KEEPING OUR PROMISE TO AMERICA'S VETERANS

Washington Headquarters
1300 I Street, NW, Suite 400 West
Washington, DC 20005
tel 202-554-3501
dav.org

STATEMENT OF
NAOMI M. MATHIS
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
FOR THE RECORD OF THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
FEBRUARY 25, 2025

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

Thank you for inviting DAV (Disabled American Veterans) to submit testimony for the record of this legislative hearing. As you know, DAV is a congressionally chartered and Department of Veterans Affairs (VA) accredited veterans service organization. We provide meaningful claims support free of charge to more than 1 million veterans, family members, caregivers and survivors. We are pleased to provide our views on the bills under consideration by the Committee.

H.R. 472, the Restore VA Accountability Act of 2025

DAV has consistently advocated for a culture of accountability within the VA, where VA employees are held to the highest standards of performance and conduct. We applaud the committee for its efforts to address longstanding issues within the VA and to ensure that federal employees are responsible for their actions. We concur that bad employees must be held accountable to ensure that the best federal employees are serving veterans; however, accountability must include due process principles, protecting the rights of employees, including veterans, who make up nearly 30% of VA's workforce.

H.R. 472, the Restore VA Accountability Act of 2025, makes several changes to the due process of appeals for employees at the VA. The Act would allow for expedited disciplinary actions for certain categories of VA employees based on substantial evidence of misconduct or poor performance. Specifically, the bill would remove the Performance Improvement Plan (PIP) requirement and the appellant's review by the Merit Systems Protection Board (MSPB).

Although the goal of the Restore VA Accountability Act is to increase accountability by streamlining the disciplinary process and ensuring that VA employees who do not meet performance standards or engage in misconduct can be held accountable more swiftly and effectively, DAV asks the committee to give careful consideration to our concerns, which may have an indirect impact on the high quality of care and benefits services provided to veterans.

DAV's major concern is the exclusion of the MSPB from the appeals process for federal employees. The MSPB has historically served as an independent and impartial body that reviews agency decisions and safeguards employees from arbitrary or unjust actions. By removing the MSPB from the appeals process, we risk depriving employees of a crucial avenue for redress and oversight.

Additionally, DAV has concerns with provisions that eliminate the necessity for PIPs before any disciplinary measures are taken. PIPs provide employees with a fair opportunity to address and correct performance issues before facing more severe consequences. Eliminating this critical step could lead to unjust disciplinary actions.

DAV wholeheartedly supports the Committee's commitment to accountability within the VA. However, striking a balance between holding civil servants accountable for their performance while maintaining the VA as an employer of choice for the best and brightest to ensure veterans receive the best care and timely services remains our priority.

We firmly believe that due process must not be compromised in pursuit of these goals, which has been reiterated within DAV's Resolution No. 138 that notes any bill enacted by Congress should include standards by which accountability can be measured while ensuring due process and fairness for VA employees subject to such standards.

H.R. 740, Veterans' ACCESS Act of 2025

The VA health care system is vital to millions of service-disabled veterans, offering comprehensive primary care and specialized programs tailored to their unique needs. While community care should be available as a supplement when the VA cannot provide timely, accessible, or high-quality care, it should not replace the VA's primary role in delivering and coordinating integrated care for enrolled veterans. The lack of expansion in the VA's capacity to meet the increasing demand for care has led to an over-reliance on external providers. The growing reliance on community care in recent years presents significant challenges to this comprehensive, evidence-based care model.

The VA MISSION Act of 2018 (P.L. 115-182) introduced a new process for integrating community care with the VA's hospital care, medical care, and extended care services, ensuring veterans receive the highest standards of care regardless of limitations within the VA health care system. The legislation aimed to expand access to non-VA care when necessary while strengthening the VA direct care system to meet the growing needs of enrolled veterans.

The Act established the Veterans Community Care Program (VCCP), setting wait time and travel distance standards. The goal was to ensure the VA maintained overall responsibility for veterans' care by coordinating their treatment and requiring community providers to meet the same quality standards as VA providers. Unfortunately, the VA

has yet to implement the intended quality standards for non-VA providers or establish a robust care coordination program for veterans receiving both VA and community care.

The Act also included provisions to enhance the VA's internal capacity by improving the recruitment, hiring, and retention of qualified clinicians and addressing the longstanding neglect of the VA's aging health care infrastructure. Without sufficient infrastructure and capacity to meet the rising needs of veterans, the VA has turned increasingly to community care, which has seen more rapid growth than VA services. Despite significant increases in the VA's workforce over the past six years, the Department's health care infrastructure remains critically under-funded.

