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WOUNDED WARRIOR PROJECT®

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Submitted for the Hearing to Consider Pending Legislation

Committee on Veterans' Affairs
United States Senate

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Chairman Moran, Ranking Member Blumenthal, and distinguished members of the Senate Committee on Veterans' Affairs – 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 266,000 registered post-9/11 warriors and 62,000 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.

S. 749: *Justice for ALS Veterans Act of 2025*

The Centers for Disease Control and Prevention (CDC) estimates that fewer than 30,000 people in the U.S. have Amyotrophic Lateral Sclerosis (ALS) and approximately 5,000 people receive the diagnosis each year.[1] Studies have shown that U.S. veterans are about 1.5 times more likely to get ALS compared with people who never served in the military, and for that reason, ALS became a service-connected condition for any veteran with ALS who served longer than 90 days, received an honorable discharge, and was later diagnosed with ALS.[2] Sadly, the laws intended to protect and support these veterans' survivors do not align with the rapid progression of this disease.

Under current law, VA may pay an additional monthly Dependency and Indemnity Compensation (DIC) payment to surviving spouses if the veteran's service-connected disability was rated as totally disabling for at least eight continuous years before death. For those

[1] CTRS. FOR DISEASE CONT. AND PREV., *About Amyotrophic Lateral Sclerosis*, https://www.cdc.gov/als/abouttheregistrymain/about-amyotrophic-lateral-sclerosis-als.html (last visited Apr. 27, 2026).
[2] U.S. DEP'T OF VET. AFFAIRS, *VA ALS System of Care*, https://www.va.gov/health/als.asp (last visited Apr. 27, 2026).

diagnosed with ALS, the average life expectancy after diagnosis is three years. Approximately 20 percent of people with ALS live five years, 10 percent survive 10 years and only 5 percent will live 20 years or longer.[3] The *Justice for ALS Veterans Act of 2025* would remove the eight-year criteria if the veterans died as a result of service-connected ALS due to the rapid and degenerative nature of this illness.

Wounded Warrior Project supports this necessary and compassionate fix to an outdated and restrictive statutory requirement and urges strong support to ensure dignity for all veterans with ALS and their surviving families.

S. 1127: *Dennis and Lois Krisfalusky Act*

Under current law pertaining to those whose remains are unavailable, the spouse or surviving spouse of a veteran is generally only eligible for a VA-furnished memorial headstone or marker if he or she passed away on or after November 11, 1998. The restriction creates inequitable treatment among families and undermines consistent recognition of military service.

The *Dennis and Lois Krisfalusky Act* would expand eligibility for VA-furnished memorial headstones and markers regardless of the spouse's date of death. Specifically, this legislation would remove the statutory requirement or restriction that limits eligibility to family members who died on or after November 11, 1998, and whose remains are unavailable. By removing this statutory restriction, the legislation ensures eligibility for memorial headstones and markers is based on service-related criteria and not a specific date. This thoughtful and long-overdue correction promotes fairness and honors veterans and their families' sacrifice and service.

Wounded Warrior Project is pleased to support this legislation.

S. 3000: *FRAUD in VA Disability Exams Act of 2025*

Every year approximately 200,000 Service members transition out of the military.[4] Strengthening the transition experience for Service members and their families remains a priority, and we are committed to advocating for legislation that enhances VA benefits process before, during, and after separation from the Department of Defense (DoD). The integrity of the VA disability compensation system is critical, and it is important to ensure that allegations of fraud associated with Disability Benefits Questionnaires are appropriately referred to for investigation.

This bill responds to concerns about third-party contractors and bad actors conducting medical disability evaluations, particularly high-volume third-party contractors who may be submitting materially false medical evidence. Veterans rely on a disability system that is accurate, fair, and trustworthy. When fraud occurs, this harms not only the taxpayers, but can increase negative health outcomes for disabled veterans who face longer wait times, higher

[3] ALS ASS'N, *Stages of ALS*, http://www.alsa.org/about-als/facts-you-should-know.html (last visited Apr. 27, 2026).
[4] *See, e.g.*, U.S. GOV'T ACCOUNTABILITY OFF., GAO-24-107352, TRANSITION TO CIVILIAN LIFE: BETTER COLLECTION AND ANALYSIS OF MILITARY SERVICE DATA NEEDED TO IMPROVE OVERSIGHT OF THE SKILLBRIDGE PROGRAM 1 (2024).

scrutiny, and skepticism about the entire disability benefits system for veterans based on fraudulent misconduct not caused by the veteran.

Wounded Warrior Project supports the intent of the *FRAUD in VA Disability Exams Act of 2025*; however, additional refinements may be needed to adequately protect veterans who file disability claims in good faith. These concerns are most pronounced for those who submit standardized or clinician-generated Disability Benefits Questionnaire (DBQ) as many veterans seeking service-connected disability compensation are not medical experts and must rely on licensed clinicians or accredited representatives to accurately complete forms. To mitigate this risk without undermining fraud enforcement, Congress could (1) clarify that the use of templated language is not itself evidence of claimant fraud, (2) require VA to distinguish between provider misconduct and veteran culpability prior to referral, and (3) establish a safe harbor for veterans who rely in good faith on licensed medical professionals. These guardrails would protect veterans from undue stress and investigatory backlogs while preserving the bill's core integrity objectives.

S. 3170: *Stuck on Hold Act*

Veterans routinely rely on VA customer service telephone lines for assistance with health care needs, benefits inquiries, and routine support services, yet available wait time data illustrates room for improvement. A September 2024 Government Accountability Office (GAO) report found that veterans calling to reorder sleep apnea supplies experienced average wait times of approximately 35 minutes, with some calls exceeding 80 minutes before being answered.[5] Only 37 percent of calls were answered, while 63 percent went unanswered because callers hung up before reaching a representative, often due to long hold times. While these figures are not illustrative of all VA customer service lines, they flag an opportunity to improve service and mitigate veteran frustration.

