than 190,000 members and affiliates. Today, more than 7,000 psychologists work in the VA, though that number has declined by nearly 300 since 2024. APA is proud of VA psychology's role in decades of mental health clinical and research advancements. My testimony focuses on ensuring that the legislation under consideration upholds the highest standards of veteran care, regardless of where care is delivered.

Several bills create new delivery models, programs and access points operating outside the VA's Direct Care and Community Care program. APA's concerns that building parallel systems risks further fragmenting care, separating veterans from coordinated treatment teams, and weakening benefits of the VA's integrated care model. Two bills in particular, the RECOVER Act and the Draft Health Desert Reform Act, are well-intentioned efforts to expand access, but we fear risk unintentionally reducing the quality of veteran healthcare without stronger safeguards.

APA recognizes the need to supplement VHA care. However, veterans should have the same expectations of quality and safety whether they are treated inside or outside the VA. To that end, our recommendations are as follows.

Number one, APA strongly supports requiring key training for all community providers, including those providing care through separate VA-funded grant programs. The RECOVER Act provides 60 million in grants to mental health facilities serving veterans, but does not require clinicians to meet the training standards expected of VA providers. Notably, suicide prevention training is not mandated even though the bill targets areas with high veteran suicide

risk. Veterans deserve clinicians who understand military culture, common service-related conditions, and VA medical clinical expectations.

Number two, APA leads with psychological science and emphatically recommends the use of treatments scientifically proven to be effective for the assessment and treatment of mental health disorders. The RECOVER Act does not require provider training in evidence-based practices, leaving a significant gap in provider readiness to treat conditions disproportionately impacting veterans, such as post traumatic stress, depression, and substance use disorders.

Additionally, the BEACON Act risks weakening longstanding VA leadership in traumatic brain injury research and treatment by creating a parallel research pathway outside existing rigorous VA processes. The VA's evidence-driven system has contributed to some of the most impactful TBI advances. Any new framework should reinforce, not bypass, that scientific rigor.

Number three, APA supports requiring facility accreditation and strong quality assurance for any grantee providing mental health services to veterans. The RECOVER Act does not require accreditation by the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities, diverging from accepted VA standards. Moreover, legislation should require standards for demonstrating improved clinical outcomes. Without outcome measures and enforcement, neither Congress nor the VA can assess impacts on veterans, positive or negative.

Number four, effective mental healthcare relies on coordinated care supported by shared health records. Removing the VA as the coordinator of care and creating increased fragmentation of services could worsen continuity of care challenges that veterans already experience. APA recommends requiring all community providers to participate in timely medical record exchange with the VA. This ensures clinicians have the full health history needed to provide safe and consistent care.

Number five, APA supports efforts to give veterans the information they need to make informed decisions about their care. We are encouraged by the creation of a publicly available directory for CHAMPVA healthcare providers as required in the Clarity on Care Options Act.

We also support the intent of the Veterans Mental Health and Addiction Therapy Quality of Care Act. However, the bill falls short in enabling meaningful comparisons and quality assessments.

It is an honor to represent the American Psychological Association and advocate for the essential work psychologists do for our veterans and military. As the spouse of a disabled Army veteran, who is with me here today and who receives his care through the Hampton VA Medical Center, ensuring high-quality care across all settings is deeply personal to me.

Distinguished members of the subcommittee, we know that each of you are earnest in your commitment to improve veteran healthcare access and quality. The VA remains a national leader and we stand ready to work with you on these legislative endeavors. Thank you.

[THE PREPARED STATEMENT OF K. CONWELL SMITH APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Ms. Conwell Smith. Thank to all of our witnesses for their thoughtful input.

Ranking Member Brownley, you are now recognized for 5 minutes for any questions you may have.

Ms. BROWNLEY. Thank you, Madam Chair.

Thank you, Ms. Smith, for your testimony. Ms. Smith, as written, the BEACON Act would be paid for by diverting funding from existing VA mental healthcare programs and from VA's National Center for Post-Traumatic Stress Disorder (PTSD). Can you expand on how diverting these funds will impact VA's ability to provide clinical care and continue to conduct research through programs?

Ms. SMITH. Thank you for that meaningful question. The VA's National Center for PTSD is a recognized leader across all of our healthcare system. I think the concern is that sidestepping scientific rigor of the VA and the gains made in PTSD and TBI research could potentially cost much more than money. It could cost clinical advancements. I think working how—figuring out how different entities work in tandem, but maintaining very high level of standards and not defunding the VA is a critical approach.

Ms. BROWNLEY. Thank you. Thank you for that. You know, I asked this question of the second panel, but I was curious to know if you are aware of any statutory or practical barriers to VA either through its existing research infrastructure or academic affiliations programs.

Ms. SMITH. I am not.

Ms. BROWNLEY. Thank you. I also noted in my opening statement that I have concerns about the weak oversight mechanisms of the grant program that would be created by the RECOVER Act. Ms. Smith, I would like to get your take on whether the RECOVER Act is robust enough from a clinical perspective. From your read of the bill, would it expand existing services or improve quality of care for veterans?

Ms. SMITH. I think as far as expanding services, my read of the bill is that it does not necessarily do so. It allows grantees to bill the VA and other insurers and also receive a $1.5 million grant with no require to treat higher numbers of veterans.

On the quality front, unlike VA facilities, the bill does not impose accreditation requirements, peer review processes, or evidence-based treatments or training in those evidence-based treatments. I believe that it requires one provider to be trained in cultural competency. Obviously, APA feels very strongly that all providers of mental and behavioral healthcare should receive core competencies training.

Ms. BROWNLEY. Thank you. Are there any requirements in the bill that would ensure grantees engage in care coordination of the VA, returning medical records, or making sure veterans receive follow-up care from VA?

Ms. SMITH. I do not believe that the bill mentions transmitting records to the VA. Of course, there is not a requirement to join the community care program where oversight exist. You know, there was a recent U.S. Government Accountability Office (GAO) report that demonstrated that 33 percent of VA referrals to behavioral health in the existing community care program were missing the initial visit record. This is a very serious problem and I really ap-

preciate that members of the committee were addressing the importance of shared record exchange to quality of care.

Ms. BROWNLEY. Thank you. Another question. Is there any way that Congress would know whether the RECOVER Act grantees are following evidence-based practices in the provision of care for veterans?

Ms. SMITH. I do not believe, without a requirement, I do not believe that there would be an ability to know. I think oversight and accountability require processes that I am not familiar with regard to this bill.

Ms. BROWNLEY. What kind of clinical outcomes would you expect to see reported following the provision of care by a RECOVER Act grantee versus similar care delivered by the VA?

Ms. SMITH. Well, we are encouraged that the bill does mention clinical outcomes, but it is a vague word without, again, requirements and a building structure. Without evidence of grantee level effectiveness, how can Congress or the VA know what the positive and negative impacts are on veterans? We do not know that those care outcomes would be related to symptom improvement, for example. I think we could look to the congressional report on the Fox grants to demonstrate that if you do not have requirements and you do not have enforcement, there might be little there to be able to evaluate a program's effectiveness.

Ms. BROWNLEY. Thank you for that and I will yield back. I will just say that, you know, I certainly respect the intentions of this bill, but I just feel like it needs more accountability, more guardrails to ensure evidence based practices and quality of care.

I yield back.

Ms. MILLER-MEEKS. Thank you, Ranking Member Brownley.

The chair now recognizes Representative King-Hinds for 5 minutes for any questions she may have.

Ms. KING-HINDS. Thank you, Madam Chair.

First of all, Mr. Whaley, great to see you again. It was great meeting you the other day when we had the BEACON Act press conference.

Mr. WHALEY. Yes, ma'am.

Ms. KING-HINDS. Honorable Charles Uwakwe. A lot of my questions are going to be focused on conversations about the RMI and my legislation that expands the—not expands, but actually upholds the current statutory requirements to extend VA benefits to our Freely Associated States citizens. Let us just start off by having you describe what are the most unique challenges that our vets face in the Freely Associated States and how many of them are actually returning home.

Mr. PAUL. Well, thank you. Thank you very much, Congresswoman, for that.

Some of the unique challenges that our vets are experiencing living in the Marshall Islands, basically, as outlined in my statement, healthcare, I mean, a lot of them did not identify that they are veterans when they get healthcare because there is no benefit for them to do so. Also there are different types of, like, healthcare needs that the Islands are just not equipped to provide because we do not have wars or combat zones near anywhere around our is-

lands. There are certain things like PTSD, things of that nature——

Ms. KING-HINDS. Okay.

Mr. PAUL.—that we are seeing.

Ms. KING-HINDS. That is kind of what I wanted to get into in terms of the types of actual physical conditions, whether it be PTSD or any type of visible injury. Right?

Mr. PAUL. Right. Yes. Like, visible injuries, things like, you know, lost limbs from being Active Duty, but also mental, a lot of mental issues and mental health issues where a lot of folks that, you know, commit suicide in veterans. Just a couple months ago, a veteran jumped off a ship, and there is really no treatment facility for—we have one psychiatrist in the Marshall Islands for the whole country. The veterans are not getting the care that they deserve.

Ms. KING-HINDS. You heard the conversation, the dialog that I had with the VA in the previous panel and, you know, you heard the challenges that they race with regards to the transportation of medication and whatnot. Right? The shipping issue and the different statutes that are required to be negotiated. I think it would be helpful for the panel to kind of hear what your healthcare system sound—what it is actually, what is there, because when you hear that description, it makes it seem as if you have zero healthcare facility and no medication is currently being shipped in. I mean, in your testimony, you pointed out that there is actual Department of Defense presence there, which I assume, you know, there is regular goods and commodities that are being brought in through DOD. Can you just speak on that with the very little time that we have?

Mr. PAUL. Sure. Thank you so much.

Yes, so we have dispensaries and hospitals that are being built by compact funds for over the past 35 years. We have doctors that are trained and licensed from the United States in the Marshall Islands. In fact, if I may speak to about September 2024, we started engaging the VA to discuss—do environmental scans and what the facilities are in the Marshall Islands. I believe about January, February 2025, we are this close to starting negotiating an agreement. That was about less than 6 months going back and forth. We would hold monthly meetings with the VA. You know, we are this close to executing an agreement that would resolve a lot of the issues that were brought up today, so. I believe we can get there, we will keep talking and try to come up with an agreement so we can provide the healthcare that is needed.

Ms. KING-HINDS. Okay. Thank you for your time.

I yield back the remainder of my time.

Mr. PAUL. Thank you.

Ms. MILLER-MEEKS. Thank you. The gentlewoman yields back.

The chair now recognizes Dr. Dexter for 5 minutes from for any questions she may have.

Ms. DEXTER. Thank you, Chair Miller-Meeks, and thank you to our ranking member for her service here. It is going to be very sad without you here on our subcommittee and a year we have.

Ms. Smith, thank you so much for coming and I very much appreciate that your statement reflects your organization's commit-

ment to high-quality, outcomes-driven, and accessible healthcare for our veterans. As you said, for our veterans, those things are often best possible when veterans have access to clinicians and facilities that are accredited and fully trained and really culturally competent.

I also just want to shout out the outcome transparency and accountability that you referenced because it is really crucial. I am a physician, was honored to practice in a VA. It is crucial for making sure that what we think is science-based is actually driving better outcomes for our patients. Thank you for calling that out.

Last thing I wanted to highlight is your statement about medical record exchange. Having provided care in a VA as well as a community care provider, I cannot list how many times we led to redundant care or subjected people to recurrent, repeated, unnecessary treatments because we did not realize they had already been given somewhere else.

I want to ask some questions related to the Health Desert Reform Act, which I will reiterate as very well intentioned. We have to be able to provide community care to our veterans when they do not have access to a VA that can give timely care. That is absolutely. This is not a political issue. This is a priority issue that I think we all share here.

The section of the bill on oversight, I will just note, is less than a page long and it includes rather vague requirements that the VA Secretary track access, cost, quality, and veteran satisfaction for each hospital that enters into an agreement under the bill. Ms. Smith, do you have confidence that this requirement will be sufficient to ensure the care delivered by those hospitals is of equivalent or superior quality to the care delivered by a VA facility?

Ms. SMITH. As it is currently written, I do not feel like there is the structure to give me that confidence. Am I encouraged that it could be? Certainly. I just think as it is written right now, no. I would have to say no.

Ms. DEXTER. I share that concern. Under this bill, there appears to be very few parameters placed on pilot program eligibility. It does not stipulate that for-profit or private equity-backed hospitals cannot take advantage of the program nor does it require that a hospital be located in an area with a demonstrated wait time or drive time issue. In your opinion, what risks does this pose in terms of possible exploitation, overutilization, or unnecessary duplication of services?

Ms. SMITH. APA has long been concerned that unfettered growth in the community realm without accountability could have a negative impact on the integrated care system of the VA. We do share that concern. I think there, again, I do think that there are structures even in the community care program that provide more oversight that could be applied in this case.

Ms. DEXTER. I just want to highlight an issue that I have raised in this committee that the VA budget, unfortunately, is a zero-sum game. If we take it from VA facilities to provide this care, it does not come back. This bill includes no cap on the amount of funding that can be used to furnish care through the arrangements that it authorizes. That means it is entirely possible that we could siphon large amounts of funding away from the VA where we know our

veterans get the highest quality and best satisfaction. This has been documented, and for uncertain quality and it may or may not be necessary. Is that your concern as well?

Ms. SMITH. It is our concern. You know, we are down 300 psychologists over just this past year and we know that the demand for mental health treatment within the VA is skyrocketing. I think that, you know, using funds to also invest in the VA's ability to meet the demand by staffing is a really important piece of the puzzle. If money is going from one place to the other, how can we reinvest there as well?

Ms. DEXTER. With my last few seconds, I just want to underline that because I have heard that even physicians who have long been practicing, at least in our Portland VA, that they cannot get their patients in for appointments because the staff who help coordinate or get them in for those appointments have been dismissed. It feels like right now we should be underlining the commitment to making sure veterans have access to the VA facilities that we have already funded.

Thank you. With that, I yield back.

Ms. MILLER-MEEKS. Thank you. The gentlelady yields.

The chair now recognizes General Bergman for 5 minutes for any questions he may have.

Mr. BERGMAN. Thank you, Madam Chair. Mr. Whaley, good to see you again.

Mr. WHALEY. Good to see you, sir.

Mr. BERGMAN. Just like a couple of days when we are out on the lawn or over, you know, presenting on what you all do, and you do it very well.

Mr. WHALEY. Thank you.

Mr. BERGMAN. In talking with veterans in my district and across the country, it is clear that mild chronic TBI is far more common than is often recognized, frequently missed and undiagnosed. This prevalence seems to exceed what the VA's current clinical footprint alone would suggest. With only five polytrauma centers nationwide, the current system simply does not have the capacity to meet the full scope of need. The question, why is additional targeted funding necessary? What kinds of community partners, nonprofits, or academic centers are best positioned to extend that care and innovation beyond the VA's walls?

Mr. WHALEY. Thank you, sir, for that question. We listen to veterans, we take their opinions in an unbiased, unfiltered way, and then we share it, of course, with all of you and with the media as well as our fellow veterans. It is clear when we speak to them that they want to be able to have the ability to get treatment early on in this process before it exaggerates, before it grows, before it affects their job, before it affects their family. It is a spiraling effect, right? When one thing goes bad, then the next and then the next, and before we know it, we are on a slippery slope to a bad place.

When we can get to this early and get treated and get the access to healthcare in a proper way, then we can mitigate that. We can slow it down. We can get them the assets and the technology and the medication in some cases that they need.

When I think about organizations that are doing great work here, I think about the Avalon Action Alliance, which has a num-

ber of facilities and partners across the country that right now are doing that, God's work for helping veterans with TBI, sometimes very mild, sometimes very severe. They are doing it in a way that is very costly to them and not sustainable long term for them to do without getting support.

I think it is important for us to realize that this is a national issue, just not a veteran issue, and that if we cannot solve TBI for those that have served our country, then we are not going to be able to solve TBI for our citizens. I think it is important to invest in this. I think it is important to make sure we have the assets to do that. We bring the best and brightest organizations to take a look at this.

Obviously, we need guardrails. Right? I mean, there has to be checks and balances to make sure that this is done in the right way. I applaud the efforts of those on this committee and all of you for your work.

I think everybody has the best intentions here and we want the very best for our veterans and their families. I say their families because if you have one veteran that has this problem, it affects his spouse, it affects the children. When we think about it, there is 18 million veterans in our country. When you think about those dependents, you are now talking about 30 or 40 million Americans that this impacts. Right now we are only having access through the VA to half of those veterans. This is a big problem. Thank you.

Mr. BERGMAN. Yes, thank you. I noticed that at Mission Roll Call and I took a photo of the backdrop. It said, "The key word takeaway is listening." In any conversation or any dialog, at least one entity has to be listening. Thank you for being a listener.

Ms. McCoy, if this research leads to clear evidence of what works, how could that improve day-to-day care for veterans living with TBI?

Ms. MCCOY. Thank you for that question, sir. I would like to echo many of Mr. Whaley's points here, that it really is our belief that innovation can come from anywhere. We are committed to efforts that reduce suicide risk among veterans living with long-term effects of brain injury, and that is a population that we serve regularly.

I believe that all of these efforts collaboratively can be streamlined, as you point, under the Fox grant. Ultimately, it is going to improve alignment, avoid duplication of care, and really improve medical outcomes for veterans.

Mr. BERGMAN. Thank you. You know, this is not—we talk about in weapons system, fire and forget. What we are trying to do here is not a fire and forget. We just throw something out, create the beacon. You know, whatever it is we are trying to do, the therapy, it is not a fire and forget. We got to keep working it because things are going to change.

With that, Madam Chair, I yield back.

Ms. MILLER-MEEKS. Thank you, General Bergman.

The chair now recognizes Dr. Morrison for 5 minutes for any questions she may have.

Ms. MORRISON. Thank you, Madam Chair and Ranking Member Brownley. I reiterate Dr. Dexter's comments. Thank you for your service and for your mentorship. You will be dearly missed. Thanks

to each of the witnesses testifying before the committee today, grateful for your presence.

In Minnesota, I represent Minnesota's Third District and we are very proud of the Minneapolis VA. It goes above and beyond for veterans in our State. While certainly a testament to the leadership and community in Minnesota, this recognition is also a timely reminder of how critical healthcare workers are to the success of VA. Intentionally tackling this burnout underscores how important investing in the VA workforce is and our ability to deliver on the promise that we have made to our veterans.

Having myself been one of the 70-plus percent of American doctors who has completed part of their medical training at a VA hospital, it also leads me to think about the unique challenges that veterans face when it comes to mental health, substance use disorder, and overdose risk. As our country struggles with the opioid crisis nationwide, my heart breaks for our veterans that research has repeatedly shown to be at higher risk of death from overdose, further complicated by chronic pain, service-related injuries, or other service-related trauma.

A major part of what compelled me to serve in Congress was my firsthand experience as a doctor seeing how difficult navigating our healthcare system can be. Helping veterans face unique challenges and elevated risk requires intentional work to break down those barriers.

Now, as a member of this committee, I am honored to have the opportunity to lead policies that will help meet veterans where they are. That is why I am proud to have joined with another experienced doctor, Congressman Conaway, to introduce H.R. 5999, the Veteran Opioid Emergency Treatment Act. This bill would reduce the barriers veterans face to accessing naloxone, a life-saving medication that can rapidly reverse an opioid overdose. Medication that would be life-saving in such critical moments should not be out of reach to veterans as a result of cost or difficulty scheduling appointments. I am grateful for the bill's inclusion in today's hearing and I look forward to continuing to work with Dr. Conaway and my colleagues as the bill moves through the committee.

Ms. Smith, could you elaborate on the importance of a consistent systemwide approach to ensuring timely access to naloxone? Why is this access and consistency of particular importance for veterans?

Ms. SMITH. Well, thank you for the question. Recognizing the conditions that disproportionately impact veterans is part of how we approach treating them. We are recognizing that there is definitely a sensitivity to substance use disorder and we must do all that we can to prevent unnecessary veteran death.

Ms. MORRISON. Thank you. In your testimony you highlight the importance of training an exceptional healthcare workforce. How does investing in VA providers protect the quality of care that veterans receive?

Ms. SMITH. Well, you mentioned already in your comments about being part of the 70 percent who receive their training in the VA. I have the pleasure of working with VA psychologists who are just tremendous public servants, but they also spend time training the next generation of mental health providers. I think a lot of times

it is lost that the VA is not only important to our veterans, which is first and foremost, it is important to each and every one of us because they really are training the healthcare workforce.

If I can add, because you mentioned burnout earlier, we are finding more and more psychologists' clinical time is being taken up to—you know, their entire day is filled with clinical scheduling and it is not leaving the time for clinical—for training supervision. That concerns us because I do think that there are training programs at certain VA facilities that are dying on the vine only because they do not have the time and the people to foster the training.

Ms. MORRISON. Thank you so much. Madam Chair, I yield back.

Ms. MILLER-MEEKS. The gentlelady yields.

The chair now recognizes Representative Kiggans for 5 minutes for any questions she may have.

Ms. KIGGANS. Thank you, Madam Chair, for just conducting the hearing today to talk about important pieces of legislation that will improve access to care for our veterans throughout the VA. Included in the hearing today is my legislation, the Clarity on Care Option Act.

CHAMPVA is vital for caregivers and dependents of permanently disabled veterans. It ensures they can continue to support the veteran in their lives and still receive the healthcare services they require. To support our veteran caregivers in finding providers more easily I introduced the Clarity on Care Options Act, which directs the VA's Community Care Network to create a public-facing list of all providers who are in-network for CHAMPVA enrollees. It is important for patients, for providers. There is a lot of confusion and the more we talk about all the other great issues we talked about today from mental healthcare, how we are addressing addictions, continuity of care issues, all the things we are working on, I need my veterans out there to know, to have kind of a directory so that they can find where the community care partners are. That is just what my bill does, is just establish this directory. We have so many and some of the great places our veterans live, like Hampton Roads, and just I think it would be a great addition to complimenting care. I just had a couple questions.

First to Ms. McCoy. What barriers do you see eligible families most commonly facing when they are enrolling in CHAMPVA? What barriers do they face after having access to the program?

Ms. MCCOY. Thank you so much for your question, Representative Kiggans. Surviving families and caregivers often face heightened mental health risks and require consistent and comprehensive support. We are in support of this bill and fully encourage efforts to expand information on how to access essential healthcare information. We believe that a national registry provides a powerful tool for these beneficiaries to secure the care and support that they deserve.

Ms. KIGGANS. Great. Thank you. Are there specific populations such as surviving spouses, caregivers, or dependents with disabilities, who face disproportionate challenges accessing CHAMPVA?

Ms. MCCOY. Absolutely.

Ms. KIGGANS. Which would you say or what are some of the more challenged groups?

Ms. MCCOY. To my understanding, survivors and dependents.

Ms. KIGGANS. I would agree with that, too. Again for Ms. McCoy, what are the most common reasons CHAMPVA claims are delayed or denied?

Ms. MCCOY. Truthfully, I would have to come back to you on that answer.

Ms. KIGGANS. I think a lot of times our veterans probably access just either Google searching or, you know, look, even hearing from friends. They make appointments and they are seen and then they find out after the fact that those were not in the network, which is what this bill is hoping to prevent.

Last question for Ms. McCoy, what factors contribute to delays in enrollment and what steps could reduce those delays?

Ms. MCCOY. At this point, I would say perhaps the Veterans Integrated Service Network (VISN) restructure, although yet it has not been implemented. We do not know what those changes will look like, but I am hopeful that we will see positive outcomes with the VISN restructuring.

Ms. KIGGANS. Good. I hope so, too. Again, I think just a directory and really I would like to see an overhaul of even just logging onto the VA system. Sometimes, you know, as a veteran, married to a veteran, and even daughter of veterans, just for me personally logging on, that log on process can be simplified. Even finding GI Bill, you know, health benefits, VA home loan, there is all the benefits that are there, but I just need my veterans to be able to access and understand that. Hopefully, this CHAMPVA piece will at least provide a little bit of clarity for our community care partners.

I have a quick question then for Ms. Conwell Smith, and welcome. I know you are from my hometown in my district. Have you heard from psychologists that service CHAMPVA that are having trouble just servicing our beneficiaries? What is the most common issue that psychologists are running into?

Ms. SMITH. I have not heard this directly, but we can certainly go back to our membership and gather more information about this. I think that you highlighted challenges of navigation of any veteran and their family, and I think those of us that are in veterans families know those, oh, too well.

Ms. KIGGANS. Yes, very much so. I know just psychologists are important care partners for us and there is a shortage of mental healthcare providers and we often speak of mental health, but thinking of the people who provide the mental health, we need to do more of that and making sure that the providers know, too. Then the patients have a directory, but there is clarity kind of on both sides. That is what we hope to accomplish with this bill.

Thank you so much and I yield back.

Ms. MILLER-MEEKS. The gentlelady yields.

I now recognize myself for 5 minutes to ask questions.

This is a question both for Mr. Whaley and Ms. McCoy and then Ms. Conwell Smith. I realize that you are not clinicians per se, but as I have listened to the testimony, the questions today, and the bills before us, I am thinking about the blast injury, mild TBI, so, i.e., a wave, shockwave, but not an actual concussion, and how difficult that is and we do not test for that. Would there be some validity to either an algorithm-based test and/or screening prior to discharge from the military for those individuals who during their

training, although they may not be in combat, but during their training may have exposure to a blast neurotrauma and not a TBI or concussion in the typical diagnosed fashion?

Mr. WHALEY. Thank you for that insight and question. We could not agree more. We have talked to a number of veterans, either in our roundtables or in our polling, and found out that—and find out on a systemic basis that many times someone does not know they have had a TBI until a number of things have happened. By then you are kind of picking up the pieces versus getting——

Ms. MILLER-MEEKS. Yes. I realize the brain activity and connections may be very different than what you see in a TBI.

Mr. WHALEY. Right.

Ms. MILLER-MEEKS. I do not have a lot of time because I want to ask other questions. Ms. McCoy.

Ms. MCCOY. Thank you for your question. I think it directly leads into H.R. 6444, which is the establishment of the task force, where we are able to begin to accumulate and/or leverage currently collected data on the DOD side of the House and allow that full migration of information to accompany the servicemember as they move into veteran status.