H.R. 740, the Veterans' Assuring Critical Care Expansions to Support Servicemembers (ACCESS) Act of 2025, aims to improve the provision of care and services under the VCCP and enhance veterans' health care with defined eligibility standards, mandatory notification of eligibility and denial of requests, consideration of veterans' care preferences, and extension of claim submission deadlines. It also seeks to streamline specialized mental health treatment programs with a standardized eligibility process and make improvements to the Mental Health Residential Rehabilitation Treatment Program (RRTP). The legislation also includes provisions to establish an interactive online self-service module for care, change requirements for the Center for Care and Payment Innovation (CCPI), and mandate pilot programs and reports to ensure effective implementation.

The ACCESS Act stands to bring substantial changes to the VCCP, potentially impacting the VA's mission of delivering timely, high-quality, veteran-focused health care and services to enrolled veterans. As we move forward with proposed program changes, we believe that it is essential to appropriately balance the role community care plays in the VA's provision of specialized health care and support to our nation's ill and injured veterans.

The Independent Budget for fiscal year 2026-2027—coauthored by the DAV, Veterans of Foreign Wars and Paralyzed Veterans of America, calls on Congress to ensure that VA remains the primary provider and coordinator of care for veterans and that community care is available and accessible to veterans as needed to support and supplement VA care. With this background and context, DAV offers the following comments and recommendations regarding H.R. 740.

Section 101: Codification of Requirements for Eligibility Standards for Access to Community Care from the Department of Veterans Affairs

Section 101 of the bill would codify the minimum access standards for community care from the VA including all extended care services, except for nursing home care and mandate the VA to review these standards with an expanded stakeholder group and report to Congress triennially. Provisions in this section would prohibit telehealth appointments from fulfilling access standards if an in-person VA appointment is unavailable within the standards. It would also require that canceled VA appointments

restart the wait time calculation from the original request date, and any deviations in wait time or distance agreed upon by a veteran and their provider must be documented and provided to the veteran and apply to all VA care and patients, whether new or established.

DAV has no concerns with codifying the eligibility standards for access to community care from VHA, while emphasizing the need for thorough and periodic reviews of these standards. However, we strongly recommend amending the provision that the Secretary shall not take into consideration the availability of telehealth appointments from the Department when determining whether the VA is able to furnish such care or services. We believe that a telehealth appointment should be considered as an option if agreeable with a veteran. Additionally, if a veteran is eligible and opts for an in-person community care appointment because VA only had a telehealth appointment available, that appointment in the community should be for an in-person appointment only. Telehealth services would have already been offered or provided by the VA under Section 105 of this act, which requires the VA to discuss telehealth with veterans as an option for care, both in the VA health care system and in the community, if telehealth is available, appropriate, and acceptable to the veteran.

We endorse the mandate in this section of the bill to document medical records and make them accessible to veterans through digital platforms such as VA.gov, email, and mobile text, except where veterans specifically request them and lack digital access.

Section 102: Requirement that Secretary Notify Veterans of Eligibility for Care under Veterans Community Care Program

Section 102 mandates the VA to promptly notify veterans of their eligibility for community care. To ensure clarity, we propose that the two-day notification requirement includes digital methods, as traditional mail may not meet the deadline. We recommend expeditious deployment of the External Provider Scheduling (EPS) system within the Community Care Network (CCN) to facilitate real-time scheduling when the VA cannot provide direct care or meet access standards, thereby enhancing more timely and effective communication and care coordination for veterans.

Section 103: Consideration of Veteran Preference for Care, Continuity of Care, and Need for Caregiver or Attendant

Section 103 of the Veterans ACCESS Act would require the VA to consider various factors when determining if it is in the best medical interest of a veteran to seek care in the community. These factors include the veteran's preference for when, where, and how to receive care, continuity of care, and the veteran's need or desire for a caregiver or attendant to accompany them.

We have concerns with the definition of veterans' preference for where, when, and how to seek hospital care, medical care, or extended care services. While we want

the veteran's preference to be considered when determining the best option for care, the best medical interest including the distance to care, the frequency of care, and the availability of appointments, should be the primary factors considered, as provided in the MISSION Act.

Section 104: Notification of Denial of Request for Care under Veterans Community Care Program

Section 104 mandates that if the VA denies a veteran's request for community care, it must provide the veteran with the reason for the denial and instructions for appealing the decision through the Veterans Health Administration's clinical appeals process. DAV has no concerns with this section. In fact, our benefits advocates stand ready to assist any veteran with filing a clinical appeal.

