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STATEMENT OF

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UNDER SECRETARY FOR HEALTH

BEFORE THE
SENATE COMMITTEE ON VETERANS' AFFAIRS

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Good morning Mr. Chairman and Members of the Committee:

Thank you for inviting me here today to present the Administration's views on several bills that would affect Department of Veterans Affairs (VA) programs that provide veterans benefits and services. With me today is Walter A. Hall, Assistant General Counsel. I will address the five bills on today's agenda and then I would be happy to answer any questions you and the Committee members may have.

S. 2142 "Veterans Emergency Care Fairness Act of 2007"
S. 2142 would make mandatory, standardize, and enhance the two existing authorities the Secretary has to pay for expenses incurred in connection with a veteran's receipt of emergency treatment in a non-VA facility. The two authorities under which the Secretary may currently pay these claims are discretionary in nature ("may reimburse" as opposed to "shall reimburse") and cover different veteran populations and use different standards to define a medical emergency.

As background, the Secretary is authorized to pay the reasonable expenses incurred by a veteran for non-VA emergency treatment of a service-connected disability, a non-service-connected disability aggravating a service-connected disability, any disability of a veteran with a permanent and total disability, or for a covered vocational rehabilitation purpose. In these claims, VA medical professionals must determine whether a medical emergency existed (i.e., if there was an actual emergency of such nature that delay in obtaining treatment would have been hazardous to life or health.) Expenses incurred after the medical emergency has ended, that is, after the point in time the veteran could have been transferred safely to VA or another Federal facility, may not be reimbursed.

The Secretary may also reimburse or pay a veteran for expenses incurred for non-VA emergency treatment of a non-service connected disability. In these claims, the law requires use of a prudent layperson standard to determine the need for the non-VA emergency treatment. Thus, if it turns out that the veteran's condition was not an actual medical emergency, VA can still pay the expenses if a prudent layperson would have thought it reasonable for the veteran to seek immediate medical treatment. This happens, for instance, when a veteran goes to the nearest emergency room because of the belief he or she is having a heart attack but turns out only to

have a severe case of heartburn. Similar to claims for service-connected conditions, the Secretary is only authorized to pay for the emergency treatment expenses, and the emergency ends at the point the veteran can be transferred safely to a VA facility or other Federal facility.

S. 2142 would amend both existing authorities by requiring the Secretary to pay the expenses of any veteran who meets eligibility criteria. It would also standardize these programs by applying the prudent layperson definition of "emergency treatment" in both situations. And most importantly it would define "emergency treatment" as continuing until (1) the point in time the veteran can be transferred safely to a VA or other Federal facility, or (2) such time as a VA facility or other Federal facility agrees to accept such transfer if, at the time the veteran could have been transferred safely, the non-VA provider makes and documents reasonable attempts to transfer the veteran to a VA facility or other Federal facility.

VA strongly supports S. 2142; effective emergency room reimbursement has been an issue of concern to the Department. In fact, VA is in the process of drafting regulations to address these concerns within the authority it has under current law.

It is VA's expectation that facilities aggressively work to accept the transfer of a veteran in these situations. We are aware, however, that there have been cases where VA has been unable to find a facility that had the bed, capability, staff, or resources needed to furnish the care required by the veteran. In those cases, which we believe are the exception and not the norm, the non-VA providers ultimately billed the veterans for those expenses. This can impose a serious monetary hardship for our beneficiaries.

S. 2142 would properly put the financial onus on the Department to provide appropriate care either in the VA or Federal system or at the non-VA facility. Enrolled veterans are eligible for needed hospital or medical care. Good medical practice demands we furnish such care in a manner that advances a seamless continuum of care and reduces fragmentation of such care. Clearly these goals are best achieved by bringing the veteran into the VA health care system as soon as possible. In those rare cases where VA cannot immediately agree to accept the patient transfer, it would be entirely appropriate for VA to be responsible for the expenses related to the veteran's needed continued hospital care in the private facility until the point VA can take over.