The *Stuck on Hold Act* would provide a targeted response to this challenge. The bill directs VA, within one year of enactment, to implement an automated system on covered VA customer service telephone lines that informs callers of anticipated wait times and automatically offers a callback option when the expected wait exceeds ten minutes. It also requires the Secretary to issue internal guidance aimed at reducing average wait times to ten minutes or less. The bill expressly excludes the Veterans Crisis Line and VA emergency department phone lines.

This approach reflects customer service practices already used in the federal government. The Internal Revenue Service implemented callback technology that saved callers an estimated 3.6 million hours of hold time in fiscal year 2022, demonstrating the effectiveness of wait-time transparency and callbacks.[6] Importantly, the bill is intentionally narrow and creates no new programs, staffing mandates, or funding obligations.

The *Stuck on Hold Act* represents a practical, low-cost modernization effort that respects veterans' time and improves access to routine services. WWP is pleased to support this bill.

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[5] U.S. GOV'T ACCOUNTABILITY OFF., GAO-24-107010, VA ACQUISITION MANAGEMENT: ADDITIONAL ACTIONS NEEDED IN SERVING VETERANS WITH SLEEP APNEA (2024).

[6] U.S. TREASURY INSPECTOR GEN. FOR TAX ADMIN., REPT. NO. 2023-10-046, THE CUSTOMER CALLBACK SYSTEM BENEFITS TAXPAYERS; HOWEVER, PERFORMANCE MEASURES ARE NOT COMPREHENSIVE AND MORE CALLERS COULD QUALIFY FOR CALLBACK OFFERS (2023).

S. 3311: *Veterans Affairs Peer Review Neutrality Act of 2025*

Ensuring the quality and safety of care delivered to veterans depends in part on the credibility and impartiality of VA's peer review process. Recent investigations have raised concerns that facility-level peer reviews may involve individuals who were directly involved in the care under review or who are otherwise unable to provide a fully impartial assessment, and that no neutral second-level review is consistently required. Following a 2021 investigation into patient care at the Detroit VA Medical Center, the VA Office of Inspector General (OIG) identified ongoing concerns regarding the integrity and neutrality of peer review determinations, even after corrective actions were taken.[7]

The *Veterans Affairs Peer Review Neutrality Act of 2025* would establish clear statutory guardrails to address these concerns. The bill requires any individual who participated in the care under review, or who cannot be impartial, to recuse themselves from participating in a peer review committee. It also requires that the results of such reviews be subject to a final-level review by a neutral peer review committee at another VA medical facility, ensuring an independent perspective. By codifying recusal and neutral review requirements, S. 3311 would strengthen confidence in VA's quality-of-care oversight while preserving the peer review process's confidential and non-punitive nature. These protections help ensure that peer review findings are credible, unbiased, and focused on improving care for veterans.

The *Veterans Affairs Peer Review Neutrality Act of 2025* advances a straightforward and necessary reform to reinforce trust, accountability, and patient safety within VA medical facilities. WWP is pleased to support this bill.

S. 3395: *Mammography Access for Veterans Act*

More than two million women veterans currently live in the United States, with approximately 930,000 enrolled in VA health care.[8] Women aged 45 to 54 make up the largest demographic of women veterans, and the American Cancer Society recommends annual mammograms for this age group.[9] Access to breast cancer screening services within VA has historically been inconsistent, particularly for veterans in rural or underserved areas. To address these gaps, Congress enacted the *Making Advances in Mammography and Medical Options (MAMMO) for Veterans Act* (P.L. 117-135) in 2022, legislation aimed at expanding and improving breast cancer screening and related medical services within VA. Among its key provisions, the law requires the agency to implement a three-year telescreening mammography pilot program at select VA facilities, primarily serving in rural areas where access to breast imaging services is limited or unavailable. The program allows veterans to receive mammograms locally, with images transmitted electronically to specialized radiologists for

[7] Office of Inspector Gen., Review of VISN 10 and Facility Leaders' Response to Recommendations from a VHA Office of the Medical Inspector Report, John D. Dingell VA Medical Center in Detroit, Michigan 23, https://www.vaoig.gov/sites/default/files/reports/2023-07/VAOIG-22-04099-153.pdf (July 28, 2023)

[8] U.S. DEP'T OF VETERANS AFF., *Women Veterans Health Care: Facts and Statistics*, https://www.womenshealth.va.gov/materials-and-resources/facts-and-statistics.asp (last visited Apr. 27, 2026).

[9] Jennifer Pitman et al., *Screening Mammography for Women in their 40s: The Potential Impact of the American Cancer Society and US Preventive Services Task Force Breast Cancer Screening Recommendations*, 209 AM. J. ROENTGENOLOGY 697 (2017) (*available at* https://ajronline.org/doi/full/10.2214/AJR.16.17759).

interpretation. VA launched the first of five pilot sites in May 2023, with the program scheduled to conclude in May 2026.

This bill expands and makes permanent VA's telescreening mammography program by removing the pilot status under existing law and requiring VA to ensure that mammography services through telescreening, full-service VA facilities, or VA mobile mammography programs are offered in every state and Puerto Rico within two years of enactment. Additionally, all programs are required to be accessible to veterans with disabilities, including those with paralysis or spinal cord injuries. Finally, the bill extends reporting requirements through May 1, 2027, and clarifies VA's authority to expand telescreening services beyond pilot sites or states without existing VA breast imaging facilities, maintaining flexibility for broader implementation.

This bill would address persistent gaps in breast cancer screening by making telescreening mammography a permanent component of VA health care and ensuring nationwide availability of screening options. By requiring at least one screening modality in every state and Puerto Rico, the bill expands access regardless of location and helps reduce delays associated with travel burdens and specialist shortages. One in eight women will be diagnosed with breast cancer in their lifetime and over 1,200 veterans enrolled in VA care receive this diagnosis each year, underscoring the importance of timely screening. Implementation will require continued investment in VA clinical infrastructure, staffing, and equipment, particularly in rural and underserved areas. Strong oversight will be important to ensure equitable availability and quality across facilities.