Section 106: Extension of Deadline for Submittal of Claims by Healthcare Entities and Providers under Prompt Payment Standard

Section 106 extends the deadline for health care entities and providers to submit claims for reimbursement for community care services from the current 180 days to up to one year after service, aligning with industry standards.

DAV has no concerns with this section, as it provides a more flexible timeframe for providers without compromising the timely processing of claims or the quality of care for veterans.

Section 202: Standardized Process to Determine Eligibility of Covered Veterans for Participation in Certain Mental Health Treatment Programs

Section 202 would require the VA to establish a standardized screening process to determine, based on clinical needs, whether a covered veteran satisfies criteria for priority admission to a covered residential rehabilitation treatment program (RRTP). As part of the evaluation process a veteran must be screened and admitted into a program within 48 hours if determined eligible for RRTP. Either a veteran or relevant health care provider can make the request for admission into a treatment program if they meet criteria for priority admission.

We recommend that the language in this section be amended to require that a VA clinician make the determination if the veteran meets the eligibility criteria for priority admission within 48 hours of the request.

We appreciate the provision in this section of the bill that requires non-department RRTP facilities to be properly licensed by a state and accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission.

Section 203: Improvements to Department of Veterans Affairs Mental Health Residential Rehabilitation Treatment Program

We appreciate that Section 203 includes requirements for the VA to develop a process for assessing the quality of specialized RRTP care delivered by both VA and non-VA providers, including the use of evidence-based treatments, cultural competency, clinical outcomes and oversight, and referral of billing practices.

The VA is advancing efforts to give veterans faster and simpler access to its mental health RRTPs, which provide around-the-clock support for substance use disorders, posttraumatic stress disorder, depression, and other mental health conditions common among veterans. Over 27,000 veterans were treated at VA RRTPs in fiscal year 2024, and we urge the department to increase its bed capacity to expand these critical services.

The VA's national RRTP conference in September 2024 underscored the high priority the VA is giving to fostering more timely access for veterans who need these programs. The VA is focused on implementing a new centralized screening process for each region. However, there are still limits to timely access to these specialized services, and we want to ensure veterans do not have barriers to accessing this life-changing care. Accountability and oversight are paramount to ensure facilities meet the quality of care standards, include veteran-centric programming, and demonstrate effective patient outcomes.

Section 301: Plan on Establishment of Interactive, Online Self-Service Module for Care

Section 301 mandates the VA to create an interactive, online self-service module to help veterans schedule appointments, track referrals, appeal care denials, and receive reminders for both VA and community care appointments.

DAV is supportive of this effort but suggests that alternative methods and adequate support be provided to bridge the digital divide and guarantee equitable access to care for all veterans, including those living in rural and remote communities.

Section 302: Modification of Requirements for the Center for Innovation for Care and Payment of the Department of Veterans Affairs and Requirement for Pilot Program

Section 302 would require the VA to establish and report to Congress on a three-year pilot program allowing enrolled veterans to access outpatient mental health and/or substance use services through community care network providers without referral or pre-authorization. This pilot program would be conducted in areas with varying degrees of urbanization, locations with high rates of veteran suicide, overdose deaths, calls to the Veterans Crisis Line, and long wait times for VA mental health and substance use disorder services. The VA would also be required to develop a care coordination plan

with appropriate oversight and patient safety plans to monitor and support veterans participating in the pilot.

The bill requires development of robust metrics and measures to track and oversee the program's implementation, patient safety, and patient outcomes. Annual reports would be required to the Committee on Veterans' Affairs, detailing the number of participating veterans and health care providers, program effectiveness, costs, and other relevant matters.

We appreciate the intent behind the proposed pilot program aimed at improving access to outpatient mental health and substance use services for veterans. However, we have significant concerns about the bill's lack of a requirement for clinical authorization for such care from the VA.

While we fully support the goal of enhancing access to critical mental health and substance use services, the absence of a clinical authorization requirement raises serious questions about the quality and coordination of care. Clinical authorization is a key element in ensuring that veterans receive appropriate, evidence-based treatment that is tailored to their individual needs. Without this oversight, there is a risk of fragmented care, potential overuse or misuse of services, and the potential for insufficient monitoring of treatment outcomes.