Again, to your point, we know that blast overpressure has been kind of linked to cumulative neurological effects. How those build in each veteran and servicemember over time are so distinct that at this point, you know, we do not know what we do not know. Investment in research and innovation is just key. I think this task force will be an important infrastructural step to that goal.

Ms. MILLER-MEEKS. Thank you. How could the pilot, and some of these bills that we presented today are discussion bills, so I appreciate all the input from all of our members and our witnesses, how could the pilot in the Health Deserts bill reduce travel burdens or delays for care and veterans?

I can assure you in Iowa, especially northwest Iowa, but even in my district, veterans may have to travel 2 hours to go to a VA facility clinic, which has lesser services. In many states, including Texas, a very populated State, that drive can be over that. If you are talking about a visit for coordinated care or whatever type of care you want, that could be a 5-hour travel time just back and forth without including the physician visit. Ms. McCoy.

Ms. MCCOY. Thank you very much. I appreciate and agree with your point. I think that this is filling a crucial need. I mean, you think about a veteran that is maybe going to a hospital where certain providers or certain care modalities are covered under the community care network and others may not. An initial appointment may be covered, but a scan or, you know, some sort of Magnetic Resonance Imaging (MRI) may not be covered. That fragmentation of care has to be incredibly frustrating. It is inefficient and ultimately it is a barrier to care. A streamlined contractual agreement can produce positive outcomes for veterans.

Ms. MILLER-MEEKS. Thank you. Ms. Conwell Smith, and as a physician and a veteran, I appreciate your focus on clinical outcomes. Do you consider it a favorable clinical outcome for 17 percent of veterans to still die by suicide? Has the VA been successful? Is that a good clinical outcome measure?

Ms. SMITH. I would go back, thank you for the question, I would go back to the advances and progress within the VA when it comes to mental health treatment and effective treatments for mental health disorders, which I think have been extraordinary.

Ms. KIGGANS. Thank you.

Ms. SMITH. We do not want one veteran suicide.

Ms. KIGGANS. Neither do we, but that certainly is a clinical outcome and we have not move that needle. I think looking at approaches that deliver care to veterans, whether it is through telemedicine, community care, VA care, an algorithm-based care, new research, I think it is important. All of us on this committee want to make sure that, number one, PTSD, veteran suicide, that TBI veterans are getting the care that they need.

Then last, let me just say, Ambassador Paul, I do not have a question for you, but I just wanted to thank you for coming, for testifying today and coming this long way to make sure veterans in your area in the Marianas Islands and the FAS are—that their needs are met as well, too. I did not want you to leave without my personal thank you.

I thank the witnesses for being here today. Just in closing, I think we are looking at some bills, discussion drafts. I appreciate all of the input.

Then Ranking Member Brownley, do you have any closing remarks you would like to give?

Ms. BROWNLEY. I do not think so, but I think, you know, there have been a lot of good bills here today and that, you know, certainly require serious consideration. I think we have had a good discussion on many of these bills and ways in which they can be improved upon so that we can move them forward.

I yield.

Ms. MILLER-MEEKS. Thank you, Ranking Member Brownley.

On behalf of the subcommittee, I want to again thank all of our witnesses and members, including the VA who is on the first panel, Dr. Koeniger and Dr. Llorente, for being here today. I look forward to working with you to address the issues facing our veterans and also the suggestions that we have had from our witnesses and our members today. The complete written statements of today's witnesses will be entered into the hearing record.

I ask unanimous consent that all members have 5 legislative days to revise and extend their remarks and include extraneous materials. Hearing no objection, so ordered.

This hearing is now adjourned. Please, this room is being used immediately after this, so when the meeting is adjourned, please exit the hearing room. Thank you.

[Whereupon, at 4:19 p.m., the subcommittee was adjourned.]

A P P E N D I X

PREPARED STATEMENTS OF WITNESSES

Prepared Statement of Mark Koeniger

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
SUBCOMMITTEE ON HEALTH
U.S. HOUSE OF REPRESENTATIVES
JANUARY 13, 2026

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.

Position: 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.

Prepared Statement of Charles Rudolph Paul

Chairman, Ranking Member, and Members of the Subcommittee,

Thank you for the opportunity to testify on the U.S. Vets of the FAS Act, H.R. 6652, sponsored by Delegate King-Hinds and four other Members of the House, including Delegate Radewagen.

The Marshall Islands and the other FAS, Freely Associated States, were formerly administered by the United States as parts of a territory, but now are in the closest of possible relationships between sovereign nations with the U.S. We are the only three nations in free association with the U.S. Our associations are enshrined in compacts enacted into U.S. law.

Under these associations, we let the U.S. exercise a fundamental aspect of our sovereignty: Determining whether other nations can access an area the size of the 48 contiguous United States from Hawaii to Asia.

Our nations also host U.S. military bases. In my Marshall Islands, the Joint Chiefs of Staff say that the facility is the world's premiere range for testing ICBMs and military space operations support. Because of our location and the strategic rights that we let the U.S. exercise, our democracies are targets of aggressive efforts to weaken our alliances.

The U.S. military, additionally, recruits in the Freely Associated States as if we were U.S. States. It enlists our citizens at rates that are higher than the enlistment of U.S. citizens in most U.S. States.

Sadly, however, our U.S. military veterans are effectively compelled to remain in the U.S. after their service because they cannot receive the same healthcare if they return home.

This was a major issue in the renegotiation of our free association, which culminated in the enactment of the Compact of Free Association Amendments Act of 2024. The law was intended to resolve the issue. By agreement, it included provisions to have this healthcare available in our islands—as this Congress emphasized in November's Continuing Resolution and December's National Defense Authorization Act.

The Department of Veterans Affairs, however, has not acted to make the care available. It has acted contrary to what we negotiated, and Congress has said is the intent of the law.

The Government of the Marshall Islands, therefore, strongly supports the enactment of legislation to ensure that our veterans can receive the care if they return home.

This issue is personal at the highest levels of our government. The Minister of Foreign Affairs and Trade of the Republic of the Marshall Islands, Hon. Kalani R. Kaneko, is himself a retired United States Army veteran who honorably served for 20 years, qualifying him for full retirement under U.S. military service. During his military career, he served as an Army recruiter for more than a decade, actively recruiting across the Marshall Islands. Through that service, he recruited approximately 200 Marshallese men and women into the United States Armed Forces—individuals who answered the call because they trusted the United States, believed in the partnership between our nations, and were willing to serve wherever they were sent. Minister Kaneko has dedicated his life in service to the United States and its mission. Today, I respectfully ask the United States to stand by Minister Kaneko, and by the patriotic men and women he recruited, by ensuring access to the veterans' health care they have earned.

This issue is also personal to me.

My younger brother medically retired after 13 years of service in the United States Army, including three combat tours in Iraq. He retired due to injuries sustained during deployment. Today, he lives in the Marshall Islands,—and does not have access to health care he would have if he had not returned home.

My nephew is currently serving on active duty in the United States Army. He wants to return to the Marshall Islands 1 day to live, to raise a family, and to serve his community after he retires from military service. But he worries about whether he will be able to access health care if he comes home. That concern should not be the deciding factor in whether a U.S. veteran can go home after their service.

Importantly, access to veterans' health care in the Marshall Islands is not a new request, nor is it discretionary. It is explicitly contemplated in U.S. law and in treaty obligations.

Section 209(a)(4)(A) of the Compact of Free Association Amendments Act of 2024 directs the United States to enter into agreements to ensure the provision of veterans' services in the Freely Associated States. Congress made clear that geography should not exclude veterans residing in the Marshall Islands, the Federated States of Micronesia, or the Republic of Palau from the care they have earned.

That Compact obligation works in tandem with Section 1724(f) of title 38, United States Code, which authorizes the Department of Veterans Affairs to furnish hospital care and medical services outside the United States pursuant to agreements with foreign governments. Together, these provisions establish both clear authority and clear congressional intent.

The Freely Associated States are unique. We are the only sovereign countries in the world where the United States is permitted—by international agreement—to conduct active, routine military recruiting nationwide, without restriction as if our nations were U.S. territories. If the United States can actively recruit in the islands as if we were U.S. territories, it is reasonable—and just—that it provides care in the islands as if we were U.S. territories.

This is not only a moral obligation. It is a national security issue for both of our countries.

Veterans living in the Marshall Islands are a stabilizing force. Their presence strengthens local institutions, reinforces trust in the RMI–U.S. relationship, solidifies a vital international relationship, and serves as a deterrent to malign influences that seek to undermine this partnership.

Veterans who return home bring critical skills acquired through military service—engineering, logistics, health care, leadership, disaster response, and technical trades—that directly support national capacity-building in the Marshall Islands.

From a practical standpoint, the current gap in care creates an excessive hardship for veterans if they come home. They must fly thousands of miles for routine appointments or prescriptions—at huge personal expense and often delaying care. Telehealth services, mail-order pharmacy delivery, and travel support are practical, cost-effective solutions.

The Republic of the Marshall Islands stands ready to work constructively with Congress, the Department of Veterans Affairs, and the Administration to implement what the Compact Act of 2024 already promises.

Our veterans kept their commitment to the United States. 2024's Compact Amendments reflects the United States' commitment to them. Implementing equal veterans' health care in the Freely Associated States is not an expansion of benefits—it is fulfillment of an obligation.

Thank you. I look forward to your questions.

Prepared Statement of James Whaley

Good afternoon, Chairwoman Miller-Meeks, Ranking Member Brownley, and Members of the Health Subcommittee.

Thank you for the opportunity to testify today on behalf of Mission Roll Call and the veteran community. Our mission is straightforward: we collect data from veterans, and we make sure that data helps inform decisions made in Washington. We use polling and direct engagement to bring real, unfiltered veteran perspectives to policymakers and the public. Amplifying this data on behalf of veterans and their families allows us to advocate for meaningful change that improves the lives of those who have served.

The legislation under consideration today seeks to address issues and improve the lives of multiple generations of veterans, addressing traumatic brain injury, suicide prevention, access to care in remote or rural areas, mental health, opioid addiction, and more. Mission Roll Call's survey data shows a strong need within the veteran community to address these issues in ways that place veterans first and delivers care when and how a veteran will benefit most.

One area where that need is especially clear is suicide prevention and mental health care delivered outside of VA facilities. In Mission Roll Call's national suicide prevention polling in July 2025, nearly 80 percent of veterans told us that preventing suicide requires clinical treatment and community-based support working together, not in isolation. More than 90 percent said it is extremely or very important to include community-based organizations in prevention efforts, and an equally strong majority emphasized the importance of training, coordination, and accountability.

The RECOVER Act reflects those priorities by strengthening evidence-based mental health capacity in the community, ensuring providers are trained to understand veteran risk, and requiring outcome reporting so Congress and the VA can assess what is actually working. To veterans, this is about a system that meets veterans where they are, especially when timely access to care can be the difference between stability and crisis.

While suicide prevention often brings veterans into the mental health system, many of the underlying drivers of risk begin earlier and go untreated. Mission Roll Call's survey data shows that over 95 percent of veterans say it is extremely or very important to have access to specialized TBI care, including care delivered outside the VA. Yet, among veterans seeking care for TBI-related symptoms, 73 percent report that accessing appropriate treatment is somewhat or very difficult.

The BEACON Act responds directly to that gap by creating a structured, evidence-based framework for evaluating innovative neurorehabilitation approaches for veterans with chronic TBI, including rigorous outcome measurement and independent evaluation. Veterans are asking the VA to test promising therapies responsibly, publish results, and expand access when evidence supports it. From the veteran perspective, the BEACON Act is about restoring function, reducing downstream mental health risk, and giving clinicians better tools to intervene before injuries compound into lifelong disability.

In addition, Mission Roll Call supports efforts to modernize veteran care by expanding evidence-based options while holding the system accountable for outcomes. The NOPAIN for Veterans Act moves VA toward broader use of effective non-opioid pain management therapies, while the Veterans Mental Health and Addiction Therapy Quality of Care Act ensures Congress and the VA have reliable, independent data on how mental health and addiction care performs across VA and community settings. These measures reflect what veterans consistently ask for in our surveys: care that is grounded in evidence, reduces risk, and is evaluated based on real-world results rather than assumptions.

Mission Roll Call has always advocated that geography should not determine whether a veteran receives timely care, and supports legislation that addresses access gaps for veterans who live far from VA facilities or outside the continental United States. The Veterans Health Desert Reform Act and the U.S. Vets of the Freely Associated States Act recognize this reality and seek to leverage community providers, telehealth, and mail-order pharmacy services to close those gaps.

We believe good policy starts with listening to the veteran community and ends with accountability. Veterans overwhelmingly seek better access to care in a manner that supports their life and family, rules they can easily understand, and outcomes that can be measured and improved. The legislation before you reflects meaningful progress toward those goals, and we appreciate the Subcommittee's continued focus on practical solutions that make the veteran and their family central to the provision of care.

Mission Roll Call has submitted a Statement for the Record that provides additional detail and supporting veteran data on these issues.

Chairman, Ranking Member, and Members of the Subcommittee, thank you, and I look forward to your questions.

Prepared Statement of Elizabeth McCoy

Chairman Miller-Meeks, Ranking Member Brownley, and distinguished members of the House Committee on Veterans' Affairs, Subcommittee on Health – thank you for the opportunity to submit Wounded Warrior Project's views on pending legislation.

Wounded Warrior Project (WWP) was founded to connect, serve, and empower our Nation's wounded, ill, and injured veterans, Service members, and their families and caregivers. We are fulfilling this mission by providing life-changing programs and services to more than 255,000 registered post-9/11 warriors and 60,000 of their family support members, continually engaging with those we serve, and capturing an informed assessment of the challenges this community faces. Rooted in this experience, we are pleased to provide our perspective on pending legislation that would likely have a direct impact on many we serve.

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

In response to WWP's most recent Warrior Survey, 76 percent of warriors reported having (or experiencing) post-traumatic stress disorder (PTSD), with nearly half presenting moderate to severe symptoms. PTSD, anxiety, and depression have continually ranked among the top mental health issues among warriors. Mental health and suicide prevention continue to be top priorities for WWP, and we support an approach that integrates both government as well as non-profit and private orga-

nizations to help increase access to timely mental health care that addresses these health challenges.

The *RECOVER* Act would authorize grant funding for non-profit organizations that provide evidence-based mental health treatment services to veterans in outpatient facilities. Funding would aim to ensure that programs serve all interested veterans with care, at no cost. Communities that are medically underserved, have large veteran populations, or have large numbers of veterans at high risk of suicide would be key recipients. Grantees would be required to educate care recipients about eligibility for Department of Veterans Affairs (VA) healthcare and encourage enrollment.

While WWP appreciates the need to keep VA as a coordinator of unfragmented clinical care, we believe that it should embrace grants to direct care programs. According to VA's 2024 National Veteran Suicide Prevention Annual Report, an average of 17.6 veterans died by suicide each day in 2022, and less than half (40 percent) of those had used VHA services in the 2-years prior to their death. These grants may help connect those unconnected veterans to available and VA supported mental health resources within their communities. Additionally, this approach is particularly important given the unfortunate reality that there is some skepticism toward VA within parts of the veteran community and best reflects a commitment with putting veteran's needs first.

These figures indicate that a vast majority of veterans who die by suicide are not receiving mental health treatment from VA. Whether due to appointment hours, bad prior experiences, perceived stigma, or the thought that receiving care may take away an opportunity from someone who needs it more, many still choose not to pursue mental health care at VA or forego seeking help entirely. Mental health treatment works, but every individual has unique needs, and there is no one-size-fits-all solution.

In this context, we must do everything we can to ensure that there is no wrong door to seeking mental health care, even if the first step is taken in the community. This approach has been embraced within the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox SPGP), which has been a cornerstone of VA's community-based suicide prevention strategy since its launch. While "Fox Grants" can be used to provide baseline mental health screenings among many other upstream suicide prevention services, grants cannot be used for direct mental health care under current law. WWP supports reauthorization of the SSG Fox SPGP, and we encourage consideration to adopt the *RECOVER* Act into this system and buildupon a program already committed to improving mental health and preventing veteran suicide through early community-based intervention and support.

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

Comparative studies of VA and community-based care have drawn several conclusions that can inform public policy. Most recently, a 2025 Government Accountability Office (GAO) report, *Veterans' Community Care: VA Needs Improved Oversight of Behavioral Health Medical Records and Provider Training*, highlighted systemic oversight gaps in the Veterans Community Care Program (VCCP). Nearly 225,000 veterans used more than 357,000 behavioral health referrals between Fiscal Year 2021 and Fiscal Year 2023, yet 33 percent of referrals lacked initial medical reporting, and VA did not track final documentation, posing risks when veterans return for follow-up care. GAO also found that only 2 percent of community providers completed any of VA's eight core trainings, including opioid safety, suicide prevention, and military cultural competency. These gaps can weaken care coordination and quality assurance.

Unfortunately, these findings are not dissimilar to VA Office of Inspector General (OIG's) 2025 inspection of the Martinsburg VA Medical Center, which revealed fundamental breakdowns in leadership communication, lack of recovery-oriented programming, unclear discharge instructions, and non-compliance with suicide prevention and other trainings. These observations highlight systemic challenges in care coordination and lack of adherence to safety standards.

To address key quality gaps which exist in both VA direct care, as well as the Community Care Network (CCN), WWP supports the *Veterans Mental Health and Addiction Therapy Quality of Care Act*. This bill takes a critical next step by mandating an independent, outcome-based study comparing VA and non-VA mental health and addiction treatment using metrics such as symptom improvement, suicide risk reduction, and adherence to evidence-based practices. The bill seeks external benchmarking of care quality, including assessments of military cultural competency, integrated care coordination, and success of record-sharing and outcome

monitoring. This approach prioritizes comparative value and quality assurance, ensuring veterans receive the best possible care, wherever they seek it.

Wounded Warrior Project is pleased to support this legislation.

Discussion Draft: Veterans TBI Breakthrough Exploration of Adaptive Care Opportunities Nationwide Act of 2025 (BEACON Act of 2025)

By fostering creativity and innovation in neurorehabilitation and treatment methodologies for TBI, VA can close critical gaps in evidence and practice. For example, military-related TBI significantly increases the risk of developing new mental health conditions and, both directly and indirectly, raises suicide risk. Research also consistently shows that TBI is a major risk factor for suicide among veterans.[1] Findings like these underscore the urgent need for sustained investment in TBI research and care. By identifying mechanisms behind these risks and developing evidence-based interventions, we can improve mental health outcomes, accelerate recovery, and ultimately reduce suicide among veterans living with the long-term effects of brain injury.

One pathway to continued brain health innovation is through the *Veterans TBI Breakthrough Exploration of Adaptive Care Opportunities Nationwide Act of 2025 (BEACON Act of 2025)*, which establishes two major initiatives to improve care for veterans with chronic mild traumatic brain injury (mTBI), a condition affecting over 400,000 veterans since 2000.[2] First, it establishes the TBI Innovation Grant Program, a 3-year, $30 million initiative that authorizes VA to award individual grants of up to $5 million to nonprofits, academic institutions, and non-VA providers. These grants would support the design and testing of innovative, patient-centered neurorehabilitation treatments, prioritizing non-pharmacological approaches. Grants would also fund clinical studies to measure the effectiveness of these approaches in improving mental health outcomes and reducing suicide risk. VA would be required to align the program with the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox SPGP), issue regulations within 180 days, and require annual reports and evaluations.

Second, the bill would authorize a 3-year, $10 million research grant program to fund collaborative studies to pioneer new TBI treatment methodologies, including randomized controlled trials. The program would be overseen by an independent third party to ensure thorough evaluation and identification of evidence-based practices. It would also require annual reporting to VA and would be reviewed after the 3-year pilot to determine whether it should be reauthorized and/or expanded.

Wounded Warrior Project is pleased to support this legislation; however, we believe that more clarity on funding – which current bill language allows to be drawn from "amounts available [...] for general mental health care programs" – would help ensure that resources will not be diverted away from mental health services that veterans rely on.

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

Blast overpressure, a sudden spike in air pressure caused by an explosion or blast wave that exceeds normal atmospheric pressure, has been linked to cumulative neurological effects, including cognitive decline, neuroinflammation, and increased risk of traumatic brain injury (TBI) and psychiatric conditions, such as PTSD and depression. Studies have demonstrated that exposure to blast overpressure is linked to measurable brain changes, cognitive and gait deficits, and higher rates of TBI and mental health conditions among service members and veterans.[3] These findings were highlighted during a February 28, 2024, Senate Committee on Armed Services, Subcommittee on Personnel hearing where Dr. Lester Martínez-López, Assistant Secretary of Defense for Health Affairs, emphasized the need for comprehensive re-

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[1] *See, e.g.,* Lisa A. Brenner et al., *Associations of Military-Related Traumatic Brain Injury With New-Onset Mental Health Conditions and Suicide Risk*, JAMA NETWORK (July 2023), *available at* https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2807787; Rajeev Ramchand & Tahina Montoya, RAND, SUICIDE AMONG VETERANS (May 2025), available at https://www.rand.org/pubs/perspectives/PEA1363–1-v2.html.

[2] DEF. HEALTH AGENCY, U.S. DEP'T OF DEF., https://www.health.mil/Military-Health-Topics/Centers-of-Excellence/Traumatic-Brain-Injury-Center-of-Excellence/DOD-TBI-Worldwide-Numbers (last visited Jan. 9, 2026).

[3] *See, e.g.*, Andrea Diociasi et al., *Distinct Functional MRI Connectivity Patterns and Cortical Volume Variations Associated with Repetitive Blast Exposure in Special Operations Forces Members*, RADIOLOGY (Apr. 2025), *available at* https://pubmed.ncbi.nlm.nih.gov/40167438/; Kyle Bourassa et al., *Traumatic Brain Injury and Accelerated Epigenetic Aging Among Post–9/11 Members,* J. HEAD TRAUMA REHAB. (Aug. 2025), *availble at* https://pubmed.ncbi.nlm.nih.gov/40828005/.

search and insight to better understand risks, protect Service members, and improve brain injury treatment.

In this context, more comprehensive coordination between the Department of War (DoW) and VA can help drive progress to support Service members and veterans throughout and beyond the military lifecycle.

Currently, VA and DoW collaborate on TBI and blast injury research through the Traumatic Brain Injury Center of Excellence (TBICoE). However, gaps remain in integrating longitudinal data, coordinating research infrastructure, and conducting comprehensive long-term studies. Ultimately, these knowledge deficits limit the provision of premium care for those exposed to blast overpressure, particularly as Service members transition from active duty to veteran status.

H.R. 6444, the *Blast Overpressure Research and Mitigation Task Force Act*, aims to close these critical gaps through the VA–DoW Joint Executive Committee (JEC) and a new Blast Overpressure Task Force at VA. The Task Force would be required to establish physiological and cognitive baselines, align research agenda and acquisition strategies for blast-related care, and prioritize translational studies in areas such as cumulative mild TBI, vestibular dysfunction, autonomic dysregulation, as well as neuroinflammation, conditions that map directly onto documented blast sequelae and operational exposures in special-operations and weapons training cohorts.[4]

By mandating annual reports, cross-agency coordination, and integration of mobile, longitudinal diagnostics, H.R. 6444 would create the infrastructure needed to translate emerging evidence into standardized screening, targeted mitigation strategies, and benefits adjudication for blast-exposed veterans. Further, the inclusion of Task Force recommendations related to VA claims processing and disability evaluations hold the promise of ensuring that veterans affected by blast overpressure injuries are connected to the care and support they have earned with their service. WWP supports H.R. 6444 and the objectives of the proposed Task Force. We believe the data currently being collected and assessed across systems represents an invaluable resource. Findings should be fully leveraged for robust analysis and research to drive evidence-based improvements.

Discussion Draft: Data Driven Suicide Prevention and Outreach Act of 2025

Veterans continue to face very high risks of suicide, and current screening methods, rooted in self-reporting and periodic assessments, often fail to detect early warning signs.[5] According to VA's 2024 National Veteran Suicide Prevention Annual Report, more than half of veterans lost to suicide had not accessed VA healthcare in over 2 years at the time of their death. This underscores the urgent need for innovative approaches that integrate complex datasets and proactively identify risk factors before a crisis occurs.

The *Data Driven Suicide Prevention and Outreach Act of 2025* would direct VA to establish a pilot program awarding grants to organizations with expertise in AI and predictive analytics to develop models that evaluate suicide risk among veterans. These models could help clinicians prioritize interventions and tailor care, improving outcomes and saving lives.

This pilot program would not be VA's first attempt to incorporate predictive models into its suicide prevention efforts. REACH VET (Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment) is a VA initiative that uses predictive analytics to identify veterans at the highest statistical risk for suicide and proactively connect them with tailored care and outreach. Research on VA's REACH VET program has found that veterans flagged by REACH VET received more proactive care, such as safety planning and outpatient visits, and experienced a modest reduction in nonfatal suicide attempts.[6]

While predictive analytics can improve engagement and care processes, they will not guarantee reductions in veteran suicide. As Congress considers new AI-driven initiatives like the *Data Driven Suicide Prevention and Outreach Act*, it is critical to build on these lessons, ensuring integration with existing VA models, trans-

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[4] *See, e.g.*, Hadiyah Brendel, UNIFORMED SERVICES UNIVERSITY, INVICTA Study: Uncovering Blast Exposure's Impact on Special Operations Forces (Apr. 2025), *available at* https://www.dvidshub.net/news/555517/invicta-study-uncovering-blast-exposures-impact-special-operations-forces.

[5] *See, e.g.*, OFF. OF INSP. GEN., U.S. DEP'T OF VET. AFFAIRS, INADEQUATE STAFF TRAINING AND LACK OF OVERSIGHT CONTRIBUTE TO THE VETERANS HEALTH ADMINISTRATION'S SUICIDE RISK SCREENING AND EVALUATION DEFICIENCIES (Dec. 2024).

[6] Kallisse Dent et al., *The REACH VET Program and Mortality Outcomes Among Veterans at High Risk of Suicide*, JAMA NETWORK (July 2025), *available at* https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2836124.

parency in algorithms, and commitment to making system improvements based on evidence-informed research. We also believe that innovation should complement, rather than replace, proven strategies for veteran suicide prevention.