Wounded Warrior Project supports the *Mammography Access for Veterans Act of 2025* which builds on prior legislative efforts to address gaps in breast cancer screening within VA and takes steps toward ensuring women veterans can access timely care regardless of where they live. As the female veteran population ages, VA must be equipped to meet the growing demand for specialized care.

S. 3647: *Disabled Veterans Dignity Act of 2025*

Veterans with spinal cord injuries and disorders (SCI/D) often depend on daily bowel and bladder care to manage neurogenic dysfunction and prevent serious, life-threatening complications. SCI/D patient advocates have previously testified that VA's existing Bowel and Bladder (B&B) program is unevenly implemented and administratively fragile, with delayed payments, lack of notice when agreements expire, and claim errors that leave caregivers unpaid and veterans without essential care.[10] When these services are disrupted, veterans face increased risk of hospitalization, loss of independence, and diminished quality of life.

The *Disabled Veterans Dignity Act of 2025* directly addresses these challenges by codifying VA's Bowel and Bladder program and recognizing bowel and bladder care as a medically necessary, life-sustaining service. Codifying the program would move it from discretionary policy to statute, helping ensure consistent availability and administration across VA medical centers rather than facility-dependent access. This statutory clarity is intended to standardize program requirements nationwide, reduce variation in implementation, and

[10] Senate Committee on Veterans' Affairs, Hearing: *"Strengthening Services for Veterans with Spinal Cord Injury and Disorder"* (Sept. 17, 2025

strengthen accountability for timely delivery of care. The bill directs VA to provide care based on clinical need, establish training and payment standards, authorize multiple caregiver models (including contracted home health agencies, individually employed caregivers, and trained family caregivers), and require review by the SCI/D System of Care before denying services. It also creates a presumption of long-term eligibility after three years for veterans who continue to require care.

Wounded Warrior Project supports S. 3647 and appreciates the leadership behind this dignity-centered legislation. By establishing clear statutory authority and consistent program requirements, this legislation would stabilize access to essential care, reduce administrative disruptions, and support veterans' ability to remain safely in their homes. It also appropriately recognizes the critical role played by family members and individually employed caregivers in delivering this care. Additionally, we are engaged with stakeholders and House of Representatives partners on House-origin legislation to address the tax treatment of bowel and bladder caregiver payments, which currently differs from other VA caregiving stipends and must be resolved through separate legislation to ensure consistency across programs.

S. 3726: *National Veterans Strategy Act of 2026*

While VA is responsible for delivering health care, benefits, and memorial services to veterans, many other federal departments and agencies administer programs that affect veteran well-being, as well as the wellbeing of their families, caregivers, and survivors. These include housing, employment, education, mental health, small business support, and outdoor recreation. These efforts operate across multiple systems with separate authorities, funding streams, goals, and evaluation methods, often without a centralized mechanism to coordinate priorities or measure outcomes collectively. As a result, federal resources supporting veterans and their support networks can become fragmented, duplicative, or misaligned, making it difficult to assess overall impact, identify gaps in services, or ensure programs are working together effectively.

The absence of a coordinating framework limits the federal government's ability to intentionally align investments, sustain progress across administrations, and ensure that veteran support efforts move forward in a coherent and strategic manner. Critically, it does not provide Congress with uniform metrics that would allow for a better evaluation of the efficacy of these efforts.

The *National Veterans Strategy Act of 2025* would require the President to define veteran success and to develop and implement a National Veterans Strategy focused on improving veteran well-being after military service. The bill directs the President, in collaboration with a broad set of stakeholders including Congress, federal agencies, state and local governments, tribal organizations, veterans service organizations, nonprofits, researchers, philanthropy, and the private sector, to establish metrics to assess veteran well-being across multiple areas. These areas include physical health, mental health, spiritual health, economic security and opportunity, education, family and social engagement, and civic engagement.

Using these metrics, the bill requires the President to formulate and submit to Congress a comprehensive National Veterans Strategy at least once every four years to align the resources and efforts of federal, state, local, nonprofit, and private sector organizations. The Strategy must consider the diverse needs of veterans across demographic factors, prescribe how benefits and services should be applied to support well-being, establish standard outcome metrics for evaluating programs, and coordinate the use of direct services and federal grants. The bill includes requirements for public participation in strategy development, annual reporting to Congress on implementation and outcomes, periodic strategy reviews and updates, and a congressional disapproval process. It also includes a rule of construction clarifying that nothing in the Strategy may override existing federal law or eliminate codified veteran benefits or programs and establishes phased timelines for setting metrics and submitting the initial Strategy.

The *National Veterans Strategy Act* seeks to address this challenge by establishing a formal framework for defining veteran well-being and coordinating federal efforts that support veterans, their families, caregivers, and survivors. The bill directs the development of common metrics to assess veteran outcomes across multiple domains and requires the creation of a recurring national strategy to align the activities, resources, and objectives of federal agencies, as well as state, local, nonprofit, and private sector partners. Through structured coordination, standardized evaluation, and regular reporting, the bill is intended to create greater consistency across programs, improve visibility into how federal investments interact, and provide a mechanism for tracking progress and identifying gaps in services over time.

While WWP appreciates the intent behind this legislation, the bill's framing and implementation mechanics raise significant concerns about how coordination would function in practice and whether it aligns with longstanding veterans' policy principles rooted in earned benefits, continuity, and clear agency roles. Several aspects warrant further scrutiny. The legislative findings and supporting materials emphasize the scale and cost of federal spending on veterans' programs and frame post-service outcomes in terms of "return on investment," which risks shifting the narrative away from benefits earned through military service and toward judgments based on post-separation outcomes. Additionally, the bill grants the President broad authority to define success metrics, align federal grant funding to those metrics, and require their uniform application across agencies and grant recipients. This approach raises concerns about prescriptive, one-size-fits-all standards; the potential disruption of effective existing programs; and the consequences for veterans who do not or cannot conform to uniform measures of success.