When VA initiated drafting regulations for this program choice, it determined funds were available within the FY2008 President's Budget level for this expanded benefit.

As a final and more technical matter, I would like to clarify that if a veteran currently meets the eligibility criteria on which his or her claim is based, VA invariably pays the claim. Thus, changing the Secretary's authority from "may" to "shall" for purposes of both types of claims would have no practical effect. Nevertheless, we do not object to such a change.

S. 38 "Veterans' Mental Health Outreach and Access Act of 2007"

Section 2 of S. 38
Section 2 of S. 38 would require the Secretary to establish, not later than 180 days after enactment of the bill, a program to provide veterans of Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) "peer outreach services, peer support services, readjustment

counseling services, and mental health services." As part of this program, the Secretary would be required to furnish education, support, counseling, and mental health services to a veteran's immediate family members to assist: in the veteran's readjustment to civilian life, the veteran's recovery, and the readjustment of the family following the return of the veteran.

S. 38 would also require the Secretary to contract with community mental health centers and other qualified entities to provide the peer related, readjustment, and mental health services in areas the Secretary determines are not adequately served by VA health care facilities. Such contracts would require, to the extent practicable, that veterans providing peer related services receive training from a national not-for-profit mental health organization, which contracts with VA for this purpose. In addition, the contractor's clinicians would be required to (1) complete mandated training to ensure the clinicians can provide services in a manner that recognizes factors that are unique to the experience of OEF/OIF veterans and (2) to utilize best practices and technologies.

The centers and entities would have to comply with applicable VA protocols before incurring any liability on behalf of the Department; submit specified reports and certain clinical information to the Secretary; and meet any other requirements established by the Secretary.

VA supports many of the initiatives and certainly the stance of aggressive outreach that underlies this provision. VA does not, however, support section 2 as it is unnecessary and duplicative of current authorities. Veterans of OEF/OIF combat operations already qualify for readjustment counseling services and related mental health services under existing authority. (While limited mental health services are available in the Vet Center program, Vet Centers refer veterans with complex mental health conditions to VA medical centers.) VA's readjustment counseling authority provides for the furnishing of mental health services, consultation, professional counseling, and training to the combat veteran's immediate family members as needed for the veteran's effective and successful readjustment back to civilian life. Vet Centers are also authorized to contract for the provision of readjustment counseling services and related mental health services. Vet Centers routinely rely on contracted services to meet the readjustment needs of veterans residing in rural areas. Hence, the additional authorities related to the provision of readjustment counseling services and related mental health services for OEF/OIF veterans (either through the Vet Centers or by contract) are generally duplicative and simply not needed.

Vet Centers are already providing veteran-peer outreach and counseling services. In 2004, VA began an aggressive outreach effort, which included the hiring of OEF/OIF combat-theater veterans to provide outreach services and peer-counseling to their fellow veterans. To date, the Vet Center program has hired 100 OEF/OIF outreach workers. The Vet Center program is also undergoing the largest expansion in its history. This expansion complements the Vet Center peer outreach services initiative. These efforts together enable our Vet Centers to ensure there are sufficient staff and resources to provide the professional readjustment services needed by the new veterans as they return home.

OEF/OIF combat-theater veterans are also already eligible to enroll within two years of the date of discharge or release from active duty in VA's health care system and receive VA's comprehensive medical benefits package.

As to family support services, VA is already required to provide immediate family members of a veteran being treated for a service-connected disability with such mental health services, consultation, professional counseling, and training as necessary in connection with that treatment.

If a veteran is being treated for a non-service connected disability, the law currently authorizes the Secretary to provide family services if: the services are initiated during the veteran's hospitalization and the continued provision of these services on an outpatient basis is essential to permit the discharge of the veteran from the hospital.