Wounded Warrior Project is pleased to support this legislation.

Discussion Draft: Veterans Health Desert Reform Act of 2025

Veterans living in rural communities encounter persistent obstacles to care, from long travel times and limited specialty services to transportation challenges that often delay treatment. While VA Community Care was designed to bridge these gaps, provider shortages and hospital closures in rural areas can leave veterans with few practical options, even when referrals are approved.

Under Community Care, VA generally contracts with individual providers and facilities rather than enrolling an entire hospital as a blanket participant, though care often occurs in hospitals. Individual providers join VA's Community Care Network and may practice within hospitals, and facilities can also participate through contracts or agreements. However, participation is service-and provider-specific, not automatic for all hospital services. This structure means not every department or provider within a participating hospital is available to VA patients, and access depends on network status, contracted services, and referral authorization. Ultimately, Community Care operates through networked providers and contracted facilities, not universal hospital participation, which can lead to variability in access even within the same hospital.

The Veterans Health Desert Reform Act of 2025 would create a VA pilot program to improve access to hospital care for veterans living in rural areas. Under this program, VA would enter agreements with at least three hospitals in high-need rural regions to furnish the same hospital care and medical services that veterans are eligible to receive under the Veterans Community Care Program. Participating hospitals would be reimbursed at rates no lower than Medicare. VA would review best practices from Medicare, Medicaid, and TRICARE to inform payment models. Throughout the pilot, VA would monitor access, cost, quality, and veteran satisfaction and submit a report to Congress after the program's authority ends in 2029.

Wounded Warrior Project is pleased to support this legislation; however, we recognize that more development may be needed within the legislative text or Center for Innovation for Care and Payment implementation process to resolve issues such as conflicts with existing hospital-based providers.

H.R. 6526: Clarity on Care Options Act

Witness testimony from this Subcommittee's recent hearing, "Strengthening CHAMPVA for Survivors and Dependents," highlighted that caregivers, survivors, and dependents often struggle to find community providers who accept Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) coverage. Currently, there is no central repository for beneficiaries to look up community care network providers who accept CHAMPVA.

The *Clarity on Care Options Act* would improve outcomes for these families by creating a public-facing directory of providers in the CHAMPVA network. The bill directs the VA to mandate Community Care Network (CCN) third party administrators to query their network of providers to confirm whether those providers accept CHAMPVA assignments, and then maintain an accessible, nationwide directory, helping families improve access to timely care. The legislation sets clear and intentional timelines: initial provider queries must be completed within 90 days of enactment, and the first public directory must be published within 180 days. VA would also be required to submit annual reports to Congress for 5 years, detailing provider participation rates and identifying geographic gaps (broken down by both State and Veteran Integrated Service Network (VISN).

Wounded Warrior Project recognizes the critical importance of this effort. Surviving families often face heightened mental health risks. Spouses, children, and caregivers in these families are vulnerable to trauma and require consistent, comprehensive support. In addition, families of veterans rated 100 percent permanent and total; families of veterans in receipt of Total Disability based on Individual Unemployability (TDIU) and approved Primary Family Caregivers in VA's Program of Comprehensive Assistance for Family Caregivers (PCAFC) depend on reliable access to care. CHAMPVA plays a vital role in meeting these needs, but a lack of clarity on participating providers undermines its promise, and leaves too many without timely, quality care.

We support H.R. 6526 and urge continued efforts to expand access to essential healthcare information. A national CHAMPVA provider registry would ensure caregivers, survivors, and dependents have a powerful tool to secure the care and support they deserve.

H.R. 4509: NoPAIN for Veterans Act

While post-9/11 service has become closely associated with invisible wounds like PTSD and TBI, pain management is one of the most critical health issues in the community we serve. Chronic pain can impact an individual's physical and mental well-being and quality of life[7] and there is evidence to suggest veterans have higher prevalence of chronic pain that civilians[8]. Nearly all (95 percent) respondents to WWP's most recent Warrior Survey reported some pain in the last 3 months, and 3 in 4 (75.5 percent) provided responses indicating moderate to severe interference with activities and enjoyment of life. In addition, VA's 2024 National Veteran Suicide Prevention Annual Report indicates that pain in the year prior to death was the most common risk factor (53.8 percent) among veterans lost to suicide from 2020 to 2022.

Medication for pain can be part of the solution, but opioid-based medications carry notable risks. When prescribed after surgery or a severe injury (acute pain) for example, opioid treatment can increase the risk of addiction, especially if opioids are used for prolonged periods, at higher doses, or in individuals with a history of substance use disorders (SUD) – and nearly 14 percent (2.8 million) veterans struggle with SUDs.[9]

In this context, non-opioid medication for pain can and should be more easily accessible for veterans enrolled in Veterans Health Administration (VHA) care. Under current law, VA is not required to include non-opioid pain management drugs in its National Formulary, leaving interested patients – and their providers – to navigate a waiver system that requires increased effort, may result in delayed access, and can ultimately lead to higher costs for the veteran. The *NOPAIN for Veterans Act* would require VA to include certain non-opioid pain management drugs as part of the National Formulary to align with Medicare laws that mandate coverage of non-opioid pain drugs, biologics, or devices with an FDA-approved indication to reduce post-operative pain or produce post-surgical or regional analgesia.

Wounded Warrior Project supports the intent of providing faster, easier access to non-opioid pain management drugs to veterans; however, distinctions between Medicare and VHA prescription drug coverage may require different solutions. The most notable distinction in this context is that VHA is a direct purchaser (and distributor) of the drugs included in its National Formulary whereas the Medicare system relies on private insurance plans offering Part D and Medicare Advantage plans to handle drug purchasing and network with pharmacies. Without deeper understanding and knowledge of how previous requests to cover applicable non-opioid alternatives through the VA Pharmacy Benefits Management (PBM) Services and VA Medical Advisory Panel-VISN Pharmacist Executives (MAP-VPE) have fared, we encourage this matter to be further explored as part of the recent majority announcement of its VA Reauthorization Series, which features an intent to modernize VA's National Formulary governance.[10]

H.R. 5999: To Amend Title 38, United States Code, to Direct the Secretary of Veterans Affairs to furnish an opioid antagonist to a veteran without requiring a prescription or copayment

Veterans living with chronic pain face a heightened risk of opioid overdose, as symptom management often leads to increased reliance on these medications.[11] While some VA Medical Centers allow veterans to request opioid antagonists directly from the pharmacy, most still require a provider-issued prescription, placing administrative and cost barriers before a vulnerable population.

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[7] Kosuke Kawai et al., *Adverse Impacts of Chronic Pain on Health-related Quality of Life, Work Productivity, Depression, and Anxiety in a Community-Based Study*, FAMILY PRACTICE (Nov. 2017), available at https://pubmed.ncbi.nlm.nih.gov/28444208/.

[8] Kenneth Taylor et al., *Seventeen-year National Pain Prevalence Trends Among U.S. Military Veterans*, J. PAIN (May 2024), *available at* https://pubmed.ncbi.nlm.nih.gov/37952861/.

[9] SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVS., KEY SUBSTANCE USE AND MENTAL HEALTH INDICATORS IN THE UNITED STATES: RESULTS FROM THE 2023 NATIONAL SURVEY ON DRUG USE AND HEALTH (July 2024), *available at* https://www.samhsa.gov/data/sites/default/files/reports/rpt47095/National %20Report/National %20Report/2023-nsduh-annual-national.pdf.

[10] Press release, House Comm. Vet. Affairs, Chairman Bost, House Republicans Launch a Veteran First Initiative to Modernize VA Healthcare for the 21st Century (Dec. 10, 2025), *available at* https://veterans.house.gov/news/documentsingle.aspx?DocumentID=7810.

[11] *See, e.g.*, OFF. OF RSCH. & DEV., U.S. DEP'T OF VET. AFFAIRS, OPIOID USE DISORDER – FACT SHEET: DATA ON VETERANS USING VA HEALTH CARE (Apr. 2022), *available at* https://www.vacsp.research.va.gov/CSPEC/Studies/CSPEAR/Docs/Opioid-Use-Disorder.pdf.

Many states already allow antagonists, such as naloxone, to be obtained over the counter or through standing orders, yet VA lacks a consistent, system-wide approach to ensure timely access. Standardizing protocols and expanding availability across VA facilities would strengthen overdose prevention and give veterans a critical, potentially life-saving tool.

Providing opioid antagonists, such as naloxone, at no cost to veterans can save lives among a high-risk population. Community-based naloxone distribution programs have consistently demonstrated effectiveness in reversing overdoses and reducing fatalities. Evidence shows that jurisdictions eliminating prescription requirements and copayments achieve higher naloxone uptake and better outcomes in combating overdose deaths. RAND research further indicates that policies offering naloxone free of charge and without prescription substantially increase distribution and have the potential to reduce fatal overdoses. For veterans facing elevated risks due to chronic pain and mental health challenges, removing these barriers – as proposed – would align VA policy with proven public health strategies, ensuring immediate, cost-free access to this lifesaving medication.[12]

Wounded Warrior Project is pleased to support this legislation.

H.R. 6001: Veterans with ALS Reporting Act

Amyotrophic Lateral Sclerosis (ALS) is a devastating neurodegenerative disease without a cure or effective treatment. It is always fatal, with most individuals tragically living only two to 5 years after diagnosis. Veterans face an even greater risk, with studies showing they are twice as likely to develop ALS as the general population.[13] VA recognizes ALS as a service—connected condition and grants a 100 percent disability rating upon diagnosis, but we still lack a clear picture of why veterans are disproportionately affected or how to reduce that risk.[14, 15]

The *Veterans with ALS Reporting Act* takes an important step toward answering these questions, requiring VA, in collaboration with the Centers for Disease Control (CDC), to report on ALS incidence and prevalence among veterans, identify gaps in care and support, and outline strategies for risk reduction. This bill also calls for better access to clinical trials, expanded research participation, and continuous tracking through the CDC's ALS registry and biorepository as this younger veteran cohort age. By mandating regular updates to Congress, this legislation ensures accountability and drives progress toward better understanding, prevention, and treatment of ALS in the veteran community.

Wounded Warrior Project is pleased to support this legislation. To strengthen the bill further, we recommend adding provisions that require VA to develop and implement an action plan based on the report's findings related to gaps in care and support, rather than limiting the bill to data collection. Including specific outcome metrics and timelines for improving care access, clinical trial enrollment, and support services would ensure accountability. The bill could also mandate public reporting of corrective actions, require consultation with veteran advocacy and ALS organizations, and authorize dedicated funding for implementation so recommendations lead to real improvements. These enhancements would transform the bill from a reporting requirement into a catalyst for meaningful change in ALS care for veterans.

Agenda items not addressed in this Statement for the Record

- Discussion Draft: *U.S. Vets of the FAS Act*
- Discussion Draft: *Whole Health for Veterans Act*

Concluding Remarks

Wounded Warrior Project once again extends our thanks to the Subcommittee on Health for its continued dedication to our Nation's veterans. Our commitment to keeping the promise by rebuilding the lives of warriors impacted by war and military service remains as strong as ever, and we are honored to contribute our voice to your discussion about pending legislation. As your partner in advocating for these and other critical issues, we stand ready to assist and look forward to our continued collaboration.

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[12] RAND, STATEWIDE FREE NALOXONE (Dec. 2023), *available at* https://www.rand.org/pubs/research__briefs/RBA3054–15.html.

[13] *See, e.g.*, NAT'L ACADS. OF SCI., ENG., & MED., LIVING WITH ALS 2024, *available at*https://nap.nationalacademies.org/resource/27739/ALS__One__Pager__Veterans.pdf.

[14] I AM ALS, UNDERSTANDING VETERANS AT RISK FOR ALS, https://www.iamals.org/understanding-veterans-risk-for-als/ (last visited Jan. 9, 2026).

[15] Hari Krishna Raju Sagiraju et al., *Amyotrophic Lateral Sclerosis Among Veterans Deployed in Support of Post–9/11 U.S. Conflicts*, MILITARY MED. (Mar. 2020), *available at* https://pubmed.ncbi.nlm.nih.gov/31642489/.

Prepared Statement of K. Conwell Smith

Chairwoman Miller-Meeks, Ranking Member Brownley, and distinguished Members of the Subcommittee, on behalf of the American Psychological Association (APA), thank you for the opportunity to testify and provide comments regarding legislation being considered today. I am Conwell Smith, APA Deputy Chief for Military and Veterans Policy.

The American Psychological Association and its companion organization APA Services, Inc. (APA/APASI) serve as the Nation's largest scientific and professional nonprofit organization representing the discipline and profession of psychology. Our organization has more than 190,000 members and affiliates who are clinicians, researchers, educators, consultants, and students. Within the Veterans Health Administration, there are over 7,000 psychologists serving veterans. That number has declined by nearly 300 psychologists since November 2024.[1] APA is proud of the decades of clinical and research advancements made in mental and behavioral health thanks to psychology's role within the VA since World War II. The VA has long led the way in establishing standards for practice, training and research that serve veterans and our entire healthcare system.

We appreciate the Committee's willingness to take on the challenges surrounding the critical delivery of and access to mental health care for our Nation's veterans. Demand for VA mental health care has increased steadily over the past 20 years and continues to outpace other care within the VA.[2] Meeting this demand while maintaining the VA's high level of clinical excellence should be the priority.

My testimony will focus primarily on ways in which legislation discussed today should aim to provide veterans with care of the highest quality, regardless of site of service – care that is on par with the current standards of practice that exist within the Veterans Health Administration. Several bills being considered today create new delivery models, access points, and processes separate and apart from VHA. APASI is concerned that the creation of new systems of care outside of VA direct care or the Veterans Community Care Program (VCCP) and without VA authorization or referral only further fragments veteran care, isolating veterans and compromising the benefits of an integrated care model. APASI is also concerned that two well intentioned bills focused on **access** to care, the Recognizing Community Organizations for Veteran Engagement and Recovery or RECOVER Act (H.R. 2283) and the draft Health Desert Reform Act, risk reducing the **quality** of veteran health care without certain safeguards put in place.

APASI recognizes the need to supplement VHA care due to staffing, funding, specialty care and location considerations; however, veterans should expect the following when receiving mental health care outside of the VHA integrated health system: (1) Providers who have received key trainings currently required within the VA; (2) The use of treatments scientifically proven to be effective; (3) Quality assurance, oversight, and accountability; (4) Coordinated care and shared health records; and (5) Adequate information for informed choice.

Providers Trained to Best Serve Veterans[3]

For years, the VA has made tremendous strides in universal suicide prevention risk assessments and required trainings for providers including training in suicide prevention, lethal means safety, military culture, and military sexual trauma. The RECOVER Act, which would provide $60 million in grants to mental health facilities serving veterans, fails to require that its clinicians meet the training rigor and responsibility of VA providers. Even suicide prevention training is not required, even though the legislation appropriately targets areas with high veteran suicide risk.

APASI supports requiring key trainings for all VA community providers, including those providing mental health services through separate VA funded grant programs. A May 2025 Government Accountability Office (GAO) report recommended that VA better monitor whether community providers have completed any of eight core trainings, following findings that a mere "two percent of the community providers with a behavioral health referral from fiscal years 2021 through 2023 had completed one or more of these trainings."

The Use of Treatments Scientifically Proven to be Effective

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[1] SECVA Workforce Dashboard

[2] https://www.govinfo.gov/content/pkg/CMR-VA1–00181657/pdf/CMR-VA1–00181657.pdf

[3] Veterans' Community Care: VA Needs Improved Oversight of Behavioral Health Medical Records and Provider Training U.S. GAO

APA strongly believes in leading with psychological science and takes seriously the development of treatments scientifically proven to be effective for the assessment and treatment of mental health disorders.[4] The RECOVER Act does not require provider training in evidence-based practices, overlooking the clear need for knowledge and training on common veteran conditions such as post-traumatic stress and traumatic brain injury.

Another bill being considered today, the Veterans TBI Breakthrough Exploration of Adaptive Care Opportunities Nationwide or BEACON Act of 2025, aims to increase research on mild traumatic brain injury and mental health interventions outside "the scope of traditional Department of Veterans Affairs pathways." APASI is concerned that this approach might also undermine the bedrock of rigorous scientific study that is the gold standard of existing VA traumatic brain injury research and treatment. APASI views this alternative pathway as unnecessary, likely to duplicate internal efforts, and potentially reducing standards necessary for evidence-based care.

Quality Assurance, Oversight and Accountability

APASI encourages strong quality assurance standards and facility accreditation for any grant recipient providing mental and behavioral services to veterans. The RECOVER Act currently does not require accreditation from either The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF). This is a significant departure from quality assurance standards within the VA. APASI also encourages that both the RECOVER Act and the Veterans Health Desert Act incorporate utilization review to ensure that overutilization and unnecessary duplication of services are adequately addressed both for the quality of care for veterans and good stewardship of taxpayer funds. Finally, it is important that the RECOVER Act create a meaningful standard and process to ensure that the expressed intention to demonstrate improved clinical outcomes is fully met and enforced. We should learn from recent findings in the congressionally mandated final report of the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program whereby, despite requirements for recipients to administer both baseline and follow-up assessments, significant numbers of grantees failed to do so. Without evidence of grantee level effectiveness, we fail to understand both positive and negative impacts on veterans.

Care Coordination and Shared Health Records

Known benefits of integrated health care systems include improved care coordination, transdisciplinary care teams, efficient resource utilization, prevention and early intervention, and improved patient experience. Perhaps this is why, in 2024, VA hospitals outperformed non-VA hospitals in both patient satisfaction and hospital quality ratings[5] and 79.5 percent of Veterans using VA services responded in 2025 that they trust the VA. Removing the VA as coordinator of care and creating increased fragmentation of VA services will further weaken communication and coordination among veterans' health care providers.

Furthermore, the same GAO report listed above[6] found that 33 percent of VA referrals for behavioral health services were missing initial visit records. The quality of care for veterans can be negatively impacted by the lack of shared health records. APASI recommends that all providers of veteran care be required to participate in timely medical record exchange.

Adequate Information for Informed Choice

APASI lauds two bills today that aim to better inform veterans. APASI is encouraged by the creation of a publicly available directory of health care providers that accept assignments under the CHAMPVA program, as required in the draft Clarity on Care Options Act.

The Veterans Mental Health and Addiction Therapy Quality of Care Act, H.R. 2426, also strives to provide veterans with information needed to make informed healthcare choices. APASI supports the intent of the legislation but is concerned that it falls short of intended goals as currently written. For example, the bill does require contracts with Third Party Administrators to include the expectation of assessing patients' treatment progress. It also does not authorize the VA to access VCCP health care records. Unless the bill requires VCCP providers to submit key

[4] Guidelines for Practitioners

[5] https://news.va.gov/press-room/va-health-care-outperforms-non-va-care-in-two-independent-nationwide-quality-and-patient-satisfaction-reviews/

[6] Veterans' Community Care: VA Needs Improved Oversight of Behavioral Health Medical Records and Provider Training U.S. GAO

uniform measurement and health care record information to the VA, valid comparisons cannot be made. APASI also suggests that wait time, provider training, and additional quality metrics be added.

Finally, APASI would like to acknowledge H.R. 4509, the NOPAIN for Veterans Act and the draft Whole Health for Veterans Act for their focus on the health and well-being of veterans. By making it easier for veterans to access and afford non-opioid medications and whole health well-being services, these bills contribute to prevention and resiliency.

Conclusion

Chairwoman Miller-Meeks, Ranking Member Brownley, and distinguished Members of the Subcommittee, APASI thanks you for your leadership and for allowing us the opportunity to provide feedback on legislation. We know that each of you are earnest in your efforts to improve veteran health care access *and* quality. The VA has consistently led the way in groundbreaking mental health care research, the development of effective treatments, and the training of an exceptional health care workforce serving all Americans and we are proud of psychology's role within the VA. APASI believes in this high standard of care and in meeting the expectation of veterans to receive it.

In closing, it is an honor to serve the American Psychological Association, advocating for the vital work psychologists do every day for our veterans and military. Importantly, I speak as the spouse of an Army veteran who receives his care through the Hampton VA Medical Center. There is nothing more important to me than ensuring he and all others who serve receive the best care in every setting. Thank you.

STATEMENT FOR THE RECORD

Prepared Statement of Veterans of Foreign Wars of the United States

Chairman Miller-Meeks, Ranking Member Brownley, and members of the subcommittee, on behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, thank you for the opportunity to provide testimony regarding this pending legislation.

H.R. 2283, RECOVER Act

The VFW supports the intent of this legislation that would establish a pilot program providing grants to outpatient mental health facilities for culturally competent, evidence-based care for veterans. Too many veterans, especially in rural, underserved, and high-risk communities, still face barriers to timely mental health and addiction services. This proposal offers a targeted way to expand access while reinforcing veteran-centered, evidence-driven care.

The VFW is encouraged by the focus on accountability, clinical outcomes, and the commitment not to charge veterans for care. Removing cost as a barrier is essential, especially for veterans who are uninsured, underinsured, or concerned about finances. Prioritizing services in high suicide risk communities aligns this pilot with national suicide-prevention strategies.

To that end, the VFW strongly urges Congress to ensure that veteran and military service organizations have a formal role in helping establish the standards for cultural competency under this program. Even if these organizations are not eligible for grant funding, they represent and serve the veteran population every day and bring an essential perspective on what culturally competent care should look like in practice. Their involvement would help ensure that standards reflect veterans' lived experiences rather than narrow or academic interpretations. The VFW urges that community-based mental health care must complement, not replace, Department of Veterans Affairs (VA) services. This pilot must strengthen the overall system, not create disconnected silos. Set and enforce strong standards for care coordination, medical record sharing, and referral paths back to VA to guarantee continuity of treatment, especially for veterans with complex, chronic, or co-occurring conditions. Do not drop coordination demands, remove record sharing, or weaken VA's role. Such actions would fragment care and jeopardize outcomes. The success of this initiative depends on direct action to maintain and improve integration across care points.

The VFW urges Congress to take immediate action to ensure this pilot supplements but does not replace investment in VA's mental health system. Congress must fully invest in VA's own capacity and guarantee that expanding access through trusted partners strengthens, rather than undermines, VA's central role in coordinating veteran care. Do not let privatization weaken accountability and disrupt continuity for those who served.

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

The VFW strongly supports improving the quality, safety, and accountability of mental health and addiction care for veterans. However, we cannot accept this legislation as written because it does not provide VA with the authority, data access, or tools needed to conduct the required comparison.

The legislation requires an independent review of quality across VA and non-VA care. However, community providers do not collect or standardize data like VA does. Without comparable clinical metrics such as suicide-risk screenings, treatment adherence, or use of evidence-based practices, comparing outcomes would be flawed. Any study based on incomplete data risks producing misleading results.

The VFW is also concerned that the legislation relies heavily on raw utilization measures, such as the number of visits, as proxies for quality and effectiveness. Visit counts alone do not capture changes in symptom severity, functional status, treatment intensity, or care transitions over time. Veterans' mental health and sub-

stance use needs often fluctuate, and meaningful evaluation must account for clinical trajectories, not just service volume. Without this context, the legislation risks reducing complex care decisions to superficial metrics that do not reflect real outcomes.

This legislation also omits key tools VA would need. It does not guarantee access to community-provider data, reporting standards for non-VA providers, or risk adjustment for patient complexity and social factors. Without these, VA cannot make a fair or accurate comparison. This approach could unintentionally undermine accountability. It may create the appearance of oversight without the substance needed for improvement. Worse, incomplete or poorly contextualized findings could be misused to justify policy decisions that restrict access or shift resources based on unreliable conclusions.

Veterans deserve real accountability, not just rhetoric. Any legislation claiming to measure the quality of mental health and addiction care must initially ensure the tools, data, and standards exist to make those measurements accurate, fair, and actionable. Without these foundations, this legislation risks creating conclusions that neither improve care nor serve the best interests of veterans.

H.R. 4509, NOPAIN for Veterans Act

The VFW does not support legislation that would amend Title 38 to require VA to add non-opioid pain drugs and biologicals to its formulary on a set timeline. These products must be FDA-approved, reduce certain types of pain, and not work on opioid receptors. The VFW has not yet issued a resolution on this matter.

H.R. 5999, To amend title 38, United States Code, to direct the Secretary of Veterans Affairs to furnish an opioid antagonist to a veteran without requiring a prescription or copayment

The VFW strongly supports expanding access to opioid antagonists through VA without prescription or copayment barriers. Overdose deaths are rising, including among veterans. Removing obstacles to emergency treatment shows commitment to prevention and harm reduction.

Veterans face unique risks for opioid misuse, such as chronic pain, injuries, and mental health conditions like post-traumatic stress disorder. Broad, stigma-free access to overdose-reversal medication lets veterans, families, and communities act quickly when seconds count. This approach aligns with proven public health plans that emphasize early action and local responses.

While the VFW supports the intent of this legislation, we believe safeguards are needed. Opioid antagonists are generally safe but may pose risks for veterans with certain health issues or medicines. If available without a prescription, veterans should get counseling from a VA pharmacist. This would ensure informed use, help find risks, and reinforce safe use. Informed consent and patient safety must remain central, even if the drug is over the counter.

The VFW is also concerned about the fiscal implications of removing all copayments for these medications. VA has faced budget pressures in recent years despite funding increases. Congress must consider how a no-copay requirement would affect pharmacy budgets if demand increases. Expanding access should not come at the expense of sustainability or force VA to divert resources from other critical services.

The VFW believes making opioid antagonists widely available through VA should serve as a gateway to care, not a standalone solution. When paired with strong referral pathways to substance use disorder treatment, mental health services, and peer support, this policy can save lives while strengthening long-term recovery.

H.R. 6001, Veterans with ALS Reporting Act

The VFW supports this legislation that would require the VA Secretary to establish a triennial amyotrophic lateral sclerosis (ALS) monitoring, tracking, and reporting program. Under this requirement, VA would assess the incidence and prevalence of ALS among veterans, describe the resources VA and the Centers for Disease Control and Prevention (CDC) provide to veterans living with ALS, identify any gaps in those resources, develop a strategy to evaluate risk—reduction therapies aimed at lowering ALS incidence and prevalence among veterans, establish pathways for veterans receiving VA-provided ALS care to participate in VA-sponsored clinical trials and research, and recommend legislative solutions to address barriers to reducing ALS incidence and prevalence in the veteran population.