Further issues include the durability of a quadrennial strategy across administrations, the absence of explicit guardrails to ensure metrics are used to evaluate systems and programs rather than individual veterans, ambiguity regarding the DoD's role beyond transition-related responsibilities, and uncertainty about the treatment of non-codified programs or grants deemed misaligned with the strategy. While the stated goal is to support veterans in living successful lives, as drafted the bill could introduce substantial structural and administrative changes with unintended and potentially harmful consequences unless clearer limits, protections, and performance-focused guardrails are established. WWP stands ready to work with Congress and stakeholders to refine this legislation in a manner that preserves its coordination goals while

ensuring it remains firmly grounded in established veterans' policy principles and centered on veterans lived experiences and earned benefits.

Wounded Warrior Project welcomes the opportunity to continue working with Chairman Moran and the Committee on this legislation and continuing this meaningful discussion to help set a coordinated national strategy to improve veteran well-being after military service.

S. 3988: *Veterans STAND Act*

An estimated 42,000 veterans are living with chronic spinal cord injury (SCI), and many face lifelong medical risks and functional challenges that require ongoing, specialized care. While the VHA currently provides annual preventive evaluations for veterans with spinal cord injury or disorder (SCI/D) through clinical policy, including VHA Directive 1176, this practice is not codified in statute and remains subject to change.[11] As assistive and rehabilitative technologies continue to evolve, consistent access to comprehensive evaluations is increasingly important to maintaining independence, preventing secondary complications, and improving quality of life for veterans with SCI/D.

The *Veterans STAND Act* would require VA to offer an annual preventive health evaluation to any veteran with SCI/D who elects to receive one. The evaluation would assess health risks and comorbidities, chronic pain management, diet and weight considerations, prosthetic and equipment needs as well as the potential benefits of assistive technologies, including powered mobility devices and spinal cord neuromodulation therapies.

The bill also directs VA to consult with clinicians and subject-matter experts when developing policy, inform veterans annually of the evaluation's availability, and submit biennial reports to Congress on assistive technology utilization and related functional outcomes. By moving an existing VA practice from policy into statute, the *Veterans STAND Act* reinforces consistent access to preventive, whole-person care while preserving clinical discretion. Codifying these evaluations helps ensure that veterans with SCI/D have regular opportunities to assess emerging technologies that may enhance mobility, independence, and long-term health.

The *Veterans STAND Act* is a thoughtful and forward-looking measure that strengthens preventive care for veterans with spinal cord injuries. We support this legislation and appreciate the continued focus on ensuring veterans with SCI/D can access the evaluations and technologies that support independent living and improved quality of life.

S. 3992: *Joint Medical Facilities Fund of 2026*

The Department of Defense (DoD) and VA currently have over 185 resource sharing agreements nationwide, across 77 VA facilities and 98 DoD facilities providing care for military, veterans and their families.[12] However, there is no permanent, codified funding mechanism to support these resource sharing agreements which often involves specialty care referrals, staffing

[11] VHA Directive 1176, *Spinal Cord Injury and Disorders System of Care*, U.S. DEP'T OF VET. AFFAIRS.
[12] U.S. GOV'T ACCOUNTABILITY OFF., GAO-25-107497, HOW VA AND DOD ARE WORKING TOGETHER TO IMPROVE HEALTH CARE ACCESS (2025).

support, facility space, surgery, orthopedics, and mental healthcare. This lack of predictable funding creates real operational challenges.

Shared care arrangements such as William Beaumont Army Medical Center (WBAMC) at Fort Bliss, Texas, and Tripler Army Medical Center (TAMC) in Hawaii, demonstrate how coordination depends on reimbursement agreements, shared staffing, and access across separated DoD and VA systems.[13] GAO has similarly identified barriers including limitation on care due to slow and challenging billing practices, incompatible medical records systems, and difficulties accessing care on military installations. Specifically, GAO reported that officials at 9 of 12 sites visited said billing challenges resulted in payment delays for DoD medical claims, and one official stated that DoD limited the number of VA referrals accepted because it was not being reimbursed for services provided. These challenges reinforce the need for permanent predictable funding mechanisms for joint facilities like the Captain James A. Lovell Federal Health Care Center (Lovell FHCC) in North Chicago, Illinois – the only fully integrated DoD–VA federal health care center, originally supported through the Joint Department of Defense–Department of Veterans Affairs Medical Facility Demonstration Fund established in the FY 2010 *National Defense Authorization Act* (P.L. 111-84 § 1704).

Independent analysis from RAND and the Government Accountability Office (GAO) reinforces the need for permanent funding authority for joint DoD–VA medical facilities. RAND found that while DoD and VA have broad statutory authority to share healthcare resources and coordinate care, the lack of stable, permanent funding mechanisms creates barriers to sustaining fully integrated joint medical facilities over the long term.[14] Similarly, GAO found that changing Lovell FHCC to a traditional joint venture was neither advisable nor achievable, and both departments recommended maintaining the facility as a fully integrated federal health care center.[15]

The *Joint Medical Facilities Fund Act of 2026* would address this longstanding challenge by establishing a permanent Joint Medical Facility Fund to allow DoD and VA to jointly finance designated combined federal medical facilities. The fund would support operations, maintenance, capital equipment, and minor construction, providing the stability and predictability necessary to sustain and enhance shared facilities over time. By creating a dedicated funding mechanism, this legislation reinforces broader efforts to improve coordination, resource sharing, and interoperability between DoD and VA. These improvements are critical to reducing inefficiencies, strengthening care delivery, and ensuring Service members and veterans experience a more seamless transition between systems.