We believe no additional authority is needed as the vast majority of family members of returning OEF/OIF veterans already qualify for these services. However, neither existing authority extends to providing a veteran's family members with mental health services for their individual mental health needs that are separate and apart from the veteran's treatment needs. It is unclear whether S. 38 is intended to authorize individual mental health benefits for family members beyond services needed to assist the veteran's treatment and readjustment. If that is the case, we could not support that provision for the following reasons.

Mental health conditions often manifest with physical symptoms or sequella. In those cases, providing only mental health services to assist in a family member's readjustment could result in fragmented and inadequate treatment. The receipt of other medical care could be equally essential for that member's successful readjustment, and the failure to receive such care could impair the ability of the family as a whole to successfully readjust to the veteran's return. For that reason, we believe it would be more reasonable, from a health care perspective, to continue linking family support services to those that are essential for the veteran's readjustment. Family members should continue to receive needed mental health services from their regular providers who can treat them from a whole-person perspective and concurrently address all of their medical needs.

Also, when VA contracts for services in the community, community health centers may compete for those contracts. The provision to require VA to contact specifically with that entity may reduce the opportunity for the veteran to be cared for by the most highly qualified competent contractor.

We also note that OEF/OIF veterans who are permanently and totally disabled from a service-connected disability are able to sponsor their spouses and children in VA's Civilian Health and Medical Program (commonly referred to as "CHAMPVA"). Once enrolled in that program, their family members will be eligible to receive relatively comprehensive VA medical benefits.

As a final comment on this section, we are uncertain what is meant by the provision requiring centers to comply with VA protocols before incurring any liability on behalf of the Department.

Section 3 of S. 38
Section 3 of S. 38 would extend from 2 years to 5 years, combat-theater veterans' window of eligibility to enroll without regard to whether they have a service connected disability or their income level. VA strongly supports section 3. As the leading researcher in PTSD medicine, VA has known that the onset of symptoms or adverse health effects related to PTSD and even

traumatic brain injury can often be delayed and not manifest clinically for more than two years after a veteran has left active service. As a result, OEF/OIF may not seek VA health care benefits until after their two-year window of eligibility has already closed. Without that basis of eligibility, they may be ineligible to enroll because of the current bar on enrolling new veterans in Category 8.

We are also aware that many of these veterans are not career military and are less familiar with veterans benefits and the procedures for obtaining them. For that reason they may fail to enroll in a timely fashion.

Providing combat-theater veterans with an additional three years within which to enroll in VA's health care system will help ensure that none of them is denied the care they need and deserve for reasons wholly beyond their control. VA estimates the costs associated with enactment of section 3 to be $15.7 million in Fiscal Year 2008, and this expansion can be accommodated within the FY2008 President's Budget level. This estimate includes both expenditures and lost co-payment revenue.

S. 2004 "Epilepsy Centers of Excellence"

S. 2004 would require the Secretary, not later than 120 days after enactment of this provision, to designate at least six Department health-care facilities as epilepsy centers of excellence based on the recommendation of the Under Secretary for Health (USH). The mandate to establish and operate these centers, however, would be subject to the availability of appropriations for this purpose.

The bill defines an "epilepsy center of excellence" as a Department health-care facility that has (or in the foreseeable future can develop) the necessary capacity to function as a center of excellence in research, education, and clinical care activities in the diagnosis and treatment of epilepsy. To qualify as a center, the facility would need:

- An affiliation with an accredited medical school that provides education and training in neurology (or may reasonably be anticipated to develop such an affiliation).
- The ability to attract scientists of ingenuity and creativity.
- An advisory committee composed of veterans and appropriate health-care and research representatives of the facility and of the affiliate.
- The capability to effectively evaluate the activities of the centers.
- The capability to coordinate the centers' education, clinical care, and research activities.
- The capability to develop a national consortium of providers with interest in treating epilepsy at VA medical centers; the consortium would have to include a designated epilepsy referral clinical in each Veterans Integrated Service Network.
- The capability to assist in the expansion of VA's use of information systems and databases to improve the quality and delivery of care.