Additionally, this legislation would direct VA to track ALS prevalence among veterans through the VA ALS Registry and the CDC's biorepository. According to VA's va.gov website, studies indicate that veterans are approximately 1.5 times more likely to develop ALS than individuals with no history of military service. Establishing this comprehensive monitoring and reporting framework would better equip

VA to evaluate the effectiveness of risk-reduction strategies and improve outcomes for veterans living with ALS.

The VFW has long been a staunch advocate for legislation benefiting ALS patients and their survivors. Notably, during the 2021–2022 timeframe, the VFW Department of Virginia authored national VFW resolutions calling for commonsense modifications to ALS survivors' benefits. These advocacy efforts helped advance the *Justice for ALS Veterans Act of 2025*, in support of which the VFW provided favorable testimony.

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

The VFW supports this legislation that would directly advance the VFW's longstanding legislative priorities and active resolutions focused on traumatic brain injury (TBI), blast overpressure exposure, and related neurological and cognitive health conditions.

Modern service members, particularly those in combat arms and high-exposure occupational specialties, face repeated blast exposure that can result in cumulative, often poorly understood injuries with lifelong consequences. This legislation takes an important step toward addressing those gaps by directing VA, in coordination with the Department of Defense, to establish a task force to align research, improve clinical care, and develop mitigation strategies for blast-related injuries.

The VFW's support reflects our commitment to strengthening research, diagnosis, and treatment of blast overpressure injuries, ensuring affected veterans receive timely, evidence-based care, and improving long-term health outcomes for those who have borne the physical and cognitive costs of military service.

H.R. 6526, Clarity on Care Options Act

The VFW supports the intent of this legislation to improve access, transparency, and accountability within the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). Far too often, CHAMPVA beneficiaries—primarily surviving spouses and dependents—struggle to identify health care providers who accept the program, leading to delays in care, unexpected out-of-pocket costs, and unnecessary stress during difficult times.

This legislation appears to be designed to create a more accurate and reliable understanding of provider participation in CHAMPVA by surveying current and prospective providers. If the purpose is to strengthen VA's internal data and build the foundation for a CHAMPVA provider data base, the VFW supports that goal. However, the legislation's wording is too vague and leaves open whether this effort would result in a public, searchable directory that beneficiaries could use.

While the legislation's title suggests improved access for CHAMPVA users, the body does not clearly require VA to establish and maintain a public data base for beneficiaries to locate participating providers. If Congress intends this legislation to improve real-world access, that requirement must be explicitly stated with clear definitions of who can access the data base, how often it will be updated, and how it will be integrated into VA and CHAMPVA communications. Clarity between the title and substance is essential to ensure the policy delivers on its promise.

The VFW is encouraged by the inclusion of annual reporting to Congress, which can help identify geographic gaps in provider availability and inform future reforms. However, transparency alone is not enough. A directory, no matter how well designed, will not solve the problem if providers continue to decline CHAMPVA participation due to reimbursement challenges and administrative burdens. Congress and VA must use the data from this effort not only to inform beneficiaries, but to drive reforms that strengthen provider participation and ensure CHAMPVA networks are adequate in every region.

Families who rely on CHAMPVA have already sacrificed enough in service to this Nation. They deserve clear, dependable access to care, and this legislation is an important step toward delivering it. The VFW welcomes the opportunity to discuss CHAMPVA reform with the committee to ensure that all of VA's community care programs (Community Care Network, CHAMPVA, and the Foreign Medical Program) offer a similar structure and clarity to beneficiaries.

H.R. 6652, U.S. Vets of the FAS Act

The VFW supports legislation to expand access to health care for veterans living in the Freely Associated States (FAS), many of whom served honorably alongside U.S. forces yet face significant barriers to receiving the care they have earned. Geography should never determine whether a veteran can access timely, high-quality health services.

The VFW strongly supports the legislation's requirement that VA establish formal agreements with FAS governments and expand the use of telehealth and mail-order

pharmacy services. These tools offer practical, cost-effective solutions to improve access in remote and underserved regions where traditional VA facilities are unavailable. Providing beneficiary travel assistance for in-person care further strengthens this legislation's commitment to equity and fairness.

The VFW emphasizes that expanding access must be accompanied by strong implementation planning and sustained funding. Delivering care across international borders presents logistical, technological, and administrative challenges that cannot be solved by statute alone. Congress must ensure VA has the resources and infrastructure needed to make these services reliable, not just available on paper.

The VFW urges that this effort be viewed as part of a broader commitment to veterans in the FAS, not a limited or temporary solution. Telehealth and pharmacy access are critical first steps, but must be paired with long-term strategies to address specialty care, emergency services, and treatment continuity.

Discussion Draft, BEACON Act

The VFW supports legislation that creates grant programs within VA to support research and development of innovative treatments for traumatic brain injury, especially chronic mild TBI. It authorizes funding through 2028 for academic and nonprofit organizations to test new therapies and clinical approaches, with required oversight, annual evaluations, and coordination with existing mental health initiatives. The legislation mandates detailed reporting to Congress on research outcomes and recommendations to enhance TBI care for veterans. It also promotes the development, evaluation, and implementation of novel, evidence-based interventions to deliver more effective, patient-centered care for veterans with mild TBI.

Discussion Draft, Data Driven Suicide Prevention and Outreach Act

The VFW does not support this legislation that would establish a program to award grants for the development of predictive models to evaluate risk factors that contribute to the incidence of suicide among veterans, because it does not resolve fundamental gaps in data access and risks duplicating programs already in place at VA.

VA already operates multiple suicide-prevention and predictive-analytics initiatives, including existing risk-stratification tools and outreach models designed to identify veterans at elevated risk. Rather than strengthening these established programs, this legislation would create a parallel grant structure that republishes work VA is already authorized and funded to do, diverting attention and resources away from improving and fully implementing current efforts. More critically, the legislation fails to address one of the most significant barriers to effective suicide-prevention analytics: the absence of complete, timely data from non-VA providers. As more veterans receive care through community providers under the *VA MISSION Act of 2018* (Public Law 115–182), VA does not consistently receive behavioral health, substance use, and crisis intervention data in a way that allows for meaningful system-wide risk modeling. Without fixing this fundamental data-sharing gap, any new predictive model will be incomplete by design, limiting its accuracy and undermining its value.

The VFW is also concerned that expanding artificial intelligence–driven surveillance of veterans without first resolving interoperability, consent, and trust issues risks creating a system that feels focused on monitoring rather than on care. Veterans must not feel that technology is used to track them rather than support them.

Discussion Draft, Whole Health for Veterans Act

The VFW supports legislation to reduce financial barriers to wellness-focused services that promote veterans' physical, mental, and emotional well-being. As VA continues its transformation toward a Whole Health System of Care, veterans must not be deterred from accessing preventive and supportive services because of cost, especially those with the greatest needs.

Whole Health well-being services such as coaching, stress management education, mindfulness practices, and integrative therapies play an important role in helping veterans manage chronic pain, post-traumatic stress, and the long-term effects of military service. By eliminating copayments for veterans in Priority Groups 1 through 5 and capping monthly copayments for other enrolled veterans, this legislation would improve access for the most vulnerable while maintaining a reasonable cost-sharing structure for higher-income veterans.

The VFW recognizes that Congress and VA must establish clear implementation guidance and oversight to ensure consistent application across all VA medical centers. Whole Health services should be delivered in a manner that is evidence-informed, veteran-centered, and fully integrated with clinical care, not as a substitute

for needed medical treatment, but as a complement that strengthens overall outcomes.

Discussion Draft, Veterans Health Desert Reform Act

The VFW supports the intent of this legislation that would improve access to hospital care and medical services for veterans living in rural and medically underserved areas. Too many veterans must travel excessive distances or face long delays simply to receive basic inpatient and specialty care. No veteran should be denied timely treatment because of where they live.

The VFW is encouraged by this legislation's efforts to use existing rural hospitals to close access gaps, while ensuring that veterans receive care comparable to that available through the Veterans Community Care Program (VCCP). Reimbursing participating hospitals at or above Medicare rates is a practical way to encourage provider participation, and the legislation's emphasis on oversight, quality tracking, and veteran satisfaction is essential for accountability. While this is a positive step, the VFW believes the language should be stronger and more precise. Rather than stating that rural hospitals should receive priority, the legislation should require the Secretary to select hospitals in rural and highly rural areas to ensure the policy reaches veterans facing the greatest access barriers.

The VFW emphasizes that any expansion of hospital care through non-VA providers must remain anchored within the VA health care system. Veterans receiving care under this program should continue to meet VA enrollment requirements and qualify for care under the VCCP. Expanding access should not mean removing veterans from VA oversight or creating parallel systems that weaken accountability.

The VFW is encouraged by the legislation efforts to leverage existing rural hospitals to close access gaps, while ensuring veterans receive care comparable to that available through the VCCP. Reimbursing participating hospitals at or above Medicare rates is a practical way to encourage provider participation, and the emphasis on oversight, quality tracking, and veteran satisfaction is critical to maintaining accountability.

The VFW stresses that any expansion of hospital care outside the VA system must be paired with strong care coordination and continuity standards. Veterans, especially those with complex or chronic conditions, depend on seamless communication between providers. Without clear requirements for information sharing, referral management, and follow-up care, even well-intended access solutions risk creating fragmented treatment and poorer outcomes.

The VFW cautions against policies that could unintentionally accelerate the privatization of veteran health care. Community partnerships should strengthen VA, not replace it. Expanding rural access must complement VA's mission and preserve its role as the coordinator of care, not erode it.

Chairman Miller-Meeks and Ranking Member Brownley, this concludes my statement. Again, thank you for the opportunity to offer comments on this pending legislation.

Information Required by Rule XI2(g)(4) of the House of Representatives

Pursuant to Rule XI2(g)(4) of the House of Representatives, the VFW has not received any Federal grants in Fiscal Year 2026, nor has it received any Federal grants in the two previous Fiscal Years.

The VFW has not received payments or contracts from any foreign governments in the current year or preceding two calendar years.

Prepared Statement of Easterseals

Statement for the Record of
KENDRA DAVENPORT
President and CEO of Easterseals
Before the THE UNITED STATES HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON HEALTH
On H.R. 2283, Recognizing Community Organizations for Veteran Engagement and Recovery Act (RECOVER ACT)
January 13, 2025

On behalf of Easterseals' National Office and its network of 70 Affiliates operating in thousands of communities across the country, Easterseals urges support for H.R. 2283, the Recognizing Community Organizations for Veteran Engagement and Recovery Act (RECOVER Act), a critical piece of legislation that addresses the ongoing mental health crisis facing America's veterans.

Easterseals is a national nonprofit organization providing essential services to people with disabilities, older adults, veterans, and their families. For more than 100 years, Easterseals has delivered community-based, person-centered programs that respond to local needs while maintaining national standards of quality and accountability. Each year, Easterseals makes a lasting difference in the lives of millions of Americans.

Supporting veterans and military families is a core component of Easterseals' mission. Across its national network, Easterseals delivers a comprehensive suite of services designed to assist veterans and their families as they transition to civilian life and work to maintain long-term stability. These services include employment and career support, mental health and wellness programs, caregiver and family services, and housing and community reintegration.

H.R. 2283 would establish a three-year pilot program to evaluate whether evidence-based mental health care delivered by nonprofit outpatient mental health providers can improve outcomes for veterans. This approach recognizes the critical role that trusted, community-based organizations play in complementing the Department of Veterans Affairs' mental health system and expanding access to care beyond traditional clinical settings.

Key benefits of the RECOVER Act include improving access to timely and accessible mental health care and strengthening partnerships between the VA and nonprofit providers. By leveraging community-based capacity, the legislation would help reduce strain on VA facilities while preserving veterans' access to VA services.

Easterseals strongly supports the passage of H.R. 2283 and respectfully urges the Committee to advance this legislation. By expanding access to community-based, evidence-driven mental health services, the RECOVER Act would help address critical gaps in care, reduce the risk of mental health crises—including suicide—and ensure that veterans receive timely, effective support where they live. Easterseals stands ready to work with Congress, the Department of

Veterans Affairs, and community partners to help ensure the successful implementation of this legislation for the benefit of America's veterans and their families.

Sincerely,

Kendra Davenport
President & CEO
Easterseals, Inc.

Prepared Statement of American Federation of Government Employees, AFL-CIO

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

Eric Bunn Sr.
National Secretary-Treasurer

Dr. Everett B. Kelley
National President

Dr. Kendrick B. Roberson
NVP for Women & Fair Practices

January 13, 2025

The Honorable Marianette Miller-Meeks
Chairwoman, Subcommittee on Health
The Veterans' Affairs Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Julia Brownley
Ranking Member, Subcommittee on Health
The Veterans' Affairs Committee
U.S. House of Representatives
Washington, DC 20515

Chairman Miller-Meeks, Ranking Member Brownley, and distinguished members of the committee:

AFGE writes to strongly oppose the "Recognizing Community Organizations for Veteran Engagement and Recovery Act" (RECOVER Act), and the "Health Desert Reform Act," which will be considered at today's legislative hearing. Both would create pilot programs, that if expanded, would bypass VA authorization and significantly threaten VA's integrated delivery model.

The Recover Act would establish a three-year pilot program to provide grants to established nonprofit mental health care providers to compete with services that the VA already provides. The Recover Act would make a mockery of the Mission Act's goal to supplement and not supplant the VA by funding private mental health providers without regard to whether the VA can provide care within drive and wait time access standards. In concert with steep staff reductions and punitive work policies that have already put stress on VA's mental health delivery system, it is clear that the Restore Act's real aim is to privatize the VA. The Act doesn't require these nonprofit providers to meet the same standards as the VA. It leaves it up to the Secretary to devise regulations that require a grant recipient to "demonstrate outcomes." This equates to privatization: defund and understaff a high-quality, cost-efficient public program, and divert care to loosely supervised private contractors, and put it on the taxpayers' tab.

AFGE has similar concerns about the Discussion Draft titled the "Health Desert Reform Act," which would create a pilot program for the VA to enter into agreements with hospitals in select areas to provide "the same hospital care and medical services for which the covered veteran would be eligible under the Veterans Community Care Program" without the need to meet wait-time and drive-time access standards. While the Discussion Draft directs the Secretary to give priority to hospitals located in rural areas with a high population of covered veterans; it doesn't limit the bill to areas that lack VA facilities, a damaging omission for a bill that purports to address access. As written, selected hospitals could supplant VA care if hospital sites are chosen

in areas close to VA facilities. VA's authority to coordinate and authorize care would be subverted.

Instead of creating unnecessary alternatives to VA care, the Committee should instead focus on bolstering the VA system.

Sincerely,

Daniel M Horowitz

Daniel Horowitz
Legislative Director

Prepared Statement of ALS Association

On behalf of the more than 30,000 Americans living with amyotrophic lateral sclerosis (ALS) and their caregivers that we serve, The ALS Association thanks you for this opportunity to share our views on H.R. 6001, the *Veterans with ALS Reporting Act*. In addition, we would like to thank the co-chairs of the congressional ALS Caucus for their leadership in the fight to make ALS a livable disease while we develop a cure for this devastating disease.

The ALS Association is the largest philanthropic funder of ALS research around the world. The Association funds global research collaborations, supports people living with ALS and their loved ones in their communities, and advocates for better public policies for people with ALS. The ALS Association builds hope and enhances quality of life while urgently searching for new treatments and a cure. For more information about The ALS Association, visit our website at www.als.org.

ALS, sometimes called Lou Gehrig's disease, is a rapidly progressive and always fatal neurological disease that attacks the nerve cells responsible for controlling voluntary muscles. The life expectancy of a person with ALS averages about two to 5 years from the time of diagnosis. The cause of ALS is not known and there is no cure. Annual costs associated with ALS, both direct for medical care and indirect costs like lost income, are over $1 billion in the US.

For military veterans, the reality is even more sobering. Decades of research have confirmed that veterans, whether they serve in times of war or peace, are at significantly greater risk of developing ALS compared to their civilian counterparts. Because of ALS's connection to military service, the Department of Veterans Affairs has recognized ALS as a service-connected disease and assigns a 100 percent disability rating upon diagnosis. While this link is recognized, the causes and ways to protect military personnel defending our freedoms are still unclear.

H.R. 6001, the *Veterans with ALS Reporting Act*, represents an urgent opportunity for Congress to support our veterans living with ALS and their loved ones. This bill is no-to low-cost for the Veterans Administration (VA). Even though the VA provides excellent care for our veterans living with ALS and their caregivers through their ALS System of Care, there are gaps in care that need to be addressed for this vulnerable population. H.R. 6001 aims to find those gaps.

H.R. 6001 requires the Secretary of Veterans Affairs, in consultation with the Director of the Centers for Disease Control and Prevention, to submit a report to Congress on the incidence and prevalence of ALS in veterans. The report must include:

1. An assessment of ALS incidence and prevalence in veterans.
2. A description of resources and support provided to veterans with ALS.
3. Identification of any deficiencies in those resources and support.
4. A strategy to develop and test risk reduction strategies for ALS.
5. A pathway for veterans receiving ALS care within VA clinics to participate in clinical trials and research.
6. Recommendations for further legislative action to address the challenge of ALS among our military and veterans.
7. Ongoing tracking of ALS prevalence in veterans using the CDC's National ALS Registry and Biorepository, with updates to Congress every 3 year.

This bill serves not only as a report, but also as essential support for veterans living with ALS and their families. It represents a commitment to actively pursue solutions that address this serious disease, reinforcing efforts to promote the health and readiness of the military community.

We appreciate the Committee's consideration of H.R. 6001, the *Veterans with ALS Reporting Act*. The ALS Association strongly endorses this legislation and urges swift advancement of this bill. Veterans living with ALS do not have the luxury of time. This bill is a key step toward ensuring veterans receive the protection, information, and care they deserve.

Prepared Statement of ALS United

January 12, 2026

The Honorable Mariannette Miller-Meeks
Chairwoman, Subcommittee on Health
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

The Honorable Julia Brownley
Ranking Member, Subcommittee on Health
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Chairwoman Miller-Meeks and Ranking Member Brownley:

On behalf of ALS United and the people living with ALS and families we serve nationwide, we write to express our strong support for the Veterans with ALS Reporting Act (H.R. 6001).

ALS, commonly known as Lou Gehrig's disease, is a fatal, progressive neurodegenerative disease affecting nerve cells in the brain and spinal cord. ALS gradually results in the loss of the ability to walk, speak, move, and eventually breathe. There is still no cure, and the average life expectancy after diagnosis is often described as two to five years, though some people live longer.

For veterans and their families, an ALS diagnosis often follows years of service and sacrifice. Veterans are twice as likely to develop ALS as the general population, yet despite long-standing recognition of this increased risk, critical questions remain unanswered—why this risk exists, which factors may contribute, and what steps could help reduce risk for future servicemembers.

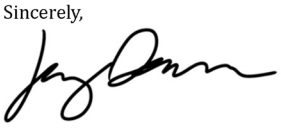
We appreciate the VA's ongoing work to monitor ALS among veterans and to improve care and research pathways. We also appreciate the bipartisan efforts of Congress to codify and strengthen these activities so they endure.

The Veterans with ALS Reporting Act is compelling because it moves us from acknowledging a troubling reality to building the evidence base to act. By directing the Department of Veterans Affairs, in consultation with the Centers for Disease Control and Prevention, to report to Congress on ALS among veterans and to identify opportunities to develop and evaluate potential risk reduction strategies, as well as to examine ways to improve pathways into VA-sponsored clinical trials and research, this bill helps ensure that prevention, research participation, and transparency remain priorities. It also creates a durable accountability loop through ongoing tracking and periodic updates, helping Congress and VA measure progress over time and identify where additional policy action is needed.

ALS United appreciates the Subcommittee's continued attention to the disproportionate burden ALS places on veterans and the bipartisan work to identify solutions. We support advancing H.R. 6001 to

help build the evidence base and sustain accountability, while continuing to work with VA and partners on the practical steps that will make the biggest difference for veterans and their families.

Sincerely,



Jerry Dawson
President and CEO
ALS United

Prepared Statement of Jason Crow

Congress of the United States
Washington, DC 20515

Congressman Jason Crow Statement for the Record
House Veterans' Affairs Subcommittee on Health Hearing

January 13, 2026

Chairwoman Miller-Meeks, Ranking Member Brownley, and Members of the House Veterans' Affairs Committee:

I am grateful for the work this committee does to improve the health and well-being of America's veterans. I appreciate the opportunity to submit testimony in support of my bill, the *Veterans with ALS Reporting Act*, a measure that I believe is consistent with the goals of this subcommittee and one that will protect those in our community who sign up to serve.

Following my three tours of combat in Iraq and Afghanistan, I came home to fight for veterans in my community — where I quickly saw firsthand that veterans disproportionately suffer from a long-list of ailments resulting from their service. This is why I was proud to support the passage of the *PACT Act*, which expanded VA health care benefits for veterans exposed to burn pits, Agent Orange, and other toxic substances while serving on behalf of our nation.

To this end, I was unsurprised to learn that veterans are twice as likely to develop Amyotrophic Lateral Sclerosis (ALS) — which is an always fatal neurodegenerative disease where people become trapped inside a body they can no longer control. Despite this disproportionate impact, little is known about *why* this link between veterans and ALS exists.

As a paratrooper, Army Ranger, and co-chair of the Congressional ALS Caucus, this problem hits close to home. This is why I worked alongside the ALS Association and my fellow co-chairs of the bipartisan ALS Caucus — Representatives Calvert, Sewell, and Fitzpatrick — to develop legislation to get to the bottom of why veterans are twice as likely to develop ALS.

This bill would require the VA to study and provide critical data regarding ALS within military and veteran communities; provide a description of the resources and support available to veterans with ALS; create a strategy to improve access to clinical trials for veterans with ALS; and create a strategy to reduce incidence and prevalence of the disease.

By studying critical data regarding ALS within veteran communities, this bill has the potential to get to the bottom of why this fatal link exists and give Congress a better idea of what can be done to protect those who serve.

I thank the ALS Association, VoteVets, the Team Gleason Foundation, and I AM ALS for their partnership on this bill. This bill is also endorsed by the bipartisan For Country Caucus, a group of over 40 military veteran Members of Congress who work together across party lines to pass thoughtful legislation to take care of our nation's veterans. I strongly support this legislation and

I encourage the members of this subcommittee to give it full consideration as we strive to better serve veterans with ALS.

Sincerely,

Jason Crow
Member of Congress

Prepared Statement of Dennis Boothe

January 9, 2026

The Honorable Mike Bost
Chair
House Veteran Affairs Committee
344 Cannon House Office Building
Washington, D.C. 20024

The Honorable Mark Takano
Ranking Member
House Veteran Affairs Committee
364 Cannon House Office Building
Washington, D.C. 20024

RE: Centerstone Letter of Support for H.R. 2283, the Recognizing Community Organizations for Veteran Engagement and Recovery (RECOVER) Act.

Dear Chairman Bost and Ranking Member Takano;

As Veteran Service Officer at the VA Community Based Outpatient Clinic in Hinesville, GA, I am writing to urge your support for H.R. 2283, the Recognizing Community Organizations for Veteran Engagement and Recovery (RECOVER) Act. This critical legislation addresses an urgent crisis facing our nation's veterans and represents a vital opportunity to save lives through enhanced mental health services.

In our experience, external partnerships, like the one we have with Centerstone, have been a collaborative partnership with our local VA services. These vital community partnerships, which can be further strengthened through H.R. 2283, serve as a safety net to ensure that no veteran in need of urgent mental health access falls through the cracks.

Additionally, there may be veterans without VA connected benefits, many of whom experienced a behavioral health incident while in active duty that resulted in the loss of their benefits. When some of these veterans receive services through our community partners, the clinical team is able to connect their service-related traumas to the reason behind their discharge status. This can result in more veterans connecting to their VA benefits to support and acknowledge their service to our country.

In brief, I believe this legislation will further strengthen our collaborative community partnerships and urge you to advance the RECOVER Act.

The Crisis We Face

Our veterans are experiencing a mental health crisis of unprecedented proportions. With an average of 17.5 veteran suicides occurring each day as of 2021, and veterans facing a suicide rate 57.3% higher than non-veteran adults, we cannot afford to maintain the status quo. Despite significant increases in VA spending to address this crisis, current efforts have proven largely ineffective, and many veterans continue to face bureaucratic barriers when seeking immediate mental health support.

The demand for quality mental health care far exceeds current capacity. This gap between need and available services is particularly acute in underserved communities with large veteran populations at high risk for suicide.

The RECOVER Act Solution

H.R. 2283 offers a targeted, evidence-based approach to addressing this crisis through:

Strategic Investment: The bill establishes a $20 million, three-year pilot program that would distribute grants of up to $1.5 million to qualified non-profit outpatient mental health facilities. This funding is entirely additive—new money that does not redirect any existing VA program funding or infrastructure.

Fills Critical Gaps, Doesn't Duplicate Services: The RECOVER Act targets communities where VA care is delayed or unavailable, particularly in areas with long wait times, shortages of VA clinicians, or high suicide risk. This legislation fills service gaps rather than duplicating existing VA services.

Evidence-Based Care: The legislation specifically focuses on expanding culturally competent, evidence-based mental health services tailored to veterans' unique needs. Only non-profit providers with at least three years of operation and demonstrated clinical effectiveness, cultural competence, and financial accountability are eligible for grants.

Strengthens, Doesn't Replace, the VA: Rather than privatizing or replacing VA services, this bill strengthens public-private partnerships. Funded clinics must promote enrollment in the VA patient system, coordinate care with the VA, and ensure continuity of care. The bill requires clinics to offer free care to veterans and cannot deny services based on insurance status.

Robust Accountability: The bill includes strong accountability provisions requiring clinical outcomes and veteran demographics, demonstrate effective use of federal funds, and justify their impact through data-driven metrics. Additionally, the VA must submit a comprehensive report to Congress evaluating the pilot program's effectiveness within 180 days of its conclusion.

Why This Matters to Our Community

As healthcare providers on the front lines, we see firsthand the challenges veterans face in accessing timely, appropriate mental health care. Many community-based organizations are already working to fill these gaps but remain under-resourced. While programs like the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program have provided valuable support, there are currently no VA programs offering grants specifically for clinical, evidence-based mental health care.