Wounded Warrior Project is pleased to support this legislation. It builds upon momentum from the FY 2026 *National Defense Authorization Act* (P.L. 119-60 § 731) to strengthen DoD–VA coordination through improved medical record sharing, provider credentialing, integrated funding, and resource sharing. The *Joint Medical Facilities Fund of 2026* would support these efforts by establishing permanent authority for transfers to the Joint

[13] *Id*.
[14] Carrie Farmer et al., *Integrating Department of Defense and Department of Veterans Affairs Purchased Care*, RAND CORP. (2018) (*available at* https://www.rand.org/pubs/research_reports/RR2762.html).
[15] U.S. GOV'T ACCOUNTABILITY OFF., GAO-17-197, FEDERAL HEALTH CENTER: VA AND DOD NEED TO DEVELOP BETTER INFORMATION TO MONITOR OPERATIONS AND IMPROVE EFFICIENCY (2017).

Medical Facility Fund from both DoD and VA on at least a quarterly basis, ensuring stable funding for shared facilities like the Lovell FHCC and improving continuity of care for transitioning Service members.

S. 3993: *Reducing Arbitrary Barriers to Apprenticeship Act of 2026*

Many post-9/11 veterans rely on their earned education benefits to transition into civilian careers, but those who choose apprenticeships or on the job training (OJT), particularly in the skilled trades, face structural disadvantages under current law. Veterans using the Post-9/11 GI Bill for OJT or apprenticeship programs receive declining monthly housing allowances, reduced payments for books and supplies, and are subject to inflexible minimum work hour requirements that do not reflect the seasonal and project-based realities of these training models. These policies create unnecessary financial barriers that discourage participation in non-traditional workforce pathways, even as demand for skilled labor continues to grow.

The *Reducing Arbitrary Barriers to Apprenticeship Act of* 2026 would address these inequities by ensuring veterans who use the Post-9/11 GI Bill for apprenticeships or OJT programs receive a full monthly housing allowance at the E5 with dependents rate for the entire duration of training. The bill would also waive certain monthly minimum work hour requirements for veterans enrolled in these programs, recognizing that many apprenticeship programs include classroom instruction and experience seasonal fluctuations. Collectively, these reforms would create parity between veterans pursuing skilled trades and those using their benefits for traditional college education.

The bill's reforms are targeted to OJT and apprenticeship programs classified under North American Industry Classification System (NAICS) Sector 23, which includes construction of buildings, heavy and civil engineering construction, and specialty trade contractors. This focus aligns with labor market realities: the Bureau of Labor Statistics reported 33.5 percent employment growth in these fields from 2014 to 2024, with continued, although slower, growth expected through 2034. Despite strong demand for skilled labor and expansion of registered construction apprenticeship programs nationwide, veteran participation in OJT and apprenticeship programs using the Post-9/11 GI Bill remains extremely low, suggesting that current benefit disparities are dampening enrollment.

By eliminating declining housing stipends and rigid work hour rules, S. 3993 would directly address barriers that have pushed veterans away from apprenticeships and toward traditional education paths. These disparities are especially consequential given that apprenticeship programs often last three to four years, meaning veterans currently experience repeated benefit reductions over time while simultaneously receiving lower support for books and supplies. Department of Labor registered apprenticeship data show that 231,137 military veterans participated in apprenticeship programs between 2019 and 2022, including significant participation in construction trades.

Wounded Warrior Project is pleased to support the *Reducing Arbitrary Barriers to Apprenticeship Act of 2026*; however, Congress may wish to further strengthen this legislation by directing VA to collect and report data on veteran participation and outcomes post enactment to

assess whether these reforms increase enrollment in non-traditional workforce training programs. Additionally, clarifying statutory definitions for "full time" participation and aligning them with Department of Labor registered apprenticeship standards could reduce implementation ambiguity and further strengthen the bill's long-term effectiveness.

S. 3999: *Women Veterans Specialty Care Access Act*

Through WWP's Women Warriors Initiative, women veterans have consistently shared challenges accessing timely gender-specific and specialty care, both within VA and through the Community Care Network (CCN). While VA has significantly expanded women's health services over the past decade, variability in local capacity, referral practices, and specialist availability continues to affect how quickly women veterans receive appropriate evaluation and treatment. Ensuring timely access while maintaining continuity and coordination of care remains a key consideration for improving outcomes for women veterans across both VA and CCN.

The *Women Veterans Specialty Care Access Act* seeks to improve access by allowing women veterans to directly seek certain specialty care services without first obtaining a referral from primary care. Care including gynecology, obstetrics, maternity, and postpartum services could be pursued at the patient's discretion, and VA would be tasked with ensuring that such direct scheduling is available through every VA medical center or clinic that offers women's specialty care. The bill reflects a desire to reduce barriers and streamline access to care, particularly when women veterans believe they need evaluation by a specific specialist.

This proposal seeks to create additional pathways to care, but ultimately challenges existing practices within VA, where primary care already plays a critical role in identifying needs, facilitating referrals, and advising veterans on appropriate next steps. Importantly, primary care serves a function beyond administrative coordination. It provides clinical assessments and reminders that help guide veterans to the most appropriate specialty, ensures symptoms are evaluated holistically, and supports continuity across physical and mental health care. In many cases, primary care clinicians also assist veterans by explaining why a particular specialty evaluation is indicated and how it fits into an overall treatment plan. Removing primary care from this process risks substituting speed for clarity, leading to fragmented care, delayed diagnosis, and unmet clinical needs.

This bill illustrates how well-intentioned efforts to expand access can encounter practical challenges in implementation. Allowing direct specialty access raises concerns related to care coordination, workforce capacity (providers and administrators), and the risk that bypassing primary care could fragment care, disrupt reminders for time-sensitive services, or delay diagnosis when symptoms span multiple specialties. These are not theoretical debates about VA versus community care, but real-world implementation issues that shape how women veterans experience and access care on a day-to-day basis.