- The capability to assist in the expansion of VA's tele-health program to develop, transmit, monitor, and review neurological diagnostic tests.

• The ability to perform epilepsy research, education, and clinical care activities in collaboration with VA's Poly-Trauma Centers.

A number of specific requirements governing the competitive selection of the six facilities are set forth in the bill, including a requirement that the Secretary consider appropriate geographic distribution when making the selections.

S. 2004 would further mandate the designation of an individual in VHA to act as a national coordinator for VHA's epilepsy programs. The bill includes a list of duties for that position, including that such individual report to the VHA official responsible for neurology.

The bill would authorize $6 million for each of fiscal years 2008 through 2012 to establish and operate the centers; such sums as may be necessary for operating the centers for each fiscal year after fiscal year 2012 would also be authorized. For the first three years of the centers operation, the bill would require that the centers be designated as a special purpose program in order to avoid funds for the centers being allocated through the Veterans Equitable Resource Allocation system. In addition to those amounts, the USH would be required to allocate such amounts as he deems appropriate from other funds made available to VHA. The bill includes a separate authorization of appropriations to fund the national coordinator position.

VA does not support S. 2004. As I have discussed in the past, I am concerned that statutory mandates for "disease specific" centers have the potential to fragment care in what is otherwise a well-designed, world-class integrated health care system. I am increasingly concerned about the proliferation of this disease-specific model and its impact on patient care and VA's integrated health care model. As it relates to a particular disease, I believe that it is much more important for VA to disseminate the best in evidence-based practices across its health care system than to establish centers that provide care for a particular disease.

Treating epilepsy, like every other serious condition, requires an interdisciplinary approach. By mandating new "education, research, and clinical centers" that are disease-specific, flexibility to respond to changing combinations of related conditions is reduced. The centers' mandated collaboration with VA's Poly-trauma Centers would not cure this short-coming.

It is also important to note that the "models" on which these Epilepsy Centers are based, the successful Geriatric Research, Education and Clinical Center (GRECC) and Mental Illness Research, Education and Clinical Center (MIRECC) programs, are not narrowly-focused on a disease process but address a wide gamut of issues facing a significant portion of the veteran population.

S. 2160 "Veterans Pain Care Act of 2007"

S. 2160 would require the Secretary to carry out an initiative on pain care management at each VA health care facility. Under the initiative, each individual receiving treatment in a VA facility would receive: (1) a pain assessment at the time of admission or initial treatment and periodically

thereafter, using a professionally recognized pain assessment tool or process; and (2) appropriate pain care consistent with recognized means for assessment, diagnosis, treatment, and management of acute and chronic pain, including, when appropriate, access to specialty pain management services. The initiative would have to be implemented at all VA health care facilities by not later than January 1, 2008, in the case of inpatient care and by not later than January 1, 2009, in the case of outpatient care.

The bill would further require the Secretary to carry out a program of research and training on acute and chronic pain within VHA's Medical and Prosthetic Research Service. These programs would be directed to meet the purposes specified in the bill. The Secretary would also be required to designate an appropriate number of facilities as cooperative centers for research and education on pain. Each such center would focus on research and training in one or more of the following areas: acute pain; chronic pain, or a research priority identified by VHA. The Secretary would also need to designate at least one of those centers as a lead center for research on pain attributable to central and peripheral nervous system damage commonly associated with the battlefield injuries characteristic of modern warfare. Another center would be the lead for coordinating the pain care research activities conducted by the centers and responsible for carrying out a number of other duties specified in the bill.

The measure would permit these centers to compete for funding from amounts appropriated to the Department each year for medical and prosthetics research. It would also charge the USH with designating an appropriate official to oversee their operation and to evaluate their performance.