- Reduce dangerous wait times for mental health services
- Expand capacity in areas with the greatest need
- Ensure veterans receive culturally competent care from trained professionals
- Create sustainable partnerships between community providers and the VA

In conclusion, the RECOVER Act offers a concrete solution to the mental health crisis impacting our veterans. We strongly urge you to advance this critical legislation.

Sincerely,

Dennis J. Boothe

Veteran Service Officer

Prepared Statement of Endeavors

ENDEAVORS®

Statement for the Record

Monday, January 12, 2026

Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the Health Subcommittee:

At Endeavors we are profoundly committed to breaking down barriers to mental health care for veterans and providing lifesaving, timely support. Today, I'm writing to urge your support for H.R. 2283, the Recognizing Community Organizations for Veteran Engagement and Recovery Act (RECOVER Act), a critical bill that addresses the mental health crisis among veterans.

Veterans are 1.7x more likely to die by suicide than civilians with an average of 17.5 suicides a day. Many VA facilities are experiencing increased demand in some regions, often leading to long wait times exceeding the 20-day wait time standard. This highlights the urgent need for innovative, data-driven solutions to help reduce the veteran suicide rate. Nonprofit community-based mental health clinics are uniquely positioned to extend access in coordination with VA care teams, providing the timely, culturally competent, evidence-based care that veterans urgently need.

The RECOVER Act would establish a three-year pilot program to demonstrate whether evidence-based mental health care, delivered by non-profit outpatient mental health facilities, can lead to improved outcomes.

Key Benefits of the Bill Include:

- **Timely, Accessible Care:** Reducing wait times and ensuring veterans can receive support when they need it most.

1. **Culturally Competent Support:** Addressing unique mental health challenges related to PTSD, combat trauma, and military sexual trauma.
2. **Strengthening VA Partnerships:** Enhancing collaboration to expand timely access to care alongside VA services.

By supporting this legislation, you'll play a pivotal role in expanding access to life-changing care for veterans and significantly lowering the risk of mental health crises, including suicide.

Thank you for your continued support for U.S. military veterans and attention to this matter.

Sincerely,

Chip Fulghum
Chief Executive Officer
Endeavors
cfulghum@endeavors.org

Prepared Statement of Fleet Reserve Association

Statement of the

Fleet Reserve Association

On

H.R. 4509, the NOPAIN for Veterans Act.

Presented to the

United States House of Representatives

Committee on Veterans' Affairs, Subcommittee on Health

By

Theodosius Lawson
Director, Legislative Programs

January 12, 2026

The Fleet Reserve Association (FRA) appreciates the opportunity to submit this statement in strong support of H.R. 4509, the NOPAIN for Veterans Act. Founded in 1924, FRA is the oldest and largest association serving the interests of the U.S. Navy, Marine Corps, and Coast Guard. FRA has a long history of advocating for sea service personnel. Our guiding principles of "Loyalty, Protection, and Service" drive our work to ensure veterans receive the quality care and protections they have earned through honorable service.

FRA has championed veterans' health reforms for nearly a century, from post-World War II benefits expansions to modern pain management and addiction prevention initiatives. Today, as veterans continue to suffer from chronic pain and the lingering effects of the opioid epidemic, H.R. 4509 stands as a significant step forward in expanding access to safe, evidence-based pain treatments.

A Brief History of Pain Management Policy and the Need for Non-Opioid Options

Veteran pain management policy has evolved in response to the devastating consequences of opioid overreliance, which contributed to widespread addiction and overdose across both civilian and veteran populations. While the Department of Veterans Affairs has taken steps to reduce opioid exposure, access to FDA-approved non-opioid pain management options remains inconsistent across VA facilities.

H.R. 4509 addresses this gap by ensuring veterans have timely and standardized access to effective non-opioid pain treatments. These alternatives help manage both acute and chronic pain while reducing the risks associated with opioid use, including dependency, overdose, and long-term health complications.

The Importance of Non-Opioid Pain Treatments for Veterans

Pain is one of the most common service-connected conditions affecting veterans, often stemming from combat injuries, training accidents, surgeries, and long-term musculoskeletal strain. Effective pain control is essential to maintaining physical function, mental health, and overall quality of life.

Non-opioid pain treatments offer veterans safer options that align with individualized care and shared decision-making. By expanding access to these treatments, the VA can reduce

unnecessary opioid exposure, improve patient satisfaction, and support long-term recovery without compromising safety.

H.R. 4509: Key Provisions and Veteran Support

H.R. 4509, the NOPAIN for Veterans Act, amends title 38 of the United States Code to expand veterans' access to non-opioid pain management medications. Specifically, the bill:

- Defines non-opioid pain management drugs or biological products as FDA-approved treatments that relieve pain without acting on opioid receptors.
- Requires the Secretary of Veterans Affairs to include eligible non-opioid pain medications in the VA National Formulary within a defined timeframe.
- Mandates that these medications be placed on the VA drug standardization list to ensure consistent availability across all VA medical facilities.
- Establishes clear implementation deadlines to accelerate access while maintaining fiscal responsibility.

This legislation has garnered bipartisan interest and strong support from veteran health advocates who recognize the importance of expanding safe pain management options within the VA system.

Specific Benefits of Expanding Non-Opioid Pain Formularies

H.R. 4509 delivers tangible benefits to veterans by strengthening access to safer pain treatments:

- Reduced Risk of Addiction: Non-opioid medications eliminate the dependency risks associated with opioid-based therapies.
- Expanded Treatment Choice: Veterans can collaborate with their providers to select pain management strategies that best align with their medical needs and personal preferences.
- Consistency Across VA Facilities: Standardized inclusion ensures equitable access regardless of location.
- Improved Long-Term Outcomes: Safer pain control supports rehabilitation, mental health stability, and sustained quality of life.

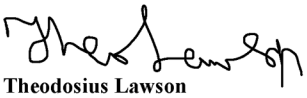
Conclusion

The Fleet Reserve Association strongly urges swift passage of H.R. 4509, the NOPAIN for Veterans Act. This commonsense reform enhances the VA's ability to deliver safe, effective, and modern pain management care while reducing reliance on opioids. By advancing this legislation, Congress can protect veterans from avoidable harm, strengthen trust in the VA healthcare system, and reaffirm its commitment to those who have served.

FRA stands ready to work with the Committee on implementation and stands with you in service to those who served.

Thank you for your leadership.

Respectfully submitted,



Theodosius Lawson
Director, Legislative Programs
Fleet Reserve Association

#######

Prepared Statement of Jewish War Veterans

Jewish War Veterans
of the United States of America

"A Jewish Voice for Veterans; a Veteran's voice for Jews since 1896."

1811 R St. NW, Washington, DC 20009 | 202.265.6280 | jwv@jwv.org | www.jwv.org

January 13, 2026

Statement for the Record
House Veterans Affairs Subcommittee on Health

H.R. 4509, the NOPAIN for Veterans Act

The Jewish War Veterans of the USA (JWV) appreciates the opportunity to submit a statement for the record for the Health Subcommittee Legislative Hearing on January 13, 2026. JWV commends the Committee leadership for ensuring veterans receive the highest level of access to care, and the NOPAIN for Veterans Act is critical and under consideration today.

JWV is the longest-serving Veterans Service Organization, founded in 1896, to challenge the antisemitic stereotype that Jews did not serve in the military. Nearly 130 years later, JWV continues to fight antisemitism and advocates for the benefits and services earned by all veterans. As the only Jewish VSO, we also stand with Israel to ensure its existence and protect its citizens.

JWV is proud to strongly support H.R. 4509, the NOPAIN for Veterans Act. Veterans have earned timely, compassionate, and effective care for service-connected injuries and conditions. Yet far too many continue to face unnecessary delays or denials of proper acute pain management, leading to avoidable suffering, the risk of addiction, and reduced quality of life. This legislation is a crucial step toward ensuring that veterans receive personalized, clinically appropriate pain care based on medical needs — not rigid policy restrictions.

The NOPAIN for Veterans Act rightly restores clinical judgment to veterans' healthcare by ensuring the Department of Veterans Affairs can offer comprehensive post-surgical pain management options while maintaining strict safeguards against misuse. Individual pain management remains vital because veterans' injuries, conditions, and responses to treatment differ greatly. Policies for acute pain management must reflect this reality and allow providers to treat the veteran as a whole.

We urge the Subcommittee, full Committee, and Congress to promptly pass the NOPAIN for Veterans Act. Veterans should never be forced to suffer from unmanaged pain due to well-meaning but overly restrictive policies. The NOPAIN for Veterans Act emphasizes veterans' dignity, access, and appropriate clinical care.

JWV applauds the leadership of the Health Subcommittee and its continued dedication to improving veterans' health outcomes and looks forward to working to get this bill signed into law.

Ken Greenebrg
National Executive Director
Jewish War Veterans of the USA

Prepared Statement of Association of VA Nurse Anesthesiologists, Association of VA Psychologist Leaders, Association of VA Social Workers, National Association of VA Physicians and Dentists, Nurses Organization of Veterans Affairs, and Veterans Healthcare Policy Institute

Chairman Miller-Meeks, Ranking Member Brownley, and distinguished members of the committee:

On behalf of our six organizations, we thank you for inviting us to submit a statement for the record for today's health subcommittee legislative hearing on improving the healthcare and services for veterans. Members of our organization are veterans, have family members who are veterans, had long careers dedicated to serving veterans, published papers on veterans' healthcare in peer-reviewed journals, presented testimony to your committee, and have served on President Trump's President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS) task force.

In today's statement, we wish to convey our appreciation for your leadership and commitment to ensuring that veterans receive the highest level of healthcare within the Veterans Health Administration (VHA) and supplementary care in the private sector when it's both needed and authorized by the VHA.

We address our comments to five of the seven bills considered at today's hearing.

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

The RECOVER Act, a 3-year pilot reintroduced by HVAC Chairman Rep. Mike Bost, would provide grants of up to $1.5 million ($60 million total) to non-profit mental health facilities serving veterans, prioritizing areas with large numbers of veterans at high risk of suicide. It would establish a parallel care system operating outside of, and disjointed from, the VA and the Veterans Community Care Program (VCCP), severely weakening the quality of services provided to veterans, as we detail below.

Undermines the Veterans Community Care Program

The RECOVER Act creates a parallel mental healthcare system that fundamentally conflicts with the existing VCCP operations and erode the MISSION Act's intention to create a single overarching, coordinated program by:

Introducing competing eligibility rules. For the past 7 years, veterans needing mental health care qualified for services through the VCCP when VA cannot provide care within 20 days or 30 minutes of drive time. This bill would bypass the VA's authorization process entirely, allowing veterans to access VA-paid mental health care from grant recipients whenever they choose, ending the foundational principle of the VA as the authorizer and overseer of veterans' care,

The bill subverts the VA's established system for veterans' priority group eligibility and co-payments. Unlike the VA and VCCP, no veteran would have a co-payment.

Duplicating existing services. Unlike the Fox Grant program, which funds services unavailable through the VA, this bill duplicates mental health services delivered by the VA and VCCP.

Removing VA as the coordinator of care. The MISSION Act designated VA as the overall coordinator of care that is furnished in the community. Mental health care delivered through these grants circumvents that coordinated framework.

Reduces Quality and Evidence-Based Care Standards

Despite its stated goal of providing culturally competent, evidence-based care, the bill's requirements fall far short. At each grant-receiving facility, only *one* clinician—not all—must be trained in "culturally competent" veterans mental health care. No providers must be trained in evidence-based practices. In sharp contrast, VA clinicians have recognized expertise in military-related conditions such as PTSD and traumatic brain injury.

Furthermore, despite prioritizing the awarding of grants in areas where there are large numbers of veterans at high risk for suicide, the bill includes no requirement for suicide prevention training.

Fails to Improve Timely Delivery of Services

The bill establishes no concrete standards for timeliness of service. Grantees' wait times could be longer than those currently experienced with VA and VCCP services.

Pays Twice for the Same Care

The bill explicitly enables existing VCCP facilities to receive grant funding without any requirement to increase services—allowing providers to layer awards on top of the VA and insurance reimbursements that grant recipients already receive for delivered care.

Eliminates Oversight, Accountability and Adherence to Standards

The bill lacks crucial quality standards and facility accreditation requirements. Unlike VA facilities, grant recipients would not be required to obtain accreditation from The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities.

There is no mandate for semi-annual peer review, quality assurance standards integral to VA-delivered mental health care.

There is neither utilization review nor limits to the number of appointments per treatment episode.

Pre-post symptom improvement is not reported, and grants are not allocated based on successful outcomes.

Unlike VCCP providers, recipient facilities face no requirement to share health records with VA—a fundamental breakdown in care coordination that could leave a veteran's treatment fragmented and potentially compromised.

Undermines the network of the 300+ Vet Centers and 80 Mobile Vet Centers

These options exist to serve veterans who hesitate to seek mental health care at VA facilities—presumably one reason for the grants that subsidize private sector clinics.

Summary and Recommendation

This legislation would severely weaken VA's healthcare model and further diminish the VA's ability to provide veterans with high-quality mental health care. Changes to the delivery of veteran mental health care and suicide prevention cannot come at the expense of VA's integrated system, which—when properly staffed and funded—consistently succeeds in providing comprehensive, coordinated mental healthcare for our Nation's veterans.

The more effective solution would be expanding VA's mental health workforce while maintaining its critical role coordinating care and leveraging community resources, rather than creating a parallel system with negligible oversight and lower standards of care.

Finally, this legislation could set a dangerous precedent, with veterans' mental health services being a test case for broad transformation of the VA from a provider of care provider to an insurance payer for care. That's not what the overwhelming number of veterans and prefer. The VA's central role in authorizing and coordinating veteran healthcare must be preserved while judiciously and effectively leveraging community resources within that framework.

Veterans Health Desert Reform Act of 2025

The Veterans Health Desert Reform Act of 2025 would establish a pilot program allowing three or more rural private sector facilities to provide hospital care and medical services to veterans outside of the Veterans Community Care Program (VCCP). Rather than protecting veterans, it could seriously compromise the healthcare access that most veterans currently depend on.

The VA MISSION Act of 2018 created a comprehensive private sector network through the VCCP, guaranteeing veterans emergency medical and psychiatric care, as well as walk-in urgent care, anywhere in the country. Veterans can also access private sector outpatient care if they would wait more than 20 to 28 days for an appointment or must drive more than 30 to 60 minutes to reach a VA facility. This new bill creates a parallel system that fundamentally conflicts with the existing VCCP structure in three critical ways.

First, it introduces competing eligibility rules that eliminate VA's role as authorizer of community care. Under VCCP, VA authorizes community care when veterans meet specific eligibility criteria. Under this bill, enrolled veterans could obtain VA-paid care at selected hospitals and their outpatient clinics simply by calling for an appointment or walking in, without any VA authorization.

This represents a dangerous departure from standard practice. Prior authorization is a routine feature of any insurance payer that pays for patient care and services. It offers critical protections to veterans who might otherwise receive unnecessary tests or procedures, or care that isn't based on scientific evidence. VA oversight

also protects taxpayers from the fraudulent billing practices that are endemic in America's profit-driven healthcare system.

Second, this bill could duplicate services already available in the VA and VCCP—including in the same geographic locations. There's no stipulation that participating hospitals must be located more than a 60-minute drive from existing VA (or VCCP) facilities. Veterans might end up traveling longer distances than they currently experience with VA and VCCP services, defeating the bill's purported purpose of addressing health deserts.

Third, unlike VCCP providers, facilities face no requirement to share health records with VA. This represents a fundamental breakdown in care coordination that could leave a veteran's treatment fragmented and potentially compromised.

Pilot programs are designed to start small before scaling up. This legislation would serve as a test case for arrangements that could eventually encompass far larger numbers of hospitals, representing another step in the accelerating privatization of VA's integrated healthcare system. As veterans shift their care to these facilities, funding follows. Declining patient volumes at VA facilities trigger budget cuts that force specialized programs to be scaled back or eliminated, ultimately depriving many veterans of the VA care they prefer and depend on.

We support a provision in the legislation that aligns healthcare reimbursement for veterans with rates paid for non-veteran patients. Financial incentives should never create a system where certain patients receive priority based on reimbursement disparities. However, this worthy reform can and should be accomplished within the existing VCCP framework, without creating a parallel system that undermines VA care and abandons the safeguards veterans need.

Recommendation

The VA's central role in authorizing and coordinating veteran healthcare must be preserved while effectively leveraging community resources within that framework. The existing VCCP already provides the structure needed to address access challenges in underserved areas. Rather than creating a competing parallel system, the bill should incentivize medical facilities not currently participating in VCCP to join that existing program.

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

The Veterans Mental Health and Addiction Therapy Quality of Care Act seeks to fulfill one of the VA MISSION Act of 2018's most important unmet promises: equipping veterans with the information they need to make informed healthcare choices and ensuring high-quality mental health care across both VHA facilities and the Veterans Community Care Program (VCCP). This is an inherently worthy objective. However, the bill as currently drafted risks undermining its own goals. Substantial revisions are needed to ensure it achieves its intended purpose.

The most fundamental flaw is the absence of any requirement for VA to modify its contracts with Third Party Administrators. Without contractual obligations, community care providers will have little incentive to assess patients' treatment progress. This means the intended comparison between VA and VCCP quality will collapse into a one-sided evaluation of VA care alone, completely defeating the bill's central intent.

Compounding this problem, the bill fails to authorize the VA or its designated evaluators to be able to access VCCP health care records. This creates a critical limitation: any comparison will be restricted to whatever records community providers happen to forward. Recent scientific studies and GAO reports reveal that only a fraction of initial records currently reach VA, with virtually nothing forwarded after initial treatment. The bill should explicitly require VCCP providers to submit both measurement data and veterans' complete health care records to VA for analysis, following the model established by the Fox Grant program.

The study design itself also needs clarification. The comparison must specifically contrast veterans treated in VA facilities with veterans treated through VCCP. As written, the bill could inadvertently compare VA patients with non-veterans in the private sector—an apples-to-oranges comparison that would yield far less meaningful results.

The bill should also specify the use of gold-standard outcome measurements that are widely accepted in the field. For PTSD, this means the PTSD Checklist. For depression, the PHQ–9. For substance use disorder, the Brief Addiction Monitor. These standardized instruments are essential for valid comparisons.

Several additional quality indicators are conspicuously absent from the current bill. There is no assessment of whether mental health and substance use providers have completed Department-accredited or other recognized training specific to the

conditions they treat—a fundamental gap in any quality evaluation. Similarly, the bill includes no requirement to track how many providers collect initial and follow-up data and enter it into the electronic health record. Provider peer review, another cornerstone of quality assurance, is entirely absent from the bill's requirements.

Wait times to commence treatment also need to be assessed.

Conducting a rigorous study of this complexity requires expertise that goes well beyond administrative capacity. The bill should designate that a scientific institution (such as the National Academies of the Sciences, Engineering, and Medicine) with demonstrated expertise in health outcomes evaluation oversee the study's design, methodology, measurement protocols, and analysis.

Finally, when evaluating the use of evidence-based practices in mental health and addiction therapy, the bill should reference the rigorously developed VA/DOD Clinical Practice Guidelines rather than the American Society of Addiction Medicine criteria.

With these revisions, the Veterans Mental Health and Addiction Therapy Quality of Care Act could fulfill its promise of empowering veterans with meaningful quality information. Without them, it risks creating an illusion of accountability while leaving veterans no better informed than they are today.

Veterans TBI Breakthrough Exploration of Adaptive Care Opportunities Nationwide Act of 2025 (BEACON Act of 2025)

The BEACON Act fundamentally undermines the VA's existing traumatic brain injury research and treatment infrastructure, particularly the VA Transitional Research Center for TBI and Stress Disorders (TRACTS). Rather than strengthening current programs and improving the lives of effected veterans, the legislation risks fragmenting and weakening the VA's coordinated efforts in this critical area.

The bill's stated purpose—to "increase research and development on integrated mTBI and mental health interventions outside the scope of traditional Department of Veterans Affairs pathways, interventions, programs, procedures, and pharmaceuticals"—appears designed to circumvent established clinical channels, potentially creating an alternative pathway for peer-based interventions that lack rigorous scientific validation.

This approach is unnecessary and counterproductive. The VA has already compiled extensive research on mild traumatic brain injury and its treatment. Veterans with mTBI currently have access to evidence-based psychotherapies that have been refined and improved over two decades of clinical practice. Creating a parallel treatment framework for mTBI ignores this substantial body of ongoing work and risks duplicating efforts and diverting needed resources.

Further, placing research grant administration outside the VA introduces organizational fragmentation and accountability gaps.

Data Driven Suicide Prevention and Outreach Act of 2025

The Data Driven Suicide Prevention and Outreach Act of 2025 would create a grant program to develop predictive models for evaluating suicide risk factors among veterans. While improving suicide prevention is undeniably critical, this legislation fundamentally duplicates the VA's existing big-data predictive analytics approach. Rather than strengthening the current program, it risks fragmenting and weakening the VA's efforts in this vital area.

Over the last decade, the VA has developed and refined a sophisticated suicide risk prediction algorithm and implemented the Recovery Engagement and Coordination for Health–Veterans Enhanced Treatment (REACH VET) program. REACH VET identifies VA patients at extraordinarily high risk for suicide—specifically, the top 0.1 percent risk tier, patients predicted to die by suicide at a rate 30 times that of the overall VHA patient population. This risk identification is then provided to local REACH VET program coordinators, who inform the patient's clinicians so both can work proactively to enhance care.

The program has demonstrated tangible results. A 2021 study found that REACH VET was associated with more outpatient encounters, increased documentation of new suicide prevention safety plans, and fewer inpatient mental health admissions, emergency department visits, and documented non-fatal suicide attempts. While the study did not identify differences in suicide or all-cause mortality, these process improvements represent meaningful enhancements to care coordination and crisis response.

The bill's stated purpose—awarding grants to develop predictive models evaluating risk factors that contribute to veteran suicide—creates a parallel framework that ignores this substantial body of ongoing work. This approach is both unnecessary and counterproductive. Any algorithms developed through the grant program

would be based on much smaller populations than the VA's comprehensive data base, inherently reducing their predictive value.

Creating competing systems fragments resources and effort. Rather than paying twice for the same application of artificial intelligence and predictive analytics, Congress should invest in expanding, refining, and properly resourcing the existing REACH VET infrastructure. The VA's program already has the population-scale data, established clinical integration pathways, and demonstrated track record needed to identify at-risk veterans and connect them with enhanced care.

Thank you for the opportunity to offer our input on these important pieces of legislation.

Prepared Statement of Cohen Veterans Network, Inc.

Statement for the Record submitted by Cohen Veterans Network, Inc.

House Committee on Veterans' Affairs Subcommittee on Health Hearing on H.R. 2283, the RECOVER Act January 13, 2026

Chairwoman Miller-Meeks, Ranking Member Brownley and distinguished members of the Subcommittee:

Thank you for the opportunity to submit this written testimony on behalf of the Cohen Veterans Network (CVN) in support of H.R. 2283, the RECOVER Act. As the Committee examines ways to ensure our nation's veterans have access to the highest quality mental health care, CVN appreciates the chance to provide insights into our work and underscore the importance of this legislation in addressing the persistent mental health and suicide crisis within the veteran community.

CVN is a **not-for-profit** philanthropic organization founded in 2016 that serves veterans, service members, and military families through a nationwide system of mental health clinics. We operate 22 clinics providing care across 20 states, including telehealth services. Our clinics offer treatment for a range of issues, including depression, anxiety, adjustment challenges, substance misuse, anger, post-traumatic stress disorder (PTSD), grief and loss, family issues, transition difficulties, sleep problems, relationship problems, and children's behavioral issues. We also provide comprehensive case management services to address social determinants of health, such as unemployment, food insecurity, finances, housing, and more. CVN does not turn veterans away based on discharge status or insurance, and we serve the whole family as defined by the veteran or service member.

Since our inception, CVN has served nearly 95,000 clients in over 850,000 clinical sessions, with nearly 480,000 of those delivered via telehealth. Over 54 percent of our clients have been veterans and service members, approximately 30 percent have been non-veteran adult family members, and 16 percent have been children. Notably, 31 percent of our veteran clients are female veterans. Our clinicians are trained in evidence-based practices and deliver measurable outcomes. We track satisfaction and clinical improvement across all clinics, with over 90 percent of clients reporting they would recommend CVN services to others. Our care model is military culturally competent, data-driven, and focused on filling gaps in the system through public-private partnerships.

While the Department of Veterans Affairs (VA) has made significant investments in expanding mental health services, challenges persist in the Community Care program, and the suicide epidemic among veterans continues unabated. CVN helps alleviate these pressures by providing barrier-free, high-quality outpatient treatment in military community settings, alongside the VA. We are proud to complement the VA's mission and extend its reach, ensuring that veterans and their families receive timely, effective support.

H.R. 2283, the RECOVER Act, represents a vital step forward in this effort. This legislation would establish a pilot grant program to support non-profit clinics like CVN in delivering culturally competent, evidence-based mental health care without cost being a barrier to the veteran. By fostering public-private partnerships, the RECOVER Act can help close access gaps,

particularly in underserved areas, and extend a lifeline to family members who are often excluded from the traditional VA system. This is not an attempt to privatize the VA, as some detractors may claim, but rather a targeted initiative to enhance the existing framework and solve the ongoing mental health and suicide crisis in the veteran community while also measuring the performance through detailed metrics of non-profit community organizations.

For some medical conditions that are too important to allow bureaucratic red tape to interfere with veterans' timely access to care, Congress has directed streamlined access to ensure that eligibility or billing questions don't stand in the way of necessary and timely treatment. For example, the VA Millennium Act of 1999 authorized VA to cover treatment costs for enrolled veterans who access emergency care services at non-VA facilities, coverage that was later mandated by Congress. The COMPACT Act of 2020 directed VA to cover emergency suicide care at any VA or non-VA facility, regardless of whether those veterans were enrolled in the VA healthcare system. The logic behind these streamlined provisions of care is simple: when veterans are in crisis or need sustained treatment, then VA should ease their access to the greatest extent possible. H.R. 2283, given its focused emphasis on mental health care and with carefully constructed guardrails around its funding authorization, is perfectly in line with these past bipartisan accomplishments.