Wounded Warrior Project supports the intent of the *Women Veterans Specialty Care Access Act* and appreciates its focus on improving access for women veterans. We believe this legislation provides an important opportunity to examine how access, care coordination, and primary care functions intersect, and to ensure that reforms strengthen, rather than disrupt,

comprehensive and veteran-centered care. We believe a starting point could be to learn more from various stakeholders about VA's implementation of its December 2025 policy to allow women to directly access VA or community-based gynelogical care without referral from a VA primary care provider.

S. 4043: *Health Care for Homeless Veterans Act*

Veterans experiencing or at risk of homelessness face disproportionately high health burdens that complicate access to consistent care. The U.S. Department of Housing and Urban Development (HUD) 2024 Annual Homelessness Assessment Report: Part 1: Point-in-Time Estimates revealed that 32,882 veterans experienced homelessness on a single night in January 2024, and VA research indicates that unsheltered homeless veterans frequently have higher physical and mental health comorbidity, including PTSD and substance use disorders.[16] Population-based research further demonstrates that one in ten U.S. veterans has experienced homelessness, with those veterans facing significantly higher rates of depression, anxiety, PTSD, substance use disorders, and suicide risk compared to housed veterans.[17] While VA has made meaningful progress in reducing veteran homelessness through targeted housing and supportive services, maintaining timely and continuous access to health care remains essential to sustaining those gains and preventing veterans from cycling back into homelessness.

VA has operated the Health Care for Homeless Veterans (HCHV) program since 1992 to provide outreach, treatment, rehabilitation, and housing services to veterans who are homeless, have a mental health condition, or both. The statutory authority for HCHV has historically included a sunset provision requiring periodic reauthorization. This temporary nature can create uncertainty, leaving essential services at risk of interruption and complicating long-term planning for outreach, case management, and permanent housing for these vulnerable veteran populations.

The *Health Care for Homeless Veterans Act* would make permanent VA's existing authority to provide treatment and rehabilitation services to veterans who are both seriously mentally ill and experiencing homelessness by removing the current statutory limitation on that authority. While VA is already delivering these services under current law, this legislation would codify and extend that authority on a permanent basis, reducing uncertainty and ensuring long-term continuity for programs serving highly vulnerable veterans.

Wounded Warrior Project is pleased to support this legislation.

Discussion Draft: *Veteran Acquired Brain Injury Caregiving Act*

As part of the *Sen. Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act* (P.L. 118-210 § 123(b)), Congress helped facilitate the continued expansion of VA's Veteran-Directed Care (VDC) program by requiring its availability at all VA Medical Centers. VDC helps veterans at risk of institutionalization to continue to live at home and engage in community life by creating the ability to manage their own flexible budgets, decide

[16] *See, e.g.*, Jack Tsai et al., *Multimorbidity of Mental Health and Substance Use Disorders Among Housed and Homeless U.S. Veterans*, 15 SCIENTIFIC REPORTS 15185 (2025) (*available at* https://www.nature.com/articles/s41598-025-99394-x).
[17] Brandon Nichter, et al., *Prevalence, Correlates, and Mental Health Burden Associated with Homelessness in U.S. Military Veterans*, 53 PSCYCHOL. MED. 3952-62 (2023) (*available at* https://pubmed.ncbi.nlm.nih.gov/35301973/).

what mix of goods and services best meet their needs, and hire and supervise their own workers. "Providers" – which include Aging and Disability Resource Centers and centers for independent living – are community-based organizations that receive referrals (and funding) from VA and then help eligible veterans design a plan that typically includes components of personal care and other services that can improve support and quality of life.

The *Veteran Acquired Brain Injury Caregiving Act* would create a 5-year pilot to allow "veteran mission-driven nonprofit" organizations to receive VDC funds for providing services to veterans who have been clinically assessed to have an acquired brain injury. These organizations would be required to have 501(c)(3) status, provide services that support clinical needs and improve quality of life, and serve a population group that is comprised of at least 70 percent veterans. These organizations would effectively become a new variety of "provider" that can subcontract to deliver components of VDC specifically to veterans with TBI. The pilot program would be carried out at not fewer than five VA medical centers.

In 2025, VDC participation grew by 40.7% and provided more than 12,800 veterans with more flexibility to manage their care needs.[18] However, like other VA long term supportive services (LTSS), VDC largely serves elderly patients. More can be done to shape VDC into a program that effectively serves younger veterans with heightened at-home care needs due to mental, behavioral, and neurocognitive challenges associated with TBI. While organizations like those contemplated by this bill have potential to apply elevated knowledge and expertise of caring for veterans with TBI to deliver a more tailored VDC experience, additional tactics can help reach more of these younger veterans. To further improve this legislation, we recommend incorporating provisions that order stronger coordination of VDC benefits for veterans utilizing VA's TBI – Residential Rehabilitation (TBI-RR) program[19] and allowing for VDC use while they reside in an assisted living facility. This approach can help ensure smoother transitions back to a home environment, as the TBI-RR program is generally only for a limited time. Coordination can similarly be improved at VA's Polytrauma/TBI system of care Rehabilitation Centers and network sites, where veterans with elevated care needs prepare to return home with ongoing needs for support.

Wounded Warrior Project would be grateful for the opportunity to continue working with Sen. Cassidy and members of the Committee to pass this important legislation.

S. 4220: *Veterans Health Administration Novel Therapeutics Preparedness Act*

Despite historic investment in mental health care, veteran suicide rates remain unacceptably high, exceeding 6,000 deaths annually and far outpacing rates among non-veterans. This reality underscores that traditional mental health treatments have not produced durable improvements for all veterans. Innovate therapies, including certain psychedelic-assisted therapies currently under Food and Drug Administration (FDA) evaluation, may offer new options for a subset of veterans who have exhausted existing treatments. These interventions require a fundamentally different model of care, one that depends on specialized infrastructure,

[18] U.S. DEP'T OF VET. AFFAIRS, FY 2027 BUDGET SUBMISSION: MEDICAL PROGRAMS 2 OF 5 102–03 (2026).
[19] U.S. DEP'T OF VET. AFFAIRS, *Traumatic Brain Injury – Residential Rehabilitation (TBI-RR)*, https://www.va.gov/geriatrics/pages/Traumatic_Brain_Injury_Residential_Rehabilitation_TBI_RR.asp (last visited Apr. 27, 2026).

interdisciplinary teams, and rigorous safety oversight beyond what VA's traditional mental health delivery system has historically supported.