VA health care is delivered in accordance with patient-centered medicine. Fundamental to this is effective pain management. In 2003 VHA established a National Pain Management Strategy to provide a system-wide approach to pain management to reduce pain and suffering for veterans experiencing acute and chronic pain associated with a wide range of illnesses. The national strategy uses a system-wide standard of care for pain management; ensures that pain assessment is performed in a consistent manner; ensures that pain treatment is prompt and appropriate; provides for continual monitoring and improvement in outcomes of pain treatment; uses an interdisciplinary, multi-modal approach to pain management; and ensures VA clinicians are prepared to assess and manage pain effectively. The national strategy also called for pain management protocols to be established and implemented in all clinical settings and directed all VHA medical facilities to implement processes for measuring outcomes and quality of pain management.

To oversee implementation of the National Pain Management System, VHA established an interdisciplinary committee. Part of the committee's charge is to ensure that every veteran in every network has access to pain management services. The committee is also responsible for making certain that national employee education is provided to VHA clinicians so that they have the needed expertise to provide high quality pain assessment and treatment and for identifying research opportunities and priorities in pain management. It also facilitates collaborative research efforts and ensures that VHA pain management standards have been integrated into the curricula and clinical learning experiences of medial students, allied health professional students, interns, and resident trainees.

Because pain management is already a subject of systematic and system-wide attention in the VHA health care system, S. 2160 is superfluous and duplicative of what is already happening in VA healthcare. We would be very happy to meet with the Committee to discuss VA's ongoing pain management program and activities.

S. 2162 "Mental Health Improvements Act of 2007"
Title I. Substance Use Disorders and Mental Health Care
Mr. Chairman, title I of this bill focuses on VA treatment programs for substance use disorders and mental health disorders, particularly PTSD. Section 102 would require the Secretary to ensure the provision of the following services for substance use disorders at every VA medical center:

- Short term motivational counseling services.
- Intensive outpatient care services.
- Relapse prevention services.
- Ongoing aftercare and outpatient counseling services.
- Opiate substitution therapy services.
- Pharmacological treatments aimed at reducing cravings for drugs and alcohol.
- Detoxification and stabilization services.
- Such other services as the Secretary deems appropriate.

The Secretary could, however, exempt an individual medical center or Community-Based Outpatient Clinic (CBOC) from providing all of the mandated services. Annually the Department would have to report to Congress on the facilities receiving an exemption under this provision, including the reason for the exemption.

Section 103 would require the Secretary to ensure that VA treatment for a veteran's substance use disorder and a co-morbid mental health disorder is provided concurrently by a team of clinicians with appropriate expertise.

Section 104 would require the Secretary to carry out a program to enhance VA's treatment of veterans suffering from substance use disorders and PTSD through facilities that compete for funds for this purpose. Funding awarded to a facility would be used for the six purposes specified in the bill, in addition to the conduct of peer outreach programs through Vet Centers to re-engage OEF/OIF veterans who miss multiple appointments for PTSD or a substance use disorder. Another specified purpose for the funds would be to establish collaboration between VA's urgent care clinicians and substance use disorder and PTSD professionals to ensure expedited referral of veterans who are diagnosed with these disorders.

Not later than one year after the bill's enactment, the Secretary would need to submit a report to Congress on this program and the facilities receiving funding.

S. 2162 would provide for funding by requiring the Secretary to allocate $50 million from appropriated funds available for medical care for each of fiscal years 2008, 2009, and 2010. The bill would require the total expenditure for PTSD and substance use disorder programs to not be less than $50 million in excess of a specified baseline amount. (The bill would define the

baseline as the amount of the total expenditures on VA's treatment programs for PTSD and substance use disorders for the most recent fiscal year for which final expenditure amounts are known, as adjusted to reflect any subsequent increase in applicable costs to deliver those programs.)