These bipartisan efforts demonstrate a long history of Congress enabling veterans to utilize outside help where it makes sense, without undermining the VA's core role. The RECOVER Act builds on this foundation by empowering non-profits to provide complementary services, ensuring a more comprehensive and responsive community-wide system. A recent study in JAMA Network Open (May 21, 2025), titled "Experiences With VA-Purchased Community Care for US Veterans With Mental Health Conditions," highlighted these ongoing challenges, noting that vulnerable veterans often face difficulties navigating community care. The study underscores the need for targeted quality and care coordination strategies—precisely what the RECOVER Act aims to advance. CVN strongly agrees that community care must function as a complementary element to the VA, jointly improving access, options, and standards of care for veterans.

CVN stands ready to support the implementation of the RECOVER Act and pledges to continue working with the Committee, the VA, and other stakeholders to meet the full scope of veterans' mental health needs, including those of their families. Thank you to Chairman Bost for introducing the legislation. And thank you to the subcommittee for its leadership in advancing solutions like this legislation, which will save lives and strengthen our commitment to those who have served. We welcome any questions we can help the subcommittee with and look forward to ongoing collaboration.

Respectfully submitted,

Dr. Anthony Hassan
CEO & President

Prepared Statement of Aspire Health Partners

ASPIRE HEALTH PARTNERS

January 12, 2026

House Committee on Veterans' Affairs – Health
364 Cannon House Office Building
Washington, D.C. 20515

Statement for the Record - H.R. 2283 RECOVER Act

Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the Health Subcommittee:

At Aspire Health Partners, our mission has always been grounded in one simple belief: no veteran should have to wait for the mental health support they deserve. Every day, we see how timely, compassionate care can change lives—and, in many cases, save them. That's why I'm reaching out to ask for your support of H.R. 2283, the Recognizing Community Organizations for Veteran Engagement and Recovery (RECOVER) Act.

Across the country, veterans face a mental health landscape that is increasingly difficult to navigate. Veterans die by suicide at a rate 1.7 times higher than civilians—an average of 17.5 lives lost each day. Meanwhile, many VA facilities remain stretched beyond capacity, with wait times that too often exceed the 20-day standard. These delays come at a moment when swift intervention can make the difference between stability and crisis.

Community-based nonprofit mental health providers like Aspire are already stepping into that gap. We provide agile, evidence-informed care that meets veterans where they are—often faster, closer to home, and in a setting that feels more approachable. The RECOVER Act would establish a three-year pilot program to evaluate how partnerships with nonprofit outpatient clinics can strengthen outcomes for veterans and ease the strain on VA systems.

The RECOVER Act would:

- **Expand timely access to care** by offering veterans more options to receive support as soon as they need it.
- **Deliver veteran-centered services** that recognize the distinct experiences of combat trauma, PTSD, and military sexual trauma.

- continued -

- **Build stronger bridges between the VA and community providers,** improving coordination while preserving veterans' access to essential VA resources.

Your support for this legislation would help ensure that veterans can access the right care at the right time—care that can prevent crises, reduce suicide risk, and support long-term recovery.

Thank you for your steadfast commitment to those who have served our country and for considering this important step forward.

Warm regards,

Babette Hankey

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Prepared Statement of Berry Law

Written Statement for the Record of
Stephanie Costello, Esq., Senior Counsel[1]
Berry Law[2]

Submitted for a Legislative Hearing before the
Committee on Veterans' Affairs, Subcommittee on Health
U.S. House of Representatives

January 13, 2026

Chairwoman Miller-Meeks, Ranking Member Brownley, and Members of the Subcommittee,

My name is Stephanie Costello, and I am a Senior Counsel with Berry Law. I am proud to submit this statement for the record in support of the Subcommittee's work on legislation affecting veterans' health care and disability benefits.

Berry Law represents veterans nationwide in VA disability claims, including complex cases involving chronic pain, neurological conditions, mental health disorders, and service-connected toxic exposures. Through this work, our firm has gained extensive firsthand experience with how VA health care delivery, clinical documentation, and administrative policy affect veterans' ability to establish service connection and receive accurate disability ratings.

Our attorneys and staff regularly interpret and apply VA statutes, regulations, and claims guidance, providing practical insight into how legislative and policy changes operate in practice, both in the delivery of care and in the evidentiary record used to adjudicate claims. This claims-focused perspective allows Berry Law to evaluate proposed legislation not only as a matter of policy, but also in terms of its tangible impact on veterans navigating the VA system.

Our perspective complements the indispensable work of Veterans Service Organizations by offering formal legal expertise, appellate advocacy, and an integrated understanding of how medical evidence, access to care, and benefits adjudication intersect. Because veterans' health outcomes, access to care, and disability compensation are deeply interconnected, improvements to

[1] Biography available at: www.jsberrylaw.com/attorneys/stephanie-costello
[2] Berry Law is a midwestern law firm established in 1965 that handles personal injury litigation and veterans' disability appeals, providing legal counsel to injured civilians and veterans nationwide with an emphasis on securing VA benefits and compensation entitlements. For more information, visit www.ptsdlawyers.com.

VA claims processes directly reinforce the Subcommittee's mission of ensuring timely, high-quality care for those who served.

While this hearing primarily focuses on health care delivery and outcomes, the bill evaluations that follow also highlight how the proposed measures can strengthen VA disability compensation processes. Each analysis demonstrates that improved access to care, enhanced research, and higher-quality clinical documentation not only support health outcomes but also reinforce service-connection determinations, enable more accurate disability ratings, and improve the efficiency and fairness of claims adjudication. These recommendations are designed to complement the health-focused goals of the legislation, ensuring that enhancements in care and treatment also translate into meaningful benefits for veterans navigating the VA claims process, without creating unnecessary administrative burdens for veterans or their care teams.

The recommendations that follow are based on Berry Law's experience representing veterans and are offered to provide practical, actionable insight into how the proposed legislation may affect both health care delivery and disability claims outcomes.

Legislation Summary Table

This summary provides an overview of the key provisions discussed through this testimony, their potential impacts on VA disability claims, and our recommended refinements to maximize benefits for veterans.

Bill Name	Purpose	Key Support Points	Primary Recommendations
BEACON Act (TBI Research)	Fund VA grants for chronic mild TBI research & clinician training	Advances neurorehabilitation evidence; strengthens service-connection adjudication; improves clinician training	Link research outcomes to VA DBQs and rating schedules; ensure veterans & representatives have access to findings
Blast Overpressure Task Force Act	Coordinate research on blast-related health effects	Generates robust clinical evidence; standardizes neurological evaluations; annual reporting to Congress	Require VA to adopt Task Force recommendations; publish guidance for examiners; ensure transparency & timelines
Clarity on Care Operations Act	Publish CHAMPVA provider directory	Improves access and transparency for dependents; reduces administrative burden	Set usability standards; promote provider outreach; validate data and include feedback mechanisms

Bill Name	**Purpose**	**Key Support Points**	**Primary Recommendations**
Data-Driven Suicide Prevention & Outreach Act	Fund predictive suicide risk modeling using AI/ML	Enhances clinical documentation; targets high-risk veterans; supports mental health claims	Link research to claims exams; ensure transparency and access; implement privacy and ethical safeguards
U.S. Vets of the FAS Act	Furnish VA care to veterans in Freely Associated States	Improves care access; supports longitudinal medical records; facilitates telehealth and pharmacy services	Standardize documentation for claims; ensure telehealth and pharmacy interoperability; clarify travel payment guidance
NOPAIN for Veterans Act	Add FDA-approved non-opioid pain therapies to VA formulary	Expands access; reduces opioid reliance; strengthens documentation for pain-related claims	Establish documentation standards; integrate into multimodal pain management; clarify records' impact on ratings
Opioid Antagonist Access Act	Provide naloxone without a prescription or copay	Improves overdose prevention; supports medical documentation for substance-related claims	Require structured documentation; link access to follow-up care; provide education on use and documentation
Veterans with ALS Reporting Act	Report ALS prevalence, gaps, and resources	Supports epidemiological evidence for service connection; improves claims consistency	Link findings to exam standards; publish accessible summaries; establish functional documentation guidelines
Whole Health for Veterans Act	Limit copayment for Whole Health services	Encourages service utilization; supports documentation of functional health; enhances multimodal care records	Establish documentation standards; clarify record use in adjudication; improve veteran awareness and participation
RECOVER Act	Fund community-based mental health services	Expands culturally competent care; improves access and documentation	Ensure community documentation aligns with VA standards; track claim-relevant metrics; evaluate pilot for scalability
Veterans Health Desert Reform Act	Pilot access to hospital care in rural "health deserts"	Expands access; generates longitudinal records; aligns reimbursement with Medicare	Require standardized functional assessment documentation; evaluate impact on claims; clarify

Bill Name	Purpose	Key Support Points	Primary Recommendations
			eligibility & scope of services
Veterans Mental Health & Addiction Therapy Quality of Care Act	Compare VA vs. non-VA mental health care	Supports evidence-based improvements; strengthens documentation for compensation	Link study findings to claims adjudication; provide accessible summaries; require follow-up implementation plan

* * *

The following sections expand on these recommendations in greater detail, offering specific guidance to ensure each bill not only advances veteran care but also directly supports the development of claim-usable evidence, strengthens clinical documentation, and improves outcomes in VA disability compensation adjudication.

Veterans TBI Breakthrough Exploration of Adaptive Care Opportunities Nationwide (BEACON) Act of 2025

Support with Recommendations

The Veterans TBI Breakthrough Exploration of Adaptive Care Opportunities Nationwide (BEACON) Act of 2025 would establish a VA grant program to fund research and clinical trials focused on neurorehabilitation treatments for chronic mild traumatic brain injury (mTBI) and related conditions. The bill also supports clinician training and outreach based on emerging evidence and authorizes funding for fiscal years 2026 through 2028. Its overarching goal is to advance the understanding of effective interventions and improve care and outcomes for veterans with traumatic brain injury.

A. Rationale for Support

Berry Law supports the purpose of the BEACON Act.

Expanded scientific research and evidence-based clinical guidance can improve the accuracy, consistency, and fairness of VA disability claims adjudication. Many claims involving TBI and co-occurring conditions rely heavily on medical evidence that clearly links service-connected injury to current functional impairment. By fostering clearer diagnostic standards and more robust clinical documentation, this legislation has the potential to strengthen the evidentiary record used in service-connection determinations and disability rating decisions.

Rigorous research into neurorehabilitation for chronic mild TBI remains a high priority for veterans with service-connected neurological injuries. The bill's proposed grant structure would

support prospective randomized controlled trials and outcome-based studies of innovative treatments, generating high-quality clinical evidence that can inform both medical care and benefits determinations.

Improved clinical data also has direct relevance to VA compensation claims. Research funded under this Act may refine diagnostic criteria and functional outcome measures that are critical to determining appropriate disability ratings for TBI and associated mental health conditions. In addition, enhanced clinician training and outreach can reduce evidentiary gaps by increasing the likelihood that treating providers produce well-reasoned, service-relevant medical opinions suitable for use in VA claims and appeals.

B. Concerns and Recommendations

While Berry Law supports the intent of the BEACON Act, we respectfully recommend targeted refinements to ensure that research investments translate into measurable improvements in veterans' compensation outcomes.

(1) Strengthen Linkages Between Research Findings and VA Claims Adjudication

As drafted, the bill authorizes research and clinician training but does not explicitly connect resulting findings to the VA disability rating and adjudication process. We recommend:

- Requiring that research outcomes be shared with VA Compensation Service for consideration in refining TBI diagnostic policies, Disability Benefits Questionnaires (DBQs), and rating schedule criteria; and
- Establishing a stakeholder forum that includes researchers, the Board of Veterans' Appeals, and accredited representatives to translate clinical insights into clearer claims documentation and adjudicatory standards.

These steps would help ensure that scientific advancements funded under the Act improve claims adjudication quality, not solely clinical knowledge.

> Proposed language: *Not later than 180 days after the completion of each research study funded under this Act, the Department of Veterans Affairs shall provide a report to the Office of the Under Secretary for Benefits summarizing study outcomes and any clinical practice guidelines developed. VA shall consider these findings in updating TBI-related Disability Benefits Questionnaires, rating schedule criteria, and examiner training modules. The Secretary shall establish a stakeholder forum including VA Compensation Service, the Board of Veterans' Appeals, funded researchers, and accredited veteran representatives to review study findings and recommend updates to claims adjudication standards.*

(2) Ensure Veteran and Representative Access to Research Findings

We further recommend that the legislation require timely access for veterans and their accredited representatives to summaries and findings from funded studies. Without transparency and accessibility, high-quality research risks remaining siloed within academic or VA research environments, limiting its usefulness in claim development, appeals, and litigation.

> Proposed language: *The Secretary shall make publicly available, in a veteran-friendly format, summaries of all research outcomes and clinical guidance produced under this Act. These summaries shall be posted on the VA website and disseminated to accredited veteran representatives, with a requirement to update the information within 90 days of each study's completion.*

> Proposed language: *The Secretary shall include in annual reporting to Congress a description of how research outcomes have been integrated into claims development, including changes to DBQs, rating schedules, examiner training, and clinical evaluation guidance for TBI and related conditions.*

Blast Overpressure Research and Mitigation Task Force Act

Support with Recommendations

The Blast Overpressure Research and Mitigation Task Force Act would establish a joint VA and Department of Defense (DoD) task force to coordinate research on the health effects of blast overpressure exposure. The Task Force would identify best practices, research gaps, and strategies to improve clinical evaluation and treatment of blast-related injuries. The bill also requires annual reporting to Congress, including recommendations for improving both clinical care and the evaluation of evidence in VA disability claims.

A. Rationale for Support

Berry Law supports the purpose of this legislation.

Improved scientific understanding of blast-related injuries, combined with annual reporting and interagency coordination, can promote evidence-based improvements in veteran health care while directly supporting more accurate and consistent VA disability claims adjudication.

From a compensation advocacy perspective, the Task Force has the potential to strengthen the scientific foundation for establishing service connection for blast-related conditions. By prioritizing research into cumulative blast exposure and associated outcomes such as traumatic brain injury, neuroinflammation, sensory decline, and cognitive impairment, the Task Force can generate robust clinical evidence that is directly relevant to linking in-service blast exposure to current disability.

The bill's requirement that the Task Force develop recommendations on how VA evaluates evidence of blast-related neurological injury is particularly significant. If implemented effectively, these recommendations could reduce variability in how VA examiners and adjudicators assess complex neurological cases, leading to greater consistency, accuracy, and fairness in claims and appeals.

B. Concerns and Recommendations

While Berry Law supports the intent of the bill, we respectfully recommend several refinements to ensure that Task Force findings meaningfully improve veterans' compensation outcomes.

(1) Clarify How Task Force Findings Will Be Incorporated into VA Adjudication and Rating Practices

Although the bill calls for recommendations on evaluating evidence, it does not explicitly require VA to incorporate Task Force findings into the disability claims process. We recommend that Congress:

- Require VA to publish guidance, policy updates, or regulatory changes informed by Task Force findings, particularly as they relate to neurological examinations, nexus opinions, and rating criteria; and
- Encourage incorporation of Task Force recommendations into VA Training Letters or other formal guidance provided to medical examiners and rating specialists.

These steps would help ensure that research findings translate into higher-quality evidence development and more consistent adjudication outcomes.

> Proposed language: *Not later than 180 days after the submission of each annual Task Force report, the Secretary of Veterans Affairs shall issue guidance, policy updates, or regulatory changes incorporating Task Force findings into VA disability claims adjudication. Such guidance shall include updates to neurological examination protocols, Disability Benefits Questionnaires (DBQs), nexus opinion standards, and rating schedule criteria. The Secretary shall also ensure that findings are integrated into VA examiner and rater training materials within 90 days of policy issuance.*

(2) Ensure Transparency and Access to Task Force Findings for Veterans and Their Representatives

Without explicit public access requirements, Task Force research and recommendations may remain internal to VA or DoD, limiting their usefulness for claimants. We recommend that the bill require VA to:

- Make Task Force reports and scientific findings publicly available on VA websites in a veteran-friendly format; and
- Provide plain-language summaries tailored to veterans and accredited representatives explaining how research findings may support claims and appeals.

Transparency will help ensure that veterans and their advocates can fully benefit from the research Congress directs.

> Proposed language: *The Secretary shall make all Task Force reports, research findings, and recommendations publicly available on VA websites in a veteran-friendly format. Plain-language summaries shall also be published and distributed to accredited veteran representatives. These summaries shall describe how research findings may inform clinical evaluations, functional assessments, and claims development for veterans exposed to blast overpressure*.

(3) Include Timelines and Accountability Measures for Implementation

While the bill establishes a 180-day deadline to create the Task Force and requires annual reports, it does not specify timelines for VA action on Task Force recommendations. We recommend adding language directing VA to respond within a defined period, such as 180 days after each annual report, detailing how it will implement, adopt, or otherwise address Task Force recommendations in policy or practice.

Clear timelines and accountability measures will help ensure that research findings result in meaningful, timely improvements for veterans.

> Proposed language: *Within 180 days of receipt of each Task Force annual report, the Secretary shall submit to Congress a written plan detailing actions taken or planned to implement Task Force recommendations. The plan shall specify timelines, responsible offices, and performance metrics for integrating findings into VA clinical practice and claims adjudication processes. Subsequent annual submissions shall report progress and any barriers encountered.*

Clarity on Care Operations Act

Support with Recommendations

The Clarity on Care Operations Act would require the VA to compile and publish a publicly available directory of health care providers who accept CHAMPVA assignment. The directory is intended to help CHAMPVA beneficiaries more easily locate participating providers, understand where benefits may be used, and avoid unexpected costs. By improving transparency and predictability, the bill seeks to strengthen access to care for eligible veterans' dependents.

A. Rationale for Support

Berry Law supports the purpose of this legislation.

Improving access to and transparency in CHAMPVA-covered care supports veterans by stabilizing family health care access and reducing administrative and financial stressors that can interfere with veterans' engagement in their own VA health care and benefits processes.

From a benefits and compensation perspective, smoother coordination of dependent care can reduce disruptions that complicate benefit administration and medical record management. A centralized, searchable directory would allow beneficiaries to identify participating providers more efficiently, reducing billing disputes, claim denials, and delays that often result in fragmented or incomplete medical documentation.

Predictable access to dependent care also supports continuity of treatment, which can mitigate secondary stressors affecting veterans managing service-connected disabilities. Over time, increased transparency may also encourage broader provider participation, strengthening CHAMPVA networks and improving care coordination across VA-administered benefit programs.

B. Concerns and Recommendations

While Berry Law supports the intent of the Clarity on Care Operations Act, we respectfully recommend the following refinements to ensure effective implementation and maximize benefits for veterans and their families.

(1) Establish Clear Implementation and Usability Standards

Although the bill requires VA to publish a provider directory, it does not specify usability or accessibility requirements. We recommend that Congress direct VA to ensure that the directory: is searchable by geographic location and provider specialty; is mobile-friendly and accessible to users with disabilities; is updated on a regular and clearly defined schedule; and includes plain-language explanations of what it means for a provider to "accept CHAMPVA assignment," in order to reduce beneficiary confusion and billing disputes.

> Proposed language: *The Secretary of Veterans Affairs shall ensure that the CHAMPVA provider directory is searchable by geographic location and provider specialty, is mobile-friendly, meets accessibility standards for users with disabilities, and is updated at least quarterly. The directory shall include plain-language explanations of CHAMPVA assignment and participation requirements to reduce beneficiary confusion and prevent billing disputes.*

(2) Promote Provider Outreach and Education

Publishing a directory alone may be insufficient if providers are unfamiliar with CHAMPVA participation requirements. Congress should encourage VA to pair directory publication with targeted provider education and outreach regarding CHAMPVA billing and

participation. VA should also implement mechanisms that allow providers to update their participation status more frequently than on an annual basis.

> Proposed language: *The Secretary shall implement a program to educate and inform CHAMPVA providers about participation requirements, billing procedures, and directory use. Providers shall be able to update their participation status at least quarterly. VA shall provide targeted outreach to encourage provider enrollment and timely directory updates*.

(3) Ensure Data Accuracy and Ongoing Validation

Without routine validation, provider directories risk becoming outdated and unreliable. We recommend that Congress require periodic verification of provider participation and authorize a beneficiary feedback mechanism to report inaccuracies. VA should also be encouraged to report on directory accuracy and maintenance as part of ongoing program oversight.

> Proposed language: *The Secretary shall establish a verification process to confirm provider participation at regular intervals and provide a mechanism for beneficiaries to report inaccuracies. VA shall submit an annual report to Congress detailing directory accuracy, validation measures, and any corrective actions taken*.

Data Driven Suicide Prevention and Outreach Act of 2025

Support with Recommendations

This bill would establish a grant program for nonprofits, academic institutions, and research organizations to develop predictive suicide risk models for veterans using artificial intelligence and machine learning. The goal is to identify high-risk individuals earlier and implement targeted interventions to reduce veteran suicide rates, particularly in geographic areas with higher incidence or longer wait times for care.

A. Rationale for Support

Berry Law supports the purpose of this legislation.

From a VA compensation claims perspective, advanced analytic approaches to suicide prevention have the potential to indirectly improve clinical documentation and functional assessments relevant to disability claims. By prioritizing predictive suicide prevention research, the VA can strengthen evidence supporting service-connected mental health conditions while focusing on the most underserved veteran populations. Further:

- Grant funding may produce validated models enabling earlier identification of at-risk veterans, supporting timely clinical intervention for PTSD, major depressive disorder, and other mental health conditions frequently involved in claims.

- Improved predictive models may result in higher-quality documentation of functional impairments and symptom severity, supporting nexus development for service-connected mental health claims.
- Prioritizing high-risk regions may generate data relevant to veterans who face barriers to care, improving both treatment outcomes and documentation needed for claims adjudication.

B. Concerns and Recommendations

While Berry Law supports the intent of the bill, we recommend refinements to ensure that research outcomes translate into actionable evidence for disability compensation claims:

(1) Link Research Outcomes to Compensation Exams and Guidance

The bill focuses on research and predictive modeling but does not require VA to integrate findings into compensation exams or rating guidance. Congress should encourage VA to issue implementation guidance explaining how predictive suicide risk models should be incorporated into clinical evaluation reports, Disability Benefits Questionnaires (DBQs), and compensation examinations. Examiner training modules should reflect validated research on suicide risk and functional impacts relevant to service-connected conditions.

> Proposed language: *The Secretary of Veterans Affairs shall ensure that validated predictive suicide risk findings from federally funded research are incorporated into clinical evaluation reports, Disability Benefits Questionnaires (DBQs), and compensation examinations for service-connected mental health conditions. VA shall update examiner training and guidance to reflect validated research on suicide risk indicators, functional impairment, and symptom severity relevant to service-connected disabilities.*

(2) Transparency and Access for Veterans and Representatives

Without explicit access requirements, veterans and accredited representatives may be unable to use research findings to support claims or appeals. Congress should require VA to publish summaries of predictive model findings and methodologies in veteran-friendly formats. Outreach should inform veterans and advocates how research results can support clinical treatment and disability evaluations.

> Proposed language: *VA shall publish veteran-friendly summaries of predictive suicide risk research findings, including methodologies and implications for clinical care, functional assessments, and disability evaluations. VA shall conduct outreach to veterans, accredited representatives, and advocates to explain how research findings may be used to support claims, appeals, and treatment planning.*

(3) Ethical and Privacy Safeguards

Use of AI-based predictive models raises concerns regarding privacy, algorithmic bias, and misclassification risk, which could indirectly affect clinical documentation used in claims. Congress should emphasize transparent validation standards and safeguards to prevent bias against subgroups of veterans. VA should clearly communicate model limitations to ensure adjudicators interpret predictive findings appropriately in the context of claims.

> Proposed language: *Congress emphasizes that all AI- and machine learning-based suicide risk models funded under this program shall meet transparent validation and privacy standards, including safeguards against algorithmic bias and misclassification of veteran subpopulations. VA shall provide guidance on the appropriate interpretation and limitations of predictive findings when used in clinical evaluations or claims adjudication to ensure fair and accurate consideration in disability determinations*.

U.S. Vets of the Freely Associated States Act (H.R. 6652)

Support with Recommendations

The U.S. Vets of the Freely Associated States Act would direct the VA to enter into agreements with the governments of the Freely Associated States (FAS) to furnish hospital care, medical services, telehealth, and mail-order pharmacy services to eligible veterans residing in those jurisdictions. The bill also authorizes beneficiary travel payments when necessary and requires regular reporting to Congress on implementation and costs.

A. Rationale for Support

Berry Law supports the purpose of this legislation.

From a veterans' health and compensation perspective, improved access to VA-furnished care for veterans residing in the Freely Associated States can directly strengthen the development of medical evidence used in disability claims and appeals.

By authorizing VA to furnish care through agreements with FAS governments and providers, the bill helps ensure that veterans living outside the continental United States can obtain consistent medical treatment for service-connected conditions. More consistent care supports the creation of longitudinal medical records, which are often critical to establishing service connection, demonstrating chronicity, and supporting accurate disability ratings.

The inclusion of telehealth and mail-order pharmacy services further promotes continuity of care for chronic and service-connected conditions, particularly where in-person access is limited. Continuity of care improves the completeness, reliability, and probative value of medical documentation relied upon in VA adjudication. In addition, authorization of beneficiary travel

payments reduces financial barriers to obtaining necessary in-person examinations, specialty care, diagnostic testing, or medical nexus opinions required for claims development.

Finally, the bill's reporting requirements promote oversight and accountability, helping identify and address care delivery challenges that could otherwise impede access to examinations or evidence development for claims.

B. Concerns and Recommendations

While Berry Law supports the intent of the bill, we respectfully recommend several refinements to ensure that care furnished under this authority meaningfully supports veterans' compensation outcomes.

(1) Clarify Documentation Standards for Use in VA Disability Claims

Although the bill focuses on care delivery and access, it does not address how clinical encounters conducted under FAS agreements will be documented for claims purposes. We recommend that Congress encourage VA to:

A. Adopt standardized documentation practices aligned with VA compensation evidence requirements, including clear functional assessments, diagnostic findings, and nexus-relevant narratives; and

B. Ensure that medical records generated under FAS agreements are fully integrated into veterans' VA electronic health records and claims files in a format usable by adjudicators.