The VA has a comprehensive understanding of veterans' unique health care needs and a robust system for coordinating care across the system. By bypassing clinical authorization, the bill may undermine the VA's ability to properly manage and oversee the delivery of care effectively. This could result in inconsistent treatment plans, gaps in care continuity, and ultimately, negative impacts on veterans' health outcomes.

We recommend that the bill be amended to include a requirement for clinical authorization from the VA for all services provided under the pilot program. This would ensure that veterans receive high-quality, veteran-centric, coordinated care that aligns with best practices and leverages the VA's expertise in managing veterans' health care and these specialized services. Incorporating this requirement will strengthen the program's effectiveness and safeguard the well-being of our veterans.

In conclusion, while we understand and support the intent of the pilot program, we urge the Committee to address the critical concern of clinical authorization. Ensuring that the VA retains a central role in authorizing and coordinating care will enhance the program's success and better serve our nation's veterans. We appreciate the opportunity to submit this statement and welcome further discussion on this important matter.

H.R. 1041, the Veterans 2nd Amendment Protection Act

and

Discussion draft to prohibit the VA Secretary from transmitting certain information to the Department of Justice for the NICS list.

The federal Gun Control Act of 1968, as amended, prohibits certain classes of persons from purchasing or possessing firearms and ammunition. One of the classes of prohibited persons are those who have been "adjudicated as a mental defective." A person may be "adjudicated as a mental defective" if a court, board, or commission finds that they are a danger to themselves or others.

Under the provisions of the Brady Handgun Violence Prevention Act of 1993, the Federal Bureau of Investigation (FBI) administers the National Instant Criminal Background Check System (NICS) that allows federally-licensed firearms dealers to perform a required background check on potential buyers to ensure they are not prohibited from purchasing firearms and ammunition.

Historically, it has been the VA's policy to submit the names of all beneficiaries determined to be incompetent to the Attorney General for inclusion in NICS. However, incompetency within VA regulatory provisions (38 C.F.R. 3.353) defines a mentally incompetent person as someone who because of injury or disease lacks the mental capacity to contract or to manage his or her own affairs, including disbursement of funds without limitations. It does not address the requirement of a finding that they are a danger to themselves and others.

On March 15, 2024, VA announced that through the remainder of fiscal year 2024, VA would only report to the FBI NICS in instances when VA was aware that a mentally incompetent beneficiary had been found by a judicial authority to be a danger to themselves or others. While VA implemented this change and updated its electronic reporting, on March 11, 2024, VA stopped all weekly reporting to the NICS of mentally incompetent beneficiaries.

These bills focus on two main provisions that are essential to protecting veterans from unjust stigmatization and the loss of their Second Amendment rights without proper due process:

- The VA Secretary must notify the Attorney General that the basis for transmitting personally identifiable information of a beneficiary to the Department of Justice (DOJ) for use by NICS does not apply, or no longer applies, if such transmittal was solely based on a determination to pay benefits to a fiduciary.
- The VA Secretary shall not treat a person as having been adjudicated as a mental defective solely on the basis of requiring a fiduciary.

Additionally, the draft bill would require notification of lack of basis for the VA to have transmitted a veteran's information to the DOJ on or after November 30, 1993, for placement on the NICS solely on the basis of a determination by the VA to pay benefits to a fiduciary.

DAV supports these bills, to ensure that veterans are not unfairly stigmatized or deprived of their Second Amendment rights based on VA determinations without judicial oversight. Our veterans have dedicated their lives to defending the freedoms we hold dear, and it is our responsibility to safeguard their constitutional rights in return.

Discussion Draft, Student Veteran Benefit Restoration Act of 2025

Veterans have selflessly served our country, and it is our duty to ensure they receive the benefits they have earned. Unfortunately, some educational institutions have taken advantage of veterans, defrauding them of their well-deserved educational assistance.

This draft bill, the Student Veteran Benefit Restoration Act of 2025, would restore educational entitlements of those veterans who have fallen victim to fraudulent practices and would not be charged against their benefit entitlements. This includes periods when the institution was not approved or engaged in fraudulent activities. Additionally, educational institutions found guilty of fraud would be required to repay the VA Secretary any funds received fraudulently. This ensures that the burden of fraud is placed on the institutions rather than the veteran.

DAV supports this draft bill based on DAV Resolution No. 238, which calls for legislation that reduces and removes barriers to a service-disabled veteran continuing their education. We must ensure that we are protecting veterans and their hard-earned education benefits from fraud and deceptive acts.

Mr. Chairman, this concludes DAV's statement for the record.