Section 105 would require the Secretary to establish not less than six national centers of excellence on PTSD and substance use disorders. These centers would provide comprehensive inpatient treatment and recovery services to veterans newly diagnosed with these disorders. Sites for the centers would be limited to VA medical centers that provide inpatient care; that are geographically situated in an area with a high number of veterans that have been diagnosed with both PTSD and substance use disorder; and that are capable of treating PTSD and substance use disorders. This provision would also direct the Secretary to establish a process to refer and aid the transition of veterans receiving treatment in these centers to programs that provide step down rehabilitation treatment.

Section 106 would require the Secretary, acting through the Office of the Medical Inspector (MI), to review all of VA's residential mental health care facilities and to submit to Congress a detailed report on the MI's findings.

Section 107 would provide for title I of this bill to be enacted in tribute to Justin Bailey, an OIF veteran who died while under VA treatment for PTSD and a substance use disorder.

While VA respects the attention this Committee is giving these critical issues, Title I is overly prescriptive and attempts to mandate the type of treatments to be provided to covered veterans, the treatment settings, and the composition of treatment teams. Treatment decisions should be based on professional medical judgments in light of an individual patient's needs, and experienced health care managers are in the best position to decide how best to deliver needed health care services at the local level. With regard to the proposed centers of excellence, we reiterate our concerns about disease-specific treatment centers and models, although we appreciate the Committee's efforts thereby to hasten the eradication of those particular diseases. For all of the above reasons, we do not support this title.

Title II. Mental Health Accessibility Enhancements

Section 201 would require the Secretary to establish a three-year pilot program to assess the feasibility and advisability of providing eligible OEF/OIF veterans with peer outreach services, peer support services, and readjustment counseling services, and other mental health services. This pilot would begin not later than 180 days after the bill's enactment. Eligible veterans would include those who are enrolled in VA's health care system and who, for purposes of the pilot program, receive a referral from a VHA health professional to a community mental health center or to a facility of the Indian Health Service (IHS).

In providing readjustment counseling services and other mental health services to rural veterans who do not have adequate access to VA services, section 201 would require the Secretary, acting through the Office of Rural Health, to contract for those services with community mental health centers (as defined in 42 CFR §410.2) and IHS facilities.

Sites for the pilot would need to include at least two Veterans Integrated Service Networks (selected by the Secretary), and at least two of the sites would have to be located in rural areas that lack access to comprehensive VA mental health services.

A center or IHS facility that participates in the pilot program must, to the extent practicable, provide readjustment counseling services and other mental health services to eligible veterans through the use of telehealth services. It would also need to provide the services using best practices and technologies and meet any other requirements established by the Secretary. A participating center or IHS facility would also have to comply with applicable VA protocols before incurring any liability on behalf of the Department and provide clinical information on each veteran to whom it furnishes services.

The Secretary would be required to carry out a national program of training for (1) veterans who would provide peer outreach and peer support services under the pilot program; and (2) clinicians of participating centers or IHS facilities to ensure they can furnish covered services and that such services will be provided in a manner that accounts for factors unique to OEF/OIF veterans. This provision would also establish detailed annual reporting requirements for participating centers and facilities.

As we discussed in connection with section 2 of S. 38, all of these services are already available to OEF/OIF veterans, including those who served in the National Guard or the Reserves. As such, no demonstrated need exists for the pilot program or these additional authorities, which are duplicative of currently existing authorities. And VA is already working with other entities to provide treatment to veterans at the local level if VA is not able to provide the needed care; therefore, the requirement to contract specifically with a community health center or IHS facility would limit the local VA providers' flexibility in finding the most appropriate care for our veterans.

Title III. Research

Section 301 would require the Secretary to carry out a program of research into co-morbid PTSD and substance use disorder. The purpose of this program would be to address co-morbid PTSD and substance use disorder; provide systematic integration of treatment for these two disorders; develop protocols to evaluate VA's care of veterans with these disorders; and, facilitate the cumulative clinical progress of these veterans. This provision would charge VA's National Center for PTSD with responsibility for carrying out and overseeing this program, developing the protocols and goals, and coordinating the research, data collection, and data dissemination.