Proposed language: *The Secretary of Veterans Affairs shall establish standardized clinical documentation requirements for all medical encounters conducted under agreements with the Freely Associated States. Documentation must include functional assessments, diagnostic findings, and nexus-relevant narratives suitable for VA disability claims. All records shall be fully integrated into the veteran's VA electronic health record and claims file in a claims-usable format.*

(2) Establish Documentation and Integration Standards for Telehealth and Pharmacy Services

The bill authorizes telehealth and mail-order pharmacy services but does not specify documentation or interoperability standards. Congress should urge VA to establish minimum requirements to ensure that remote encounters generate claim-usable medical evidence and are properly integrated into VA systems. Reporting requirements should include metrics related to documentation completeness and record integration relevant to claims adjudication.

Proposed language: *The Secretary shall issue guidance establishing minimum documentation and interoperability standards for telehealth and mail-order pharmacy encounters provided under this Act. Documentation must capture clinical assessments, treatment outcomes, and functional status in a format*

compatible with VA claims adjudication. VA shall include metrics on documentation completeness and integration as part of ongoing reporting to Congress.

(3) Clarify Implementation and Outreach for Beneficiary Travel Payments

While the bill authorizes beneficiary travel payments, it does not specify eligibility guidance, timelines, or outreach requirements. We recommend that VA issue clear implementation guidance explaining how and when travel payments will be provided to veterans residing in the Freely Associated States who require in-person care or examinations. Congress should also encourage targeted outreach to ensure veterans are aware of available travel benefits that may assist them in obtaining medical evidence necessary for claims.

Proposed language: *The Secretary shall issue clear guidance on eligibility, timelines, and procedures for beneficiary travel payments for veterans residing in the Freely Associated States. VA shall implement outreach to inform eligible veterans of available travel assistance to support in-person care, examinations, or diagnostic services necessary for VA claims development.*

NOPAIN for Veterans Act (H.R. 4509)

Support with Recommendations

The NOPAIN for Veterans Act would require the VA to include FDA-approved non-opioid pain management drugs and biological products on its national formulary and drug standardization list once they meet eligibility criteria for Medicare coverage. The bill is intended to expand veterans' access to safer, evidence-based alternatives for pain management while reducing reliance on opioid medications.

A. Rationale for Support

Berry Law supports the purpose of this legislation.

From a veterans' health and compensation perspective, expanded access to non-opioid pain management therapies can improve clinical care while also strengthening the quality of medical evidence used to evaluate disability claims involving chronic pain, musculoskeletal conditions, and neurological impairments.

Requiring timely inclusion of FDA-approved non-opioid therapies in the VA formulary promotes evidence-based pain management and reduces the risks associated with long-term opioid use. Improved clinical stability and more comprehensive treatment options can produce clearer, more reliable medical records documenting pain severity, functional limitations, and response to treatment, key factors in accurate disability rating determinations.

Aligning VA formulary inclusion with Medicare coverage timelines also helps reduce treatment gaps that frequently complicate claims involving chronicity and continuity of symptoms.

Broader access to alternative pain therapies may encourage individualized pain management plans that more thoroughly document residual functional impairment, which is often the central issue in claims where pain itself is the primary disabling condition.

B. Concerns and Recommendations

While Berry Law supports the intent of the NOPAIN for Veterans Act, we respectfully recommend the following refinements to ensure that expanded access to non-opioid therapies translates into meaningful improvements in compensation outcomes.

(1) Establish Documentation Standards for Use in VA Disability Claims

The bill focuses on access to medications but does not address how use of non-opioid therapies will be documented for claims purposes. We recommend Congress encourage VA to:

- Require structured documentation of pain severity, functional limitations, and treatment response when non-opioid therapies are prescribed or administered; and
- Provide guidance and training to clinicians on documenting pain management encounters in a manner that clearly supports service-connection and disability severity determinations.

Proposed language: *The Secretary of Veterans Affairs shall require structured documentation for all non-opioid pain management therapies, including FDA-approved drugs and biological products, capturing pain severity, functional limitations, and treatment response. VA shall provide clinicians with guidance and training to ensure documentation supports service-connection determinations and accurate disability ratings.*

(2) Integrate Non-Opioid Therapies into Comprehensive Pain Management Protocols

The bill does not address how non-opioid medications will be incorporated into broader pain management strategies. VA implementation guidance should emphasize multimodal pain management approaches, including physical therapy, behavioral health interventions, and functional assessments, to ensure that clinical records reflect the full impact of pain on daily functioning. Such integration would strengthen the evidentiary record in claims involving chronic pain and related disabilities.

Proposed language: *The Secretary shall issue guidance for integrating non-opioid pain management therapies into multimodal pain management plans, including physical therapy, behavioral health interventions, and functional assessments. Clinical records should reflect the overall impact of pain on daily functioning to support claims adjudication and disability severity determinations.*

(3) Clarify How Pain Treatment Records Inform Compensation Examinations and Rating Decisions

Absent explicit guidance, inconsistencies may arise in how non-opioid pain treatment records are interpreted during compensation examinations and rating decisions. We recommend that Congress encourage VA to issue examiner and rater guidance explaining how non-opioid pain management records should be weighed when evaluating disability severity. Training materials should specifically address pain-related functional impairment as reflected in non-opioid treatment histories, particularly in musculoskeletal and neurological claims.

> Proposed language: *The Secretary shall provide examiner and rater guidance specifying how documentation from non-opioid pain management therapies should be considered in compensation examinations and rating decisions. Training materials should emphasize evaluation of functional impairment as documented in non-opioid treatment records, particularly for musculoskeletal, neurological, and chronic pain-related disabilities.*

Opioid Antagonist Access Act (H.R. 5999)

Support with Recommendations

The Opioid Antagonist Access Act would amend title 38, United States Code, to require the VA to furnish an opioid antagonist, such as naloxone, to veterans without requiring a prescription or copayment. The bill is intended to remove administrative and financial barriers to life-saving medications used to prevent fatal opioid overdoses.

A. Rationale for Support

Berry Law supports the purpose of this legislation.

From a veterans' health and compensation perspective, improving access to opioid antagonists promotes veteran safety while also supporting the development of more complete medical records related to pain management, substance use disorder, and associated secondary conditions that frequently arise in VA disability claims.

Eliminating prescription requirements increases timely access to opioid antagonists, particularly for veterans with chronic pain or substance use histories who may be at elevated risk of overdose. Removing copayments further ensures that cost does not deter veterans from obtaining or carrying these medications, aligning VA policy with established public health best practices.

Preventing fatal or severe nonfatal overdoses can also reduce the incidence of secondary injuries, such as hypoxic brain injury, neurological impairment, or cognitive deficits, that often complicate disability claims and require extensive evidentiary development. Timely intervention

can therefore improve both health outcomes and the integrity of the medical record relevant to compensation evaluations.

B. Concerns and Recommendations

While Berry Law supports the goal of expanded access, we respectfully recommend additional safeguards to ensure that opioid antagonist use and related clinical encounters meaningfully support veterans' compensation outcomes.

(1) Require Structured Documentation of Overdose-Related Encounters

The bill focuses on medication access but does not address how overdose-related events or antagonist use will be documented in VA medical records. We recommend that Congress encourage VA to require structured documentation of the circumstances surrounding opioid antagonist provision or use, including clinical context, outcomes, and any resulting functional or neurological impacts. Clear documentation can serve as critical evidence in subsequent disability claims involving cognitive, neurological, or substance-related impairments.

> Proposed language: *The Secretary of Veterans Affairs shall require that all encounters involving provision or use of opioid antagonists be documented in a structured format within the veteran's electronic health record. Documentation must include the clinical context, outcomes, and any observed functional or neurological impacts, to ensure medical records are sufficient for both clinical follow-up and VA disability claims adjudication.*

(2) Integrate Antagonist Access with Coordinated Follow-Up Care

The bill does not explicitly link opioid antagonist access to comprehensive pain management or substance use disorder treatment. VA implementation guidance should pair antagonist distribution with appropriate referral pathways to pain management, mental health, or substance use disorder services. Coordinated follow-up care improves veteran outcomes and strengthens the quality and continuity of medical records used in claims adjudication.

> Proposed language: *The Secretary shall establish protocols linking opioid antagonist access to coordinated follow-up care, including referrals to pain management, mental health, or substance use disorder services as appropriate. Records of follow-up care must be integrated into the veteran's VA medical record to support continuity of care and documentation relevant to service-connected claims.*

(3) Promote Provider and Veteran Education on Use and Documentation

Without education and outreach, utilization may lag and documentation practices may vary. We recommend that Congress encourage VA to implement provider training on documenting opioid antagonist encounters in a manner that supports both clinical care and claims adjudication.

VA should also provide veterans with clear information regarding availability, proper use, and follow-up care expectations to help ensure these encounters are appropriately captured in the medical record.

> Proposed language: *The Secretary shall implement training for VA clinicians on proper documentation of opioid antagonist provision and related clinical encounters, emphasizing both clinical care and claims relevance. VA shall also provide veterans with educational materials on availability, correct use, and recommended follow-up, and shall track outreach and training efforts to ensure consistent implementation*.

Veterans with ALS Reporting Act (H.R. 6001)

Support with Recommendations

The Veterans with ALS Reporting Act would require the VA to submit a report to Congress on the incidence and prevalence of amyotrophic lateral sclerosis (ALS) among veterans. The report would address existing resources and support programs, identify gaps in care, and outline strategies to reduce risk. The bill also directs VA to monitor ALS prevalence through existing registries and provide periodic updates to Congress.

A. Rationale for Support

Berry Law supports the purpose of this legislation.

From a veterans' health and compensation perspective, improved data collection and reporting on ALS within the veteran population can strengthen the evidentiary foundation for complex neurological disability claims and promote more consistent adjudication outcomes.

ALS claims frequently depend on epidemiological evidence, longitudinal medical documentation, and clear assessments of functional decline. Requiring VA to compile comprehensive data on ALS incidence and prevalence among veterans may help clarify service-related risk factors and support broader epidemiological evidence relevant to service-connection determinations.

Ongoing monitoring through existing registries and periodic reporting can generate longitudinal data reflecting disease progression and functional impairment, critical elements in disability rating decisions and evaluations for special monthly compensation. In addition, reporting on gaps in care and available resources can help identify systemic barriers that delay diagnosis or treatment, which often affects the completeness and timing of medical evidence submitted in support of claims.

B. Concerns and Recommendations

While Berry Law supports the intent of the Veterans with ALS Reporting Act, we respectfully recommend several refinements to ensure that reporting outcomes meaningfully support veterans' compensation claims.

(1) Connect Report Findings to Claims Adjudication Standards

The bill focuses on data collection and reporting but does not explicitly require that findings inform VA compensation examination standards or rating guidance. We recommend that Congress encourage VA to include in its report a dedicated section addressing how ALS-related data, risk analysis, and epidemiological findings should inform medical examination protocols, nexus opinions, and Disability Benefits Questionnaires (DBQs). VA should also consider consulting claims adjudicators and veteran advocates during report development to ensure clinical insights translate into claim-relevant guidance.

> Proposed language: *The Secretary of Veterans Affairs shall include in each report required under this Act a dedicated section addressing how ALS-related epidemiological data, risk analysis, and prevalence findings should inform VA medical examination protocols, nexus opinions, and Disability Benefits Questionnaires (DBQs). VA shall consult claims adjudicators, accredited representatives, and relevant stakeholders to ensure that clinical insights translate into guidance usable in service-connected disability claims and rating decisions.*

(2) Improve Accessibility of Report Findings for Veterans and Their Representatives

Highly technical reports may be difficult for veterans and accredited representatives to interpret and use in claims and appeals. We recommend that Congress encourage VA to publish plain-language summaries highlighting key findings and their implications for veterans pursuing ALS-related disability benefits. Outreach or briefings for stakeholders could further assist in translating report conclusions into practical claim development tools.

> Proposed language: *The Secretary shall provide plain-language summaries of each ALS report, highlighting key findings and their relevance to veterans pursuing ALS-related disability benefits. The Secretary shall also conduct periodic outreach, briefings, or webinars for veterans, accredited representatives, and advocacy organizations to promote understanding of how report conclusions can support claims development and appeals.*

(3) Promote Standardized Functional Documentation for ALS Claims

The bill does not address how ALS-related clinical findings should be documented to support precise disability evaluations. We recommend that VA be encouraged to develop or identify standardized functional assessment elements that clearly capture disease progression and impacts on activities of daily living. These documentation standards could later be incorporated into

compensation examinations or DBQs to improve consistency, accuracy, and fairness in ALS claims adjudication.

> Proposed language: *The Secretary shall develop or adopt standardized functional assessment elements to capture ALS disease progression and impacts on activities of daily living. These standards shall be integrated into VA compensation examinations, DBQs, and medical documentation practices to improve the consistency, accuracy, and fairness of ALS-related disability claims adjudication.*

Whole Health for Veterans Act (H.R. 6001)

Support with Recommendations

The Whole Health for Veterans Act would amend title 38, United States Code, to limit the extent to which copayments may be required for veterans receiving Whole Health well-being services. Specifically, it would prohibit copayments for veterans in Priority Groups 1–5 and cap copayments at $20 per month for other eligible veterans. The legislation seeks to expand access to complementary, integrative, and educational health services within the VA health care system.

A. Rationale for Support

Berry Law supports the purpose of this legislation.

From a veterans' health and compensation perspective, reducing financial barriers to Whole Health services encourages greater utilization of VA-furnished care and can result in more complete clinical documentation of veterans' functional health. Increased engagement with these services indirectly strengthens the evidentiary record used to support disability compensation claims, particularly for conditions involving chronic pain, mental health, and functional impairment.

Eliminating or limiting copayments makes Whole Health services more accessible, encouraging veterans to seek care earlier and more consistently. This increased utilization can generate richer medical records documenting functional limitations, symptom management, and treatment response, critical evidence in disability evaluations.

The bill explicitly supports complementary and integrative services, such as meditation, yoga, Tai Chi/Qigong, and guided imagery, which are often employed in multimodal approaches to service-connected conditions like PTSD and chronic pain. Documentation of these treatments can help demonstrate ongoing functional impairment and efforts at symptom management.

Furthermore, alignment with VA's broader shift toward veteran-centered and holistic care may reduce fragmentation in treatment histories, producing longitudinal records that strengthen claims and appeals.

B. Concerns and Recommendations

While Berry Law supports the intent of the bill, we recommend refinements to ensure that expanded access to Whole Health services translates into usable evidence for disability compensation claims:

(1) Establish Documentation Standards for Claims Evidence

The bill does not specify how encounters for Whole Health services should be documented for compensation purposes. Congress should encourage VA to adopt standardized documentation practices that capture functional limitations, symptom severity, and treatment outcomes relevant to disability evaluations. These elements could be incorporated into Disability Benefits Questionnaires (DBQs) and examiner training materials.

> Proposed language: *The Secretary of Veterans Affairs shall develop standardized documentation practices for Whole Health encounters that capture functional limitations, symptom severity, and treatment outcomes relevant to disability evaluations. Such documentation standards shall be incorporated into VA Disability Benefits Questionnaires (DBQs), clinical notes, and examiner training materials to ensure that Whole Health service records are claim-usable and support consistent adjudication of service-connected disabilities.*

(2) Clarify How Whole Health Records Are Weighed in Adjudication

The bill does not address how Whole Health service records should be considered during claims adjudication. VA should issue guidance confirming that Whole Health clinical records constitute valid medical evidence and explain how adjudicators and examiners should weigh these records when evaluating service-connected disabilities. Congress may consider requiring VA to assess and report on the impact of Whole Health utilization on claims development and outcomes.

> Proposed language: *VA shall issue guidance confirming that clinical records from Whole Health services constitute valid medical evidence and explaining how such records should be considered by adjudicators and examiners during the evaluation of service-connected disabilities. VA shall also monitor and report on the impact of Whole Health service utilization on claims development, evidence completeness, and adjudication outcomes to Congress annually.*

(3) Ensure Veteran Awareness and Consistent Utilization

Even with reduced copayments, limited awareness may restrict participation and the resulting documentation benefits. VA should implement targeted outreach and education to inform veterans and clinicians about Whole Health services and copayment limits. Reporting on utilization rates and demographic disparities could help identify barriers that indirectly affect evidence development for claims.

Proposed language: *VA shall implement outreach and education programs for veterans and clinicians regarding available Whole Health services and applicable copayment limits. VA shall regularly report utilization metrics, including demographic disparities, to identify barriers to access and ensure that service engagement translates into comprehensive medical documentation supportive of disability claims.*

RECOVER Act (H.R. 2283)

Support with Recommendations

This bill would authorize the VA to award grants to established nonprofit mental health providers to expand access to culturally competent, evidence-based mental health services for veterans. The pilot program focuses on increasing in-community mental health care, improving veteran engagement, and fostering partnerships with trusted local organizations.

A. Rationale for Support

Berry Law supports the purpose of this legislation.

From a VA compensation claims perspective, community-based mental health services can indirectly strengthen the quality of evidence used in service-connected claims by improving access, documentation, and continuity of care. Further:

- Grants facilitate veteran access to treatment in their communities, reducing barriers to consistent care and producing detailed clinical documentation relevant to PTSD, depression, and other service-connected mental health conditions.
- Treatment by evidence-based community providers can generate thorough records documenting diagnoses, treatment responses, and functional limitations, supporting nexus and severity evidence in VA claims.
- Partnering with community organizations can encourage early care-seeking, minimizing gaps in treatment histories that often complicate disability claims and appeals.

B. Concerns and Recommendations

While Berry Law supports the intent of the bill, we recommend refinements to ensure that community-based mental health services translate into actionable evidence for VA compensation claims:

(1) Link Community Provider Documentation to VA Compensation Standards

The bill funds mental health care access but does not ensure that documentation aligns with VA adjudication standards. Congress should require VA to provide guidance for community

providers on using standardized Disability Benefits Questionnaires (DBQs) or VA-compatible documentation formats to support service-connection and rating decisions. VA should also offer training to community partners on claims-relevant documentation practices.

> Proposed language: *The Secretary of Veterans Affairs shall provide guidance and training to nonprofit community mental health providers funded under this program to ensure clinical documentation aligns with VA compensation standards. Documentation shall be formatted to support service-connection determinations and disability rating decisions, including the use of VA-compatible Disability Benefits Questionnaires (DBQs) or other approved templates suitable for claims adjudication.*

(2) Track Claims-Relevant Outcomes

The pilot emphasizes mental health outcomes but does not evaluate whether participation improves evidence quality for claims. Congress should encourage VA to collect data on whether funded programs enhance claim success rates, nexus evidence quality, or reduce appeals, and report these findings to Congress.

> Proposed language: *VA shall collect and report data on the extent to which participation in RECOVER-funded programs enhances claims-relevant evidence, including documentation of functional limitations, treatment response, and nexus development. Congress shall receive periodic updates evaluating program impact on claims quality, appeals, and service-connection determinations.*

(3) Ensure Sustainability and Scalability

As a three-year pilot, the program may conclude before long-term impacts on care navigation, documentation, and claims outcomes are fully realized. Congress should require VA to evaluate pilot effectiveness and propose integration into permanent programs if successful, with mechanisms linking community provider documentation to VA claims adjudication.

> Proposed language: *Upon completion of the pilot program, VA shall conduct a comprehensive evaluation of program effectiveness, including its impact on claims documentation and adjudication outcomes. If demonstrated effective, VA shall propose integration of community-based mental health partnerships into permanent programs, with mechanisms ensuring ongoing alignment with claims documentation standards.*

Veterans Health Desert Reform Act of 2025 (H.R. 2286)

Support with Recommendations

This bill establishes a pilot program to provide hospital care and medical services through eligible hospitals in rural areas with high veteran populations, often referred to as "Veteran Health

Deserts." The program aims to improve access to care for veterans who live far from VA facilities, with oversight on costs, quality, and satisfaction, and reimbursement aligned with Medicare rates.

A. Rationale for Support

Berry Law supports the purpose of this legislation.

From a VA compensation claims perspective, improving access to care in rural areas promotes evidence collection on care delivery and strengthens the quality of medical documentation used in service-connected disability claims. Further:

- Expanding access to hospitals closer to veterans helps ensure consistent care, producing more complete and timely medical records for chronic and complex service-connected conditions.
- Oversight and reporting on care quality, outcomes, and patient satisfaction can generate longitudinal medical records critical for claims adjudication and rating determinations.
- Aligning reimbursement with Medicare rates encourages participation by local hospitals and supports continuity of care, which increases the likelihood that clinical records will be sufficiently detailed and claim-usable.

B. Concerns and Recommendations

While Berry Law supports the intent of the bill, we recommend refinements to ensure that care delivered under the pilot generates evidence directly usable in VA disability compensation claims:

(1) Standardized Documentation for Claims

Clinical data produced under the pilot may not align with VA claims standards (e.g., DBQs or functional assessments). Congress should encourage VA to issue guidance requiring pilot hospitals to use standardized documentation formats and provide training to hospital staff on capturing functional limitations and service-connection evidence.

> Proposed language: *The Secretary of Veterans Affairs shall ensure that clinical documentation produced under the Veterans Health Desert pilot program adheres to VA claims standards. Pilot hospitals shall use standardized formats, including Disability Benefits Questionnaires (DBQs) or other VA-approved functional assessment templates, and VA shall provide training to hospital staff to accurately document service-connected conditions, functional limitations, and treatment outcomes relevant to disability claims.*

(2) Evaluate Impact on Disability Claims

Current reporting focuses on health outcomes, access, cost, and satisfaction but does not assess the impact on compensation claims. Congress should require an analysis of how pilot-

generated medical records are used in claims and appeals, including their effect on timely decisions and quality of evidence.

> Proposed language: *VA shall track and report the use of pilot-generated medical records in claims adjudication, including their impact on timeliness, accuracy, and quality of service-connection determinations. Periodic evaluations shall include metrics on claims outcomes, appeals, and adjudicator feedback to measure how effectively pilot documentation supports disability claims.*

(3) Clarify Eligibility and Scope of Services

The bill references "covered veterans" and uses the Veterans Community Care Program framework, but functional assessments critical for claims may not be explicitly included. Implementation guidance should ensure that evaluations capture longitudinal functional limitations relevant to VA disability determinations.

> Proposed language: *Implementation guidance shall define eligible veteran populations and specify that evaluations conducted under the pilot program include functional assessments relevant to VA disability determinations. Pilot hospitals shall document longitudinal functional limitations and service-related health impacts to ensure medical records are sufficient for claims adjudication.*

Veterans Mental Health and Addiction Therapy Quality of Care Act (H.R. 4045)

Support with Recommendations

This bill directs the Department of Veterans Affairs to enter into an agreement with an independent, objective organization to conduct a comprehensive study comparing the quality of mental health and addiction therapy care provided by VA versus non-VA providers. The evaluation spans delivery modalities including telehealth, outpatient, and residential treatment.

A. Rationale for Support

Berry Law supports the purpose of this legislation.

From a VA compensation claims perspective, evaluating the quality of mental health and addiction services can indirectly enhance the quality of clinical documentation, which is crucial for service-connected disability claims. Further:

- Independent, objective comparisons can identify strengths and weaknesses in both VA and community treatment systems, supporting improvements in care outcomes.
- Reports include clinical outcomes (e.g., symptom improvement, suicide risk), use of evidence-based practices, care coordination, and patient satisfaction, all of which inform functional assessments relevant to compensation claims.

- Publication of findings to congressional committees and public online access ensures transparency and allows veterans, clinicians, and advocates to leverage results in treatment and claims contexts.

B. Concerns and Recommendations

While Berry Law supports the intent of the bill, we recommend refinements to ensure study findings translate into usable evidence for VA disability compensation claims:

(1) Link Study Findings to Compensation Adjudication

The bill focuses on research outcomes but does not explicitly require incorporation into claims evaluation or adjudication standards. Congress should encourage VA to include guidance in the final report on how findings inform functional limitation assessments, treatment histories, and nexus evidence used in claims. Follow-on policy should translate study results into examiner training or claims evaluation guidance.

> Proposed language: *Implementation guidance shall require that study findings on mental health and addiction therapy quality be incorporated into VA compensation evaluation standards. This shall include functional limitation assessments, documentation of treatment histories, and nexus evidence used in service-connected disability claims. VA shall issue examiner guidance and training to ensure study results are consistently applied in Disability Benefits Questionnaires, compensation examinations, and claims adjudication.*

(2) Ensure Accessibility of Findings for Claimants

Technical study reports may be difficult for veterans and accredited representatives to interpret. Congress should require plain-language summaries of key findings and encourage congressional briefings or stakeholder outreach to explain implications for claims and appeals.

> Proposed language: *VA shall publish plain-language summaries of study findings, including key clinical outcomes, care coordination metrics, and quality comparisons between VA and non-VA providers. VA shall conduct targeted outreach, including briefings and informational materials for veterans, accredited representatives, and other stakeholders, to ensure study results are accessible and usable in clinical care and VA disability claims.*

(3) Establish Implementation and Follow-Up Mechanisms

The study timeline is 18 months, but there is no mechanism for applying findings to policy or claims procedures. Congress should require VA to implement study recommendations within a defined timeframe, updating clinical practice, care coordination, and claims evaluation guidance. A follow-up report to Congress within one year of study completion should document actions taken.

Proposed language: *Within one year of study completion, VA shall submit a follow-up report to Congress detailing actions taken to implement study recommendations, including updates to clinical practice, care coordination protocols, and claims evaluation guidance. VA shall establish a defined timeline for incorporating findings into policy and examiner training to ensure study results meaningfully improve veteran care and the quality of medical documentation for compensation claims*.

***

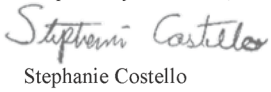
On behalf of Berry Law and the clients we serve, I would like to relay my deep appreciation for the Committee's consideration of these important legislative proposals affecting veterans' health, well-being, and access to benefits. Each of the bills discussed addresses critical gaps in care, research, and clinical documentation that directly or indirectly impact veterans' ability to obtain timely and accurate disability compensation.