The *Veterans Health Administration Novel Therapeutics Preparedness Act* directly responds to this evolving landscape by establishing an Office of Novel Therapeutics within the Veterans Health Administration (VHA). The bill creates centralized leadership through a director position empowered to plan infrastructure, coordinate policy, and guide implementation should new therapies demonstrate safety and efficacy. It also authorizes VA to establish Centers of Excellence and convene a federal advisory committee of experts to support evidence-based adoption of novel therapeutic models that differ fundamentally from standard outpatient mental health care. This bill does not mandate the use of any specific therapy, nor does it suggest these treatments are appropriate for all veterans. Rather, it focuses on preparedness – ensuring that VA has the leadership, infrastructure, and processes in place to responsibly implement new models of care if and when the scientific evidence supports their use.

The legislation complements President Trump's April 18, 2026, Executive Order 14401: *Accelerating Medical Treatments for Serious Mental Illness* directing federal agencies to accelerate evaluation and access pathways for innovative treatments for serious mental illness, particularly for veterans, while operating within existing law and prioritizing safety and rigorous clinical evaluation. Together, these efforts reflect a growing recognition that a one-size-fits-all approach is insufficient to reduce suicide risk, even as careful evaluation of clinical outcomes and safety measures remains essential.

Wounded Warrior Project supports the *Veterans Health Administration Novel Therapeutics Preparedness Act* and would be grateful for the opportunity to work with Sen. Sheehy and the Committee to continue refining this legislation and elevating its shared intent to advance research and clinical access to psychedelic-assisted therapy in a manner consistent with VA's evolving operational plans and patient safety priorities. In addition to consideration alongside Executive Order 14401, the creation of a new central coordinating office must be evaluated within the broader VHA reorganization efforts to ensure that emerging therapies fit within system-wide governance, safety, and clinical oversight systems.

S. 4108: *Veteran Burial Benefit Correction Act*

Currently, the cost of burial and funeral services has steadily risen over time, and this creates a growing financial burden for surviving families at an already difficult moment in their lives. For veterans who pass away as a result of service-connected injuries, the VA's current burial benefit has not kept pace with inflation, leaving grieving surviving spouses and families to cover significant out of pocket expenses that diminish the intent of this benefit. This legislation fixes this long-standing problem that VA burial benefits have failed to keep pace with funeral costs, negatively impacting the financial security of families and caregivers during periods of grief. Families would feel immediate relief at the reduction of immediate out-of-pocket burial expenses and would not have to rely on emergency debt relief through short-term loans or crowdfunding.

The *Veterans Burial Benefit Correction Act* seeks to address this problem by increasing the burial and funeral expense payment from $2,000 to $3,000 and establishing an automatic annual adjustment tied to the Consumer Price Index (CPI) ensuring the benefit maintains its intended value over time.

Wounded Warrior Project is pleased to support this legislation.

Discussion Draft: *Maternal Health for Veterans Act*

Women veterans face elevated maternal health risks that require coordinated, continuous care before, during, and after pregnancy. According to a 2024 Government Accountability Office (GAO) report, pregnant veterans are more likely than non-veterans to have co-occurring physical and mental health conditions that contribute to adverse maternal outcomes, and VA data has shown that the rate of severe maternal morbidity among veterans nearly doubled, from 93.5 to 184.6 per 10,000 VA-paid deliveries, between fiscal years 2011 and 2020, with the highest rates observed among Black veterans.[20,21] In response to these challenges, Congress enacted the *Protecting Moms Who Served Act* (P.L. 117-69) to strengthen VA's maternity care coordination and improve transparency around maternal health outcomes for veterans. While that law established important guardrails, its one-year funding authorization and limited reporting scope constrained the ability to assess long-term effectiveness, monitor outcomes, and ensure VA is positioned to meet growing demand for maternity care services.

The *Maternal Health for Veterans Act* reauthorizes funding for VA's maternity care coordination program at $15 million per year for five years. The bill also requires VA to report on how the funds are being used, maternal health outcomes among veterans receiving VA care, maternal outcomes for veterans dually eligible for care through VA and the Indian Health Service, and departmental recommendations to further improve maternal health outcomes. The legislation does not alter eligibility, create new clinical authorities, or mandate new services.

By extending funding and requiring regular reporting to Congress, the bill would strengthen oversight of VA's maternity care coordination while supporting continuity and stability in program delivery. The reporting requirements can improve transparency around outcomes and disparities, including among populations that may face elevated maternal health risks, while preserving VA's clinical flexibility. This data-driven approach would allow Congress to better evaluate whether existing programs are functioning as intended and where targeted improvements may be necessary, without imposing prescriptive mandates on VA.

Wounded Warrior Project is pleased to support the *Maternal Health for Veterans Act*; however, and we note one technical issue that may warrant attention. The bill ties funding to a maternity care coordination program described in a Veterans Health Administration handbook that has since been rescinded and replaced by an updated VHA directive. Referencing outdated policy could create unnecessary legal or implementation ambiguity. We believe that updating

[20] U.S. GOV'T ACCOUNTABILITY OFF., GAO-24-106209, VA SHOULD IMPROVE ITS MONITORING OF SEVERE MATERNAL COMPLICATIONS AND MENTAL HEALTH SCREENINGS (2025).
[21] Kritee Gujral et al., *Severe Maternal Morbidity and Potential Disparities by Race and Rurality Among VA-Covered Births, 2010 to 2020*, AM. J. OBSTETRICS & GYNECOLOGY (2025) (*available at* https://pubmed.ncbi.nlm.nih.gov/ 39708938/).

the legislative language to reflect VA's current maternity care coordination directive would better align the statute with existing practice and strengthen the bill's long-term effectiveness.