Section 301 would also authorize $2 million to be appropriated for each of fiscal years 2008 through 2011 to carry out this program and specifically require these funds be allocated to the National PTSD Center. The funds made available to the Center would be in addition to any other amounts made available to it under any other provision of law.

Section 302 would continue the Special Committee on PTSD (which is established within VHA) through 2012; otherwise the Committee's mandate would terminate after 2008.

While well-intended, this title is overly prescriptive and more importantly altogether unnecessary. Therefore, with the exception of the extension of the Special Committee, VA does not support the provisions in title III. VA is a world-recognized leader in the care of both PTSD and substance use disorders, particularly when these conditions co-exist in an individual. The activities required by title III are essentially duplicative of VHA's on-going efforts in this area, particularly the research efforts being carried out by VA's National PTSD Center. We would welcome the opportunity to brief the Committee on VA's achievements and efforts in this area, plus the role of the Office of Mental Health in overseeing the PTSD and substance abuse programs.

Title IV. Assistance for Families of Veterans
In connection with the family support services authorized in chapter 17 of title 38, United States Code (i.e., mental health services, consultation, professional counseling, and training), section 401 would amend the statutory definition of "professional counseling" to expressly include marriage and family counseling. This provision would also ease eligibility requirements for these family support services by authorizing the provision of these services when considered appropriate (as opposed to essential) for the effective treatment and rehabilitation of the veteran. Section 401 would further clarify that these services are available to family members in Vet Centers, VA medical centers, CBOCs, or other VA facilities the Secretary considers necessary.

Section 402 would require the Secretary to carry out, through a non-VA entity, a three-year pilot program to assess the feasibility and advisability of providing "readjustment and transition assistance" to veterans and their families in cooperation with Vet Centers. Readjustment and transition assistance would be defined as readjustment and transition assistance that is preemptive, proactive, and principle-centered. It would also include assistance and training for veterans and their families in coping with the challenges associated with making the transition from military to civilian life.

This provision would require services furnished under the pilot program to be furnished by a for-profit or non-profit organization(s) selected by the Secretary (pursuant to an agreement). To participate in the pilot, a participating organization(s) must have demonstrated expertise and experience in providing those types of services.

The pilot program would have to be carried out in cooperation with 10 geographically distributed Vet Centers, which would be responsible for promoting awareness of the assistance available to veterans and their families through the Vet Centers, the non-VA organization(s) conducting the pilot, and other appropriate mechanisms.

Section 403 would establish detailed reporting requirements and authorize $1 million to be appropriated for each of fiscal years 2008 through 2010 to carry out the pilot program. Such amounts would remain available until expended.

VA does not support title IV. First, it is unclear how these "readjustment and transition assistance" services are intended to differ from, or interact with, the readjustment counseling services and related mental health services already made available to veterans and their families through the Vet Centers. In our view, this provision would conflict in many respects with VA's

existing authorities to provide readjustment counseling and related mental health services and lend confusion to what is otherwise a highly successful program (particularly with respect to client outreach). Indeed, client satisfaction with the Vet Centers is the highest of VA's programs (98%). The services they provide already include marriage and counseling services to family members as necessary to further the veteran's readjustment.

We also do not understand the perceived need for reliance on non-VA organizations for the provision of these services. Let me again assure you that our Vet Centers readily contract with appropriate organizations and providers to ensure veterans and their families receive covered family support services. In sum, we do not see how this provision would effectively enhance current authorities or Vet Center activities; rather, we see that it has serious potential to create confusion and disruption for both VA and our beneficiaries.

We are currently developing cost estimates on the provisions of these bills, which we will share with the Committee once completed. This concludes my prepared statement. I would be pleased to answer any questions you or any of the members of the Committee may have.