As mentioned above, we strongly support the intent of these measures to expand access to evidence-based treatments, enhance clinical research, improve data collection, and reduce administrative and financial barriers to care. At the same time, we urge the Committee to ensure that implementation of these programs explicitly connects clinical and research advancements to the VA disability compensation process. Clear guidance, standardized documentation, transparency, and timely integration of findings into claims adjudication are essential to maximize the real-world benefit to veterans.

By adopting these refinements, the Committee can help ensure that these legislative initiatives not only improve clinical care and research but also strengthen the evidentiary foundation for veterans' disability claims, ultimately promoting fairness, consistency, and efficiency in the VA system.

We welcome the opportunity to provide further clarification or technical assistance to the Committee on these and other legislative matters affecting veterans' health care, research, and disability compensation. Please contact my colleague, Andy Blevins, Senior Counsel, at andy.blevins@berrylaw.com, if we may be of service.

Respectfully Submitted,



Stephanie Costello

Prepared Statement of Easterseals DC/MD/VA

Statement for the Record (HR 2283

Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the Health Subcommittee:

At Easer Seals Serving DC/MD/VA we are profoundly committed to breaking down barriers to mental health care for veterans and providing lifesaving, timely support. Today, I'm writing to urge your support for H.R. 2283, the Recognizing Community Organizations for Veteran Engagement and Recovery Act (RECOVER Act), a critical bill that addresses the mental health crisis among veterans.

Veterans are 1.7x more likely to die by suicide than civilians with an average of 17.5 suicides a day. Many VA facilities are overwhelmed, often leading to long wait times exceeding the 20-day wait time standard. This highlights the urgent need for innovative, data-driven solutions to help reduce the veteran suicide rate. Nonprofit community-based mental health clinics are uniquely positioned to fill the gaps in care, providing the timely, culturally competent, evidence-based care that veterans urgently need.

The RECOVER Act would establish a three-year pilot program to demonstrate whether evidence-based mental health care, delivered by non-profit outpatient mental health facilities, can lead to improved outcomes.

Key Benefits of the Bill Include:

- **Timely, Accessible Care:** Reducing wait times and ensuring veterans can receive support when they need it most.
2. **Culturally Competent Support:** Addressing unique mental health challenges related to PTSD, combat trauma, and military sexual trauma.
3. **Strengthening VA Partnerships:** Enhancing collaboration to reduce the overburden on VA facilities while preserving access to VA services.

By supporting this legislation, you'll play a pivotal role in expanding access to life-changing care for veterans and significantly lowering the risk of mental health crises, including suicide. Thank you for your continued support for U.S. military veterans and attention to this matter. We would welcome you to tour our veteran behavioral health clinic in Silver Spring.

Warm regards,

Jonathan Horowitch
President & CEO
Easter Seals Serving DC/MD/VA
jhorowitch@eseal.org • 301-9209719

Prepared Statement of Voices for Non-Opioid Choices

January 13, 2026

The Honorable
Chairwoman
Committee on Veterans' Affairs
Subcommittee on Health
U.S. House of Representatives
Washington, DC 2015

The Honorable
Ranking Member
Committee on Veterans' Affairs
Subcommittee on Health
U.S. House of Representatives
Washington, DC 20515

RE: ***Voices for Non-Opioid Choices Written Statement for U.S. House of Representatives, Committee on Veterans' Affairs, Subcommittee on Health Legislative Hearing, January 13, 2026***

Dear Chairwoman Miller-Meeks and Ranking Member Brownley,

Voices for Non-Opioid Choices ("Voices") appreciates the opportunity to submit this written statement for the record. Specifically, Voices – and our more than 250 member organizations and tens of thousands of advocates from around the country – would like to express our unwavering support for the *Non-Opioids Prevent Addiction in the Nation* ("NOPAIN") *for Veterans Act*, H.R. 4509, as introduced by Congressmen Greg Landsman (D-OH), Derrick Van Orden (R-WI), Jack Bergman (R-MI), Abe Hamadeh (R-AZ), Chris Pappas (D-NH), and Congresswoman Terri Sewell (D-AL).

Too many veterans lack access to many FDA-approved non-opioid pain management approaches due to overly restrictive practices of the Veterans' Affairs National Formulary (VANF). Limited choices in non-opioids lead to an over-reliance on prescription opioids to manage veterans' acute pain, including after surgery.

This practice unnecessarily exposes veterans to prescription opioids, which can lead to abuse, misuse, addiction, overdose, and death. Fortunately, these outcomes are entirely preventable by increasing access to – and use of – non-opioid pain management approaches. The U.S. Food and Drug Administration (FDA) has approved several such approaches, and many are used to manage patients' acute pain. Federal law, the *Non-Opioids Prevent Addiction in the Nation (NOPAIN) Act*, requires Medicare coverage for many of these products. Unfortunately, this statutory requirement has not extended to the VA, and the current practice of the VANF puts such non-opioid approaches out of reach for most veterans.

Make no mistake – drug overdose deaths among veterans are increasing. From 2010 to 2019, drug overdose mortality rates among veterans increased by 53 percent.[1] This makes the VANF's current practices especially problematic because:

- Two-thirds of all U.S. veterans report experiencing pain following deployment;[2]
- Nearly half report misusing prescription opioids;[3] and
- 2.4 million veterans report having a substance use disorder (SUD).[4]

Prescription opioids provide unique challenges for veterans in large part because this community experiences disproportionately high rates of mental health disorders, including depression, anxiety, post-traumatic stress disorder (PTSD), and more.[5] Often, these individuals use opioids and other illicit substances to mask emotional pain. In the United States, long-term opioid use rates following surgery typically range from 6 to 11 percent, potentially impacting more than 5 million Americans a year.[6] [7] It is especially dangerous to expose veterans to these risks.

It is critically important that we equip clinicians with more tools to manage our veterans' acute pain, including non-addictive approaches, to minimize unnecessary exposure to opioids.

The NOPAIN for Veterans Act is a critical step in the right direction.

This legislation will require the U.S. Department of Veterans' Affairs (VA) to add certain FDA-approved non-opioid acute pain management approaches to the VANF. In the process, the legislation will enable choices in how VA beneficiaries' postsurgical pain is managed, reducing the rates of opioid abuse, misuse, dependence, and addiction occurring post-surgically.

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[1] Bennett, A. S., Guarino, H., Britton, P. C., O'Brien-Mazza, D., Cook, S. H., Taveras, F., Cortez, J., & Elliott, L. (2022). *U.S. military veterans and the opioid overdose crisis: A review of risk factors and prevention efforts*. Annals of Medicine, 54(1), 1500–1514. https://doi.org/10.1080/07853890.2022.2092896.

[2] National Institute on Drug Abuse. (2019). *Substance use and military life [DrugFacts]*. National Institutes of Health. https://nida.nih.gov/publications/drugfacts/substance-use-military-life.

[3] Kelley, M. L., Bravo, A. J., Votaw, V. R., Stein, E., Redman, J. C., & Witkiewitz, K. (2019). *Opioid and sedative misuse among veterans wounded in combat*. Addictive Behaviors, 92, 168–172. https://doi.org/10.1016/j.addbeh.2018.12.007.

[4] Substance Abuse and Mental Health Services Administration. (2024). *2023 National Survey on Drug Use and Health: Among the veteran population aged 18 or older*. Center for Behavioral Health Statistics and Quality, U.S. Department of Health and Human Services. https://www.samhsa.gov/data/sites/default/files/reports/rpt53159/2023-nsduh-pop-slides-veterans.pdf.

[5] Ngo, T. P., Keyhani, S., Leonard, S., & Hoggatt, K. J. (2025). *Substance use and use disorders among veterans on long-term opioid therapy*. Drug and Alcohol Dependence Reports, 16, Article 100347. https://doi.org/10.1016/j.dadr.2025.100347.

[6] Lawal, O. D., Gold, J., Murthy, A., Ruchi, R., Bavry, E., Hume, A. L., Lewkowitz, A. K., Brothers, T., & Wen, X. (2020). *Rate and risk factors associated with prolonged opioid use after surgery: A systematic review and meta-analysis*. JAMA Network Open, 3(7), e207367. https://doi.org/10.1001/jamanetworkopen.2020.7367.

[7] Hollenbeck, B. K., Dunn, R. L., Suskind, A. M., Zhang, Y., Hollingsworth, J. M., & Birkmeyer, J. D. (2014). *Ambulatory surgery centers and outpatient procedure use among Medicare beneficiaries*. Medical Care, 52(10), 926–931. https://doi.org/10.1097/MLR.0000000000000213.

And save lives.

The men and women who so bravely serve our country as part of our Armed Services deserve the best of us. This includes setting them up for success behind their deployment. In honor of the sacrifices these brave men and women have made on behalf of our country, we have a duty and a responsibility to ensure they receive the best health benefits we can provide. In short, this means ensuring access to the full range of applicable non-opioid analgesic products after surgery.

We implore this subcommittee and the House Committee on Veterans' Affairs to favorably advance this critical piece of legislation designed to prevent opioid addiction before it starts.

Because our veterans deserve it.

We stand ready to work with both of your offices in furtherance of this shared goal, and please do not hesitate to reach out to us at chris@nonopioidchoices.org with any questions.

With gratitude,

Chris Fox
Executive Director

Prepared Statement of Centerstone

CENTERSTONE

Statement for the Record

Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the Health Subcommittee:

At Centerstone we are profoundly committed to breaking down barriers to mental health care for veterans and providing lifesaving, timely support. Today, I'm writing to urge your support for H.R. 2283, the Recognizing Community Organizations for Veteran Engagement and Recovery Act (RECOVER Act), a critical bill that addresses the mental health crisis among veterans.

Veterans are 1.7x more likely to die by suicide than civilians with an average of 17.5 suicides a day. Many VA facilities are overwhelmed, often leading to long wait times exceeding the 20-day wait time standard. This highlights the urgent need for innovative, data-driven solutions to help reduce the veteran suicide rate. Nonprofit community-based mental health clinics are uniquely positioned to fill the gaps in care, providing the timely, culturally competent, evidence-based care that veterans urgently need.

The RECOVER Act would establish a three-year pilot program to demonstrate whether evidence-based mental health care, delivered by non-profit outpatient mental health facilities, can lead to improved outcomes.

Key Benefits of the Bill Include:

1. **Timely, Accessible Care:** Reducing wait times and ensuring veterans can receive support when they need it most.
2. **Culturally Competent Support:** Addressing unique mental health challenges related to PTSD, combat trauma, and military sexual trauma.
3. **Strengthening VA Partnerships:** Enhancing collaboration to reduce the overburden on VA facilities while preserving access to VA services.

By supporting this legislation, you'll play a pivotal role in expanding access to life-changing care for veterans and significantly lowering the risk of mental health crises, including suicide.

Thank you for your continued support for U.S. military veterans and attention to this matter.

Kind regards,

Matt Hardy, Psy.D.
CEO Centerstone TN
O. 615-460-4325 | M. 931-241-0929
Matt.Hardy@Centerstone.org
1921 Ransom Place
Nashville, TN 37217

Prepared Statement of The Up Center

Statement for the Record

Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the Health Subcommittee:

At The Up Center, we are profoundly committed to breaking down barriers to mental health care for veterans and providing lifesaving, timely support. Today, I'm writing to urge your support for H.R. 2283, the Recognizing Community Organizations for Veteran Engagement and Recovery Act (RECOVER Act), a critical bill that addresses the mental health crisis among veterans.

Veterans are 1.7x more likely to die by suicide than civilians, with an average of 17.5 suicides a day. Many VA facilities are overwhelmed, often resulting in wait times exceeding the 20-day standard. This highlights the urgent need for innovative, data-driven solutions to help reduce the veteran suicide rate. Nonprofit community-based mental health clinics are uniquely positioned to fill the gaps in care, providing the timely, culturally competent, evidence-based care that veterans urgently need.

The RECOVER Act would establish a three-year pilot program to demonstrate whether evidence-based mental health care delivered by nonprofit outpatient mental health facilities improves outcomes.

Key Benefits of the Bill Include:

1. **Timely, Accessible Care:** Reducing wait times and ensuring veterans can receive support when they need it most.
2. **Culturally Competent Support:** Addressing unique mental health challenges related to PTSD, combat trauma, and military sexual trauma.
3. **Strengthening VA Partnerships:** Enhancing collaboration to reduce the overburden on VA facilities while preserving access to VA services.

By supporting this legislation, you'll play a pivotal role in expanding access to life-changing care for veterans and significantly lowering the risk of mental health crises, including suicide.
Thank you for your continued support for U.S. military veterans and attention to this matter.

Warm regards,

Tina Gill

Tina Gill
President & CEO
The Up Center
tina.gill@theupcenter.org
(757)965-8648

Prepared Statement of Air Force Sergeants Association

Chairwoman Miller-Meeks, Ranking Member Brownley, and distinguished Members of the Subcommittee:

On behalf of the Air Force Sergeants Association (AFSA), thank you for the opportunity to submit this statement for the record for today's Health Subcommittee Legislative Hearing. We appreciate your leadership and sustained commitment to ensuring veterans receive timely, high-quality, and compassionate care.

AFSA is the premier professional military association for enlisted Airmen and Guardians, representing active duty, Guard and Reserve members, veterans, retirees, and their families. Our mission is to advocate for a stronger quality of life for those who serve and have served—through effective legislation, informed policy engagement, and support to the military community. We work closely with Congress, the Department of Veterans Affairs, and partner organizations to advance commonsense reforms that strengthen readiness, improve health outcomes, and honor the Nation's commitment to those who wear or have worn the uniform.

AFSA Strongly Supports H.R. 4509, the NOPAIN for Veterans Act

Veterans have earned care that is not only available in theory, but accessible in practice. Especially when they are recovering from surgery or serious medical procedures. Yet too many veterans still describe situations where appropriate acute pain care is delayed, difficult to obtain, or constrained in ways that do not reflect the realities of individual medical need. When acute pain is not effectively managed, the consequences can be serious: unnecessary suffering, delayed recovery, avoidable complications, and increased risk of reliance on medications that may not be clinically optimal for that patient.

This legislation is a practical, veteran-centered step toward ensuring the Department of Veterans Affairs can provide clinically appropriate, individualized post-surgical pain management, including non-opioid options that can reduce unnecessary exposure to opioids while still treating pain effectively. It reinforces a simple principle: decisions about acute pain control should be guided by medical evidence and provider judgment, not one-size-fits-all constraints that can unintentionally leave veterans without the right tools at the right time.

Restoring Clinical Judgment While Supporting Responsible Safeguards

AFSA supports responsible efforts to prevent misuse of controlled substances and to promote patient safety. However, policies designed to curb misuse must not inadvertently restrict access to legitimate, medically necessary pain treatment—especially for veterans managing complex injuries, surgical recoveries, or service-connected conditions. Veterans are not a monolith. Their injuries, comorbidities, medication histories, and responses to treatment vary widely. A pain management approach that works for one veteran may be ineffective for another.

The NOPAIN for Veterans Act appropriately reinforces clinical judgment by ensuring VA providers can access a broader set of post-surgical pain management options, including non-opioid therapies, and apply them based on the needs of the individual veteran. At its core, this bill supports the ability of the care team to treat the whole patient—reducing pain, supporting mobility and rehabilitation, and improving recovery outcomes—without forcing unnecessary tradeoffs that can compromise care.

Conclusion

AFSA urges Congress to advance H.R. 4509 without delay. Veterans should never be forced to endure unmanaged pain as a consequence of well-intended but overly restrictive policy barriers. When a veteran enters a VA facility for surgery or a serious procedure, they should have confidence that their care team has access to a full range of appropriate tools to manage pain safely and effectively.

Again, we thank the Subcommittee for its leadership and continued dedication to improving veterans' health outcomes. AFSA stands ready to work with you to move the NOPAIN for Veterans Act forward and ensure it is implemented in a way that strengthens patient-centered care for all veterans.

Prepared Statement of Tragedy Assistance Program for Survivors

TRAGEDY ASSISTANCE PROGRAM FOR SURVIVORS
3101 Wilson Boulevard, Suite 300, Arlington, VA 22201
800-959-TAPS ✯ 202-588-TAPS (8277) ✯ www.taps.org

January 13, 2026

The Honorable Mariannette Miller-Meeks
Chairwoman, Subcommittee on Health
House Committee on Veterans' Affairs
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Julia Brownley
Ranking Member, Subcommittee on Health
House Committee on Veterans' Affairs
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairwoman Miller-Meeks and Ranking Member Brownley,

The Tragedy Assistance Program for Survivors (TAPS) is writing to express our strong support for the ***Recognizing Community Organizations for Veteran Engagement and Recovery (RECOVER) Act*** **(H.R. 2283).** This important legislation would establish a comprehensive, three-year pilot program that would provide targeted financial grants to qualifying outpatient mental health facilities to help increase critical access to culturally competent and evidence-based mental health care for veterans in underserved rural and urban areas.

Since our founding, TAPS has supported more than 30,000 individuals whose military and veteran loved ones died by suicide. In 2025, 29 percent of those coming to TAPS for care each day were grieving a death resulting from suicide and a life that included military service. TAPS conducts in-depth interviews with each survivor to reflect on their loved one's life before suicide. One typical pattern identified among thousands of military and veteran suicide survivors is the call for the nation and military community to prioritize mental health care as an essential element to overall wellness and readiness.

Above all, mental health care needs to be consistent. The bonds formed by veterans and providers at the start of the care cycle are critical. Having to retell their difficult stories time and time again to new providers at each visit can be debilitating. Abruptly changing care teams, especially when a veteran becomes suicidal, only heightens the sense of crisis. Familiarity and predictability are keys to effective mental health care.

Veterans are more likely to seek help from an established culturally competent provider when they feel a sense of safety and trust. Talking about thoughts of suicide with an established provider — when they are not necessarily intent or have a plan for suicide — should be seen as positive in that the veteran is trusting enough to share some of their deeper struggles.

TAPS acknowledges and appreciates the Department of Veterans Affairs (VA) ongoing investment in mental health services and suicide prevention, which includes care for posttraumatic stress disorder (PTSD), psychological effects of military sexual trauma (MST), depression, grief, anxiety, and other needs. TAPS views the ***RECOVER Act*** as a supplemental measure to enhance, not replace, these current VA efforts. Improving timely access to VA mental health care providers and accessing qualified outpatient mental health facilities, will provide better mental health care outcomes for our nation's veterans.

In addition, veteran and surviving families also need timely mental health care support, especially survivors grieving a military loved one who died by suicide. These survivors often cope with symptoms of trauma and complicated grief, putting them at increased risk for suicide, posttraumatic stress, and other mental health concerns due to the traumatic nature of their loss. It is imperative that we not wait until a crisis occurs; increasing access to mental health care providers and providing a sense of belonging and social connection earlier in the grieving process for survivors will decrease individual risks and help save lives.

On behalf of the 120,000-plus surviving families TAPS is honored to serve, we thank you for your time and consideration. On behalf of our military survivor community, TAPS appreciates your leadership in ensuring the best possible future for our veterans, families, caregivers, and survivors.

Respectfully,

Bonnie Carroll
President and Founder, Tragedy Assistance Program for Survivors (TAPS)

Prepared Statement of VoteVets

January 13th, 2026

Dear Chairwomen Miller-Meeks, Ranking Member Brownley, and Members of the Committee,

On behalf of nearly 2 million Veterans, servicemembers, and military families in the VoteVets community, I write to express strong concerns about three pieces of legislation on the agenda for the January 13th Subcommittee on Health Legislative Hearing.

As written, VoteVets opposes the RECOVER Act (H.R. 2283); the BEACON Act (H.R. 6993); and the Health Desert Reform Act Discussion Draft. While each proposal is framed as an expansion of Veteran access to care, the bills would have the opposite effect: fragmenting care delivery, draining resources from the VA, and creating new pathways that favor private industry over Veterans' well-being.

- **H.R. 2283 – RECOVER Act**
  H.R. 2283 would create a new grant program that carves out certain private mental health providers and funnels taxpayer dollars to them outside VA's existing community care structure. Veterans already have access to community providers through the MISSION Act, which ensures proper authorization, clinical continuity, and accountability. By contrast, this bill opens the door to "preferred" outside vendors with no meaningful guardrails or standards, duplicating existing programs while reducing visibility into the care Veterans receive. Instead of expanding coordinated VA capacity, the RECOVER Act shifts resources into the private marketplace, risking uncoordinated treatment, unnecessary referrals, and diminished outcomes. At its core, the bill accelerates privatization efforts driven by investor-backed entities that stand to profit from siphoning Veterans away from the care they earned.

- **H.R. 6993 – BEACON Act**
  The BEACON Act would create two potentially overlapping grant programs that divert funding from VA mental health treatment and research. The bill steers scarce resources toward private entities with no demonstrated capacity or cultural competency to treat Veterans, instead of investing in proven VA programs. At a time of rising need, fragmenting funding and care would undermine progress and put Veterans at risk.

- **Discussion Draft – Health Desert Reform Act**
  This draft legislation would create a pilot program allowing Veterans in rural areas to seek care in non-VA hospitals, without verifying eligibility or prior authorization. While expanding rural access is essential, and a laudable goal, the proposal takes a step backwards by eliminating critical safeguards and exposing Veterans to serious risks, including surprise billing, misdiagnosis, and disrupted treatment. Without access to medical histories, service-connected records, or follow-up requirements, non-VA hospitals may deliver incomplete or ineffective care, while the VA loses oversight of the Veteran's treatment journey. By deliberately bypassing the structures Congress created under the MISSION Act—structures designed to balance access with safety and coordination—the bill would weaken clinical outcomes, reduce accountability, and push Veterans into fragmented systems ill-equipped to serve them.

Unfortunately, as drafted, H.R. 2283, H.R. 6993, and the Health Desert Reform discussion draft open dangerous pathways to privatization, siphon resources away from the country's only Veteran-designed health care system, and expose Veterans to the very challenges VA was created to prevent.

We urge the Committee to reverse course and focus instead on more effective approaches to the goal we all share: providing Veterans with the highest quality healthcare our nation has to offer.

Thank you for your consideration. If you have any questions or there is anything VoteVets can do to support, please let me know.

Sincerely,

Mary Kaszynski
Director of Government Relations
VoteVets

Prepared Statement of Embassy of the Federated States of Micronesia

EMBASSY OF THE
FEDERATED STATES OF MICRONESIA
1725 N St. NW
Washington, DC 20036
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Emails: dcmission@fsmembassy.fm
Website: www.fsmembassy.fm

January 16, 2026

The Honorable Michael Bost
Chair
House Committee on Veterans' Affairs
U.S. House of Representatives
Washington, D.C., 20510

The Honorable Mark Tacano
Ranking Member
House Committee on Veterans' Affairs
U.S. House of Representatives
Washington, D.C., 20510

The Honorable Mariannette Miller-Meeks
Subcommittee Chair
House Veterans' Affairs Subcommittee on Health
U.S. House of Representatives
Washington, D.C., 20510

The Honorable Julia Brownley
Subcommittee Ranking Member
House Veterans' Affairs Subcommittee on Health
U.S. House of Representatives
Washington, D.C., 20510

Dear Chairman Bost, Ranking Member Takano, Subcommittee Chair Miller-Meeks, and Subcommittee Ranking Member Brownley,

On behalf of the Federated States of Micronesia (FSM), I am writing in connection with the House Veterans' Affairs Subcommittee on Health January 13th legislative hearing on the *U.S. Vets of the FAS Act* (H.R. 6652). This bipartisan legislation, led by Reps. King-Hinds (R-MP), Case (D-HI), Tokuda (D-HI) and Delegates Radewagen (R-AS) and Moylan (R-GU), would direct the Secretary of Veterans Affairs to furnish certain health services, including telehealth, mail order pharmacy, and beneficiary travel, to veterans of U.S. military service in the Freely Associated States (FAS), in a manner consistent with the Compact of Free Association Amendments Act of 2024.

Citizens of the FSM have served honorably and in significant numbers in the U.S. Armed Forces, underscoring the deep and enduring partnership between our nations. The U.S. and the FSM have a unique security and defense relationship, and the Compact of Free Association between our countries expressly contemplates that FSM citizens may serve in the U.S. military. Many have done so, and some have paid the ultimate price. After service in the U.S. military, many of these our veterans face often insurmountable challenges in accessing the health care benefits they have earned after they return home to the Freely Associated States. These barriers include often prohibitively costly travel to fly thousands of miles to U.S. VA facilities. This need to travel, the inherent delays in accessing U.S. care,

and the disruption of family and work lives can be mitigated through basic services that are made available to U.S. veterans. This is not a new issue, and the FSM government has requested VA services for our veterans in the FSM for decades.

Two years ago, we were optimistic about this issue being remedied in the amended Compact law. The Compact of Free Association Amendments Act of 2024 reaffirmed the special partnership between the United States and the FAS and, with very strong congressional intent in support of FSM veterans, granted new authorities to the Department of Veterans Affairs (VA) to enhance health care for FSM citizens who served in the U.S. military.

Beginning in September 2024, the FSM government engaged in seven months of productive bilateral negotiations with the VA on a framework agreement for these services. Despite these constructive discussions and substantial progress, we were deeply disappointed when the VA abruptly suspending talks in April 2025, without prior consultation with the FSM and without regard for the undisputed needs of our veterans of U.S. military service. This development was contrary to clear congressional intent in the 2024 Compact Act.

In response, we have worked constructively with congressional offices and committees to pursue legislative solutions to ensure the VA carries out these authorities. We welcomed bipartisan efforts in both chambers to address this issue, including the introduction of the *Caring for Veterans and Strengthening National Security Act* (S.3436), which passed the Senate unanimously in December 2025, and the *U.S. Vets of the FAS Act* (H.R. 6652), now under consideration by this Committee. These measures reflect commitment of its sponsors to improving access to essential services, including telehealth, mail-order pharmacy benefits, and beneficiary travel, for veterans of U.S. military service residing in the FAS.

We appreciate the Committee's consideration of this legislation at this hearing and applaud the leadership of the House and Senate sponsors of these bills which are critical solutions to support our veterans. We look forward to collaborating with the committee on this legislation and working toward solutions that uphold the intent of the veterans' care provisions included in the COFA Amendments Act of 2024.

Sincerely,

Jackson Soram
FSM Ambassador to the United States

○