S. 4197: *Veterans Outdoor Rehabilitation Act*

The mental and physical health benefits of outdoor recreation are well documented, and VA recognizes that engaging with nature can reduce stress, improve mood, and strengthen coping skills through accessible, low-cost activities integrated into daily life. VA research, including work from the South Central Mental Illness Research, Education, and Clinical Center, shows that even brief, regular time outdoors can enhance wellbeing and emotional regulation, including for veterans facing mobility or disability related barriers.[22] For many veterans, traditional clinical treatments alone do not provide the holistic recovery they seek, particularly for service-connected mental health conditions, and outdoor recreation programs can help fill this gap and should be made more readily available to all veterans.

The *Veterans Outdoor Rehabilitation Act* would establish a grant program administered by VA that provides $10,000,000 in annual funding to state veterans departments or agencies to create or expand structured outdoor recreation programs aimed at enhancing veteran wellness. Each eligible state would receive a minimum of $200,000 to support activities such as directly developing and administering programs, contracting with local providers, reducing participation costs for veterans, conducting outreach, expanding existing offerings, and coordinating with federal land management agencies including the National Park Service, Bureau of Land Management, Forest Service, Fish and Wildlife Service, and Army Corps of Engineers. At the minimum award level, the program could support up to 50 grantees annually and authorizes funding on an ongoing basis and allows any unawarded funds to be redistributed among grantees. The bill also includes annual reporting requirements that would capture both participation data and self-reported outcomes related to wellbeing, social connectedness, and physical activity, creating an opportunity to demonstrate program impact. Importantly, grant funds may be used to cover equipment, fees, and reasonable transportation costs, a provision that is especially critical for veterans with disabilities who rely on adaptive equipment and may face additional barriers to participation.

Wounded Warrior Project would be grateful for the opportunity to continue working with Sen. Cramer and members of the Committee to pass this important legislation, and we specifically urge deeper consideration of ongoing complementary efforts.

Title II of the *EXPLORE Act* (P.L. 118-234) directed federal agencies to improve coordination, planning, and accessibility related to outdoor recreation through shared inventories, accessibility assessments, and data-driven planning tools. The statute emphasizes reducing participation barriers by improving how agencies identify, plan for, and communicate access to outdoor opportunities, rather than focusing on land management or infrastructure alone. By establishing common planning structures and encouraging interagency alignment, Title II seeks to ensure that efforts to expand outdoor recreation access are consistent, accessible, and informed by reliable data across jurisdictions.

[22] Austen Anderson, *The Great Outdoors: Engaging with Nature for Mental Health*, U.S. DEP'T OF VET. AFFAIRS, https://mirecc.va.gov/MIRECC/VISN16/docs/the-great-outdoors-veteran-guide.pdf.

To strengthen implementation and reduce the risk of overlapping or fragmented efforts, more explicit alignment with *EXPLORE Act* planning tools, recreational inventories, and accessibility assessments would be beneficial. Encouraging use of these shared planning structures would help reduce duplication and support coordination with existing federal access and infrastructure efforts. In addition, aligning reporting metrics with common data standards established under the *EXPLORE Act* would improve comparability across states while minimizing reporting burden. Encouraging interstate collaboration and the sharing of best practices would further support consistency without limiting state flexibility.

The Task Force on Outdoor Recreation for Veterans (see P.L. 116-214 § 203) built on this approach by identifying participation-focused barriers specific to veterans. In its February 2026 final report, the Task Force found that challenges such as limited awareness of programs, accessibility for veterans with disabilities, transportation constraints, cost, and inconsistent coordination across VA, public land agencies, and veteran outdoor recreation organizations continue to limit veteran engagement.[23] To address these barriers, the Task Force recommended strengthening coordination through communities of practice among federal public land agencies, improved engagement with veteran organizations via special use permit programs and military Morale, Welfare, and Recreation partnerships, consideration of a resource guide to facilitate formal partnerships, and the feasibility of training for VA providers and public land staff on promoting accessible and adaptive nature-based experiences. The Task Force also emphasized measures to reduce participation barriers directly, including promoting access through a Veterans Wellness Challenge, conducting an environmental scan of VA outdoor recreation offerings, and establishing a centralized VA database and communication strategy to improve awareness, coordination, and sustainability.

Consistent with the findings and recommendations of the Task Force on Outdoor Recreation for Veterans, implementation should explicitly encourage accessibility and adaptive programming, affirm that veterans may not be excluded from participation based on disability status subject to reasonable program requirements, and promote inclusive design across funded programs. Further, incorporating a periodic, program-level evaluation focused on participation, access outcomes, and coordination would strengthen accountability and help ensure the program evolves in alignment with the participation-focused approach advanced by the Task Force. Together, these measures would help ensure that state-administered grants reflect the Task Force's emphasis on reducing barriers and improving veteran engagement in outdoor recreation.

Agenda items not addressed in this Statement for the Record

- **S. 3098, the *Presumptive CLARITY Act of 2025***
- **S. 3286, the *Veterans Appeals Improvement and Modernization Act***
- **S. 3591, the *Thomas M. Conway Veterans Access to Resources in the Workplace Act***
- **S. 3653, the *Veterans' Bill of Rights Act of 2026***
- **S. 3706, the *Produce Prescriptions for Veterans Act***
- **S. 4140, the *Carlton H. Ingram Veterans' Benefits Protection Act***

[23] U.S. DEP'T OF VET. AFFAIRS, CONGRESSIONALLY MANDATED REPORT: INTERAGENCY TASK FORCE ON OUTDOOR RECREATION FOR VETERANS – FINAL REPORT (Feb. 2026).

- **Discussion Draft, the *Optimizing the VA Workforce for Veterans Act of 2026***

Concluding Remarks

Wounded Warrior Project once again extends our thanks to the Committee